Testimony of
Timothy L. Charles
President and CEO
Mercy Medical Center
Cedar Rapids, IA
Before the
U.S. Senate Committee on Health, Education, Labor and Pensions
May 5, 2011

Senator Harkin, ranking member Enzi and members of this distinguished committee:

On behalf of Mercy Medical Center, Cedar Rapids Iowa I am gratified to have been asked to present our journey toward achieving and sustaining nationally ranked quality and safety.

Mercy was founded by the Sisters of Mercy in 1900 and for the past century has been devoted to a healthcare ministry of caring for the sick and improving the health of the communities we serve. The themes that thread their way through this long and unbroken history are to stand upon the ground of compassionate service established by the Sisters; provide the state of the art and science of medicine made possible by extremely talented providers, and the generosity of community members that see to it the organization is equipped with the most advanced facilities and technology; and finally, to place the needs of our patients and the common good at the center of all undertakings.

In December of 2009 we were invited by the Institute for Healthcare Improvement to present our path and results and to receive its recognition, along with our competitor hospital and the medical community, as one of the leading providers of high quality and cost effective care. I shared that Mercy's accomplishment was the result of years of dedicated effort and discipline. This invitation led to two additional meetings in Washington, with colleagues from a select group of communities chosen as they might offer innovative models to an industry desperately in need of reform.

The recent Commonwealth Fund case study released in March of this year recognizing Mercy as being in the top 3% of all facilities with respect to low readmission rates is further testament to this relentless commitment to quality improvement.

The pace of change at Mercy accelerated dramatically in 2003 when we became an early adopter of Dr. Don Berwick's 100,000 lives campaign and later the IHI Triple Aim: improve the health of the community and the patient experience while reducing costs. Today we can also look to the "Partnership for Patients" intention to improve quality, safety and affordability. I am pleased to inform you that Mercy Medical Center is now a member.

From 2003 forward the facility has been in relentless pursuit of improved quality while driving down costs- in other words eliminating waste. This has come in three ways:

decreasing unnecessary utilization of services; decreasing harm- through complications and/or unintended adverse outcomes; and, standardization of evidence-based practices. Long before the Accountable Care Act, Mercy was undertaking its own local initiatives.

This, in no small way, has been the product of dedicated medical institution functioning in a rather unique community where sharing knowledge and initiatives that improve quality is common, even amongst competitors. This cross-cultivation has all but assured the spread of best practices.

Specifically, with respect to treatment, the principle in play is "get it right the first time" and ensure that the treatment process is managed before, during and after acute admissions. For example, 100% of Mercy's 85 primary care providers are utilizing an electronic heath record. Health coaches are now embedded within these practices to augment and enhance the physicians' capacity to effectively interact with their respective patients to better manage chronic diseases such as diabetes, congestive heart failure, and to drive wellness and prevention initiatives.

Additionally, chronic disease management self-help courses are held throughout our community, led by Mercy trainers, supported by a curriculum developed at Stanford.

Every Mercy employed primary care physician is now on an incentive program designed to improve compliance with evidence based practices.

In the event that acute care is required, a myriad of initiatives have been undertaken to ensure top quality. Adopting the technology of LEAN, the facility is constantly challenging its performance and instituting initiatives that are evidence-based, standardized, and hard-wired. A few examples are, in 2003 rapids response teams were deployed, inpatient glycemic control protocols were instituted, clinical pharmacists were deployed to the floors to work side-by-side with bed-side nursing and physicians. In 2004, the palliative care consultative service was instituted and a 12 bed community-based hospice house was constructed. 2005 saw recognition of Mercy's cardiac care with the American Heart Associations “Get with the Guidelines” project. It has been nearly 18 months of consistent door to balloon times of less than 90 minutes, the national benchmark: in fact our times are consistently less than 50 minutes. In 2006 a Venous Thromboembolism prophylaxis initiative was instituted across all surgical and stroke patients. In 2007, an organization-wide initiative tackled hand-hygiene, the simplest and most impactful means of reducing the spread of infections. Linn County became a pilot for the state of Iowa undertaking IPOST- the creation of an advanced directives document that would be universally honored by all providers and institutions. You may have noticed that several of these, if not all are consistent with the nine areas of focus embedded within the “Partnership with Patients” Center for Innovation.

With each successive year, blending technology and LEAN process improvement the hospital environment has become safer and more reliable. Process improvement coupled with advanced technology, from robotics in the pharmacy, computerized SMART IV

pumps, bed-side medication verification and bar coding, vocera communications systems, the organization has grown in its sophistication.

The Commonwealth Fund's interest in readmissions and its subsequent identification of leading institutions is an important leading indicator of overall success in managing the clinical process. This success, from our perspective is the cumulative consequence of striving for and achieving many varied certifications and designation of expertise in specialty programs. A few examples are, the American College of Surgeons Commission on Cancer, American College of Radiologists Breast Imaging Center of Excellence, The Joint Commissions disease specific certifications such as the Advanced Primary Stroke Center and the Heart Attack in Women Program, as well as recognized as a most-wired hospital. These designations are important for the recognition that specific requirements have been met, a high standard of care has been measured and verified, and the commitment to excellence has been sustained.

The data that drives these initiatives is a critical dimension to our success story. Mercy reports core measures as all others do today. We also participate in several other comparative data bases: the American College of Cardiology-National Cardiology Data Registry (ACC-NCDR), the National Database for Nursing Quality Indicators (NDNQI) Registry, and the National Healthcare Safety Network for Infections. We are also a participant in the Cedar Rapids Oncology Project supporting 25 years of cancer research in affiliation with Mayo Clinic, and finally the Delta Groups, whose trending of Mercy's risk-adjusted mortality demonstrated a drop from 1.27 in 2003, where 1.0 is the expected, to a current rate of .44 in the most recent report.

Once a patient departs the hospital, the work doesn't stop. Most recently, Mercy's process improvement teams have been working on two initiatives: post discharge follow-up by homecare nurses for all high-risk patients, and the use of home-based monitoring systems that provides data to providers alerting them to patient progress or deterioration thus enabling early effective counter measures that avoid re-hospitalization. These monitoring systems are not compensated under the current reimbursement system but by providing the right resources to provider and patient alike, results such as reduced readmission rates can be accomplished.

Cedar Rapids may be a somewhat unique context for care that contributes to the overall performance. Today we have one dominant surgical specialty group serving both competing hospitals. We have one group of anesthesiologists and one group of radiologists. Cedar Rapids has a significant primary care community, supports a free clinic and federally qualified community health center. Access to care and services is relatively good. More importantly, access to clinical data is also remarkably good. Four years ago, Mercy brought to our community an innovative information technology product called Patientkeeper. It is an overlay that enables a doctor and or provider to acquire health information about a patient irrespective of the Cedar Rapids hospital in which they are being treated. This is important because physicians can now access information, through one device, even though that information may reside in a repository of different legacy systems of the two hospitals. Additionally, there is universal access to

radiology images. Mercy has just entered into a partnership with a young IT development company, called GEONETRIC- located in Cedar Rapids, to develop a robust patient portal that will significantly increase the engagement of patients in their own health, wellness and care.

So what will the future bring? The first is significant investment in information technology as the most powerful tool in improving communication, data gathering, sharing, verifying outcomes and empowering the individual patient to take responsibility for their health.

In step with this will be increased engagement with providers across the spectrum of the health care continuum jointly developing and overseeing community standards of practice that improve outcomes, eliminate waste and harm.

Finally, the Medical Home Model will become embedded within every primary care practice. Reducing the terrific burden of our health care system requires us to address the drivers- the epidemic of chronic diseases for example. Effectively managing the burgeoning prevalence of chronic disease, coupled with, as Senator Harkin has long understood and appreciated, a commitment to wellness is the partnership between provider and persons in their care, and is the very essence of the medical home model.

There is much yet to do. I sense that there is authentic will and leadership to get the job done. While we sort out the national agenda, I am encouraged and I respectfully suggest you can be as well by the work long underway in states like Iowa, and communities like Cedar Rapids.

Thank you again for the opportunity to be with you today.