## Health Watch USA Initiatives and Policy

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All information in this presentation is the express opinion of Kevin T. Kavanagh, MD, MS



## **About Health Watch USA**

Health Watch USA (HW USA) is a 501C3 non-profit volunteer organization composed of patient advocates and retired healthcare professionals most of whom have been injured by medical care.

Our mission is to improve patient safety through healthcare transparency and the advancement of quality metrics.



## A Few of Our Major Initiatives Which Involve Metrics

- Preventable Hospital Mortality.
- Hospital Accreditation Survey Transparency.
- MRSA Tracking and Control.
- Research Integrity.
  - Dangers of Chromium Cobalt Medical Devices.



## **Hospital Mortality – Outcome Metric**

> We estimate that each year up to 200,000 patients die from a potentially preventable adverse event at hospitals.

This is in line with other analyses which also show well over 100,000 preventable deaths per year.



Kavanagh KT, Saman DM, Bartel R, Westerman K. Estimating deaths due to hospital-related medical error: A perspective from patient advocates. Journal of Patient Safety. 2017 Feb 9: 13(1):1-5.

http://journals.lww.com/journalpatientsafety/Abstract/2017/03000/Estimating\_Hos pital\_Related\_Deaths\_Due\_to\_Medical.1.aspx

## **Preventable Hospital Mortality**

Too many excuses and poor performance.

We can not let it become normalized.
Metrics and ratings can help prevent this.

An example of normalization: If an error results in death in an elderly patient, sometimes the advanced age and frail nature of the patient is used to mitigate the error in the eyes of the family.



## **Preventable Hospital Mortality**

Are old passengers with a terminal illness who die in an airline crash not counted by the airline company because they would have died soon anyway?



## **Transparency – Accreditation Surveys**

Contain Crucial Measurable Quality Data but Shielded by a Veil of Secrecy.

Fundamental to Healthcare Transparency.

Support of This Initiative is a Test of an Institution's True Commitment to Transparency.



A Prime Example of Washingtonian Obfuscation

## **Transparency – Accreditation Surveys**

#### By Statute the U.S. Depart. of Health and Human Services Cannot Release.

Social Security Act – Section 1865: "The Secretary may not disclose any accreditation survey (other than a survey with respect to a home health agency) made and released to the Secretary by the American Osteopathic Association or any other national accreditation body, of an entity accredited by such body, except that the Secretary may disclose such a survey and information related to such a survey to the extent such survey and information relate to an enforcement action taken by the Secretary."



## Adverse Events – Outcome Metric

Adverse Events: Full Disclosure, With Apology and Rapid Compensation is Key to a Culture of Safety and Provision of High Quality Care.

Far too many institutions practice "Defend and Deny".



## **Transparency – Adverse Event**

If a car sideswipes another parked car, it is not acceptable for the driver to speed away without contacting the owner and telling him what happened.

# Especially if someone is injured or killed.



#### **Antibiotic Resistant Infections - Outcome Metric**

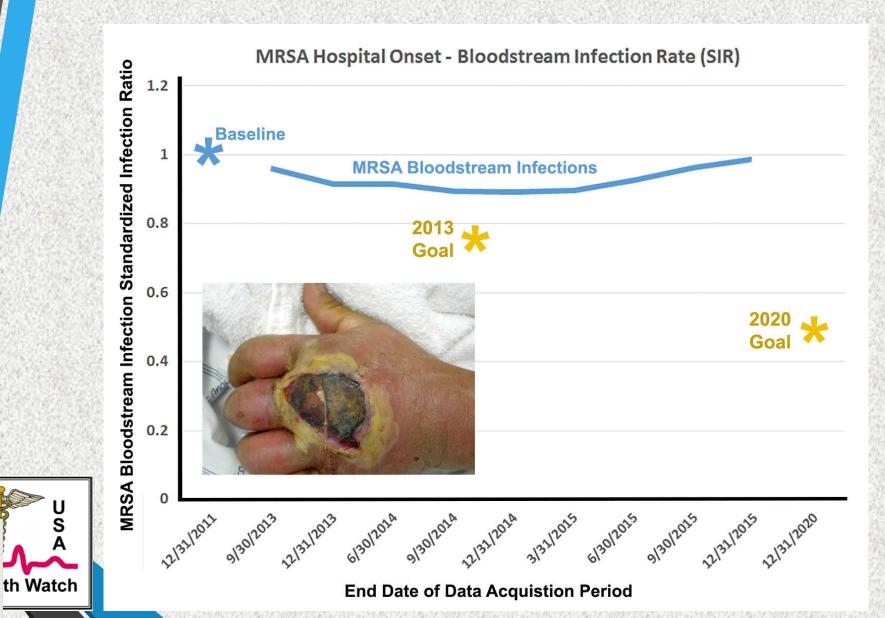
- Lack of Transparency and Suboptimal Reporting Have Inhibited our Ability to:
- Measure Infection Rates,
- Confront the Epidemic of Drug Resistant Bacteria and
  - **Rate Facilities for Value Based Purchasing.**

#### Unlike the Definition of Death, Just Agreeing On What An Infection Is, Is a Herculean Task.



Kavanagh KT, Abusalem S, Calderon LE. The incidence of MRSA infections in the United States. Is a more comprehensive tracking system needed? Antimicrobial Resistance and Infection Control. April 7, 2017. 6:34 DOI: 10.1186/s13756-017-0193-0 https://aricjournal.biomedcentral.com/articles/10.1186/s13756-017-0193-0

#### **Measurement of MRSA - Outcome Metric**



ne Metric

## **Risk Adjustment – Tracking of MRSA**

"Due to aberrations caused by changing methodology on how to track community acquired infections."

- RISK ADJUSTMENT -- CDC down adjusts hospital MRSA infections rates if there is a high rate in the community.
- All Agree We Are Nowhere on Track to Achieve Our 2020 Goal of a 50% Reduction.



## **Risk Adjustment – Tracking of MRSA**

- Remember, no matter how sick a patient is, they will not develop MRSA unless they are exposed to the bacteria.
- Risk adjustment can also be used to make bad care delivered to disadvantaged populations (the poor) to appear as good care.



## **Risk Adjustment – Tracking of MRSA**

- Frontline Hospitals May Not Have The Resources To Implement Complex Quality Assurance And Patient Safety Protocols.
- But shouldn't we provide those resources and make sure all citizens have access to quality care, rather than normalizing suboptimal care delivered to disadvantaged populations through risk adjustment.



## **Metrics – Tracking of MRSA**

Metrics need to be developed for the periodic screening of healthcare workers for MRSA carriage.

 Data indicates the MRSA carrier rate in Healthcare Workers is close to 5%.

#### The Protocols and The Screening Results Should be Publicly Available.



## **Nursing Sensitive Measures**

The importance of Nursing Sensitive Measure needs to be stressed and that Value Purchasing Initiatives of one measure will be expected to improve other Nurse Sensitive Measures.

#### **Outcome Measures**

- ➢Infections
- Pressure Sores/Falls
- Structural Measures
  > Work Environment
  > Staff Turnover Rate



## **Medical Devices – Metrics Needed**

Most Implanted Medical Devices Have Not Been Clinically Tested.

HW USA has as a major initiative the raising of awareness of the risks of cobalt poisoning and associated brain toxicity in up to 3 million

patients with hip implants having chromium cobalt components.





## **Medical Devices – Process Measures**

Are Hospitals Recording Implanted Device's UDI Number into The Patient's Medical Record?

#### Are Hospitals Reporting Device Adverse Events to the FDA?

**Corrosion of Chromium Cobalt Hip Implant** 

(Chromium Cobalt Ball - Titanium Stem)

in the second second



Multiple Areas of Corrosion



## **Research Integrity**

Bad Data,
Bad Policy,
Dead Patients



Kavanagh KT, Tower SS, Saman DM. A perspective on the principles of integrity in infectious disease research. Journal of Patient Safety. Published Online Mar. 24, 2016. PMID 27010326 <u>http://journals.lww.com/journalpatientsafety/Fulltext/2016/06000/</u>

<u>A Perspective on the Principles of Integrity in.1.aspx</u>

## **Research Integrity**

- Clouded the picture of how to prevent MRSA
  - Major articles have problems with:
    - Results Not Reflected In The Data.
    - Spinning or Overstatement of Results.
    - Changing What Is Being Tested For After the Experiment Starts.
    - Use of Uneven Trial Arms (The Control Group is Set up to Fail).

