Health Watch USA Newsletter

www.healthwatchusa.org **May 1, 2010**

Medicaid Adopting Medicare Regulations

New report from the National Academy for State Health Policy reports that 12 states deny payment for some types of adverse or preventble conditions and 5 states have already implemented Medicare's non-payment list. Note: Jill Rosenthal, the report's author, is a confirmed speaker for HW USA's 2010 Conference. http://www.nashp.org/sites/default/files/PatientSafety.pdf

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Hospital Rankings

Medscape reports that US News & World Reports ranks hopitals on the facilities' subjective reputation rather than on objective quality measures.
http://www.medscape.com/viewarticle/720536?sssdmh=dm1.612965&src=nldne&uac=123591HV

ARHQ – Updated their Healthcare Quality Indicators

http://www.qualityindicators.ahrq.gov/

Healthcare Acquired Infections:

New York Times reports we are not winning on the infection front.
http://www.nytimes.com/2010/04/14/us/14infect.html?hpw

National Healthcare Quality Report from AHRQ found that the incidence of healthcare associ infections may not be falling.
"Infections acquired during hospital care, also known as nosocomial infections, are one of the most serious patient safety concerns. It is unfortunate that HAI rates are not declining. Of all the measures in the NHQR measure set, the one worsening at the fastest rate is postoperative sepsis (Table H.3). The two process measures related to HAIs tracked in the NHQR, both covering timely receipt of prophylactic antibiotics for surgery, are improving steadily. However, HAI outcome measures are lagging; only one shows improvement over time while three are worsening and one shows no change. This may, in part, reflect improving detection of HAIs."
http://www.ahrq.gov/qual/nhqr09/nhqr09.pdf
http://www.californiahealthline.org/articles/2010/4/14/ahrq-report-hospitals-have-made-little-gains-in-preventing-infections.aspx

However, SHEA, IDSA and APIC disagree and feel the report is inaccurate because it is using billing or CPT data.
http://www.mmsend9.com/ls.cfm?r=160643905&sid=9260015&m=985957&u=SHEA&s=http://www.s

hea-online.org/Assets/files/policy/Statement_in_Response_to_AHRQ_FINAL_4_16_10v3__2_.pdf

C. Diff infections are on the rise.
http://www.webmd.com/digestive-disorders/news/20061012/c-diff-new-threat-from-old-bug

Pittsburg VA reports MRSA study results:
"Over an 8 month period there was only two surgical site infections where the two facilities combined would have on average 40 surgical site infections a year. The dementia unit at Ground south has had neither transmission nor infection in the 4th quarter of FY06."
http://www.wapatientsafety.org/downloads/Pittsburgh-VA-MRSA-project.pdf

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Transparency

Minnesota's report on Adverse Events at Hospitals is a very comprehensive report and a model for thenation. http://www.mnhospitals.org/inc/data/pdfs/ahe2010.pdf

Illinois posts an excellent transparency website for consumers. This state joins Ohio and Tennesssee, as regional states with excellent websites to aid their citizens in healthcare choices.
http://www.healthcarereportcard.illinois.gov/

Importance of Nursing Staffing to Good Patient Outcomes:

Nursing Staffing ratios reported to improve patient quality in California.
http://www.calnurses.org/media-center/press-releases/2010/april/the-evidence-is-in-california-rn-to-patient-ratios-save-lives.html http://www.medicalnewstoday.com/articles/185978.php

New study also finds the higher the nurse-to-patient ratio the lower the incidence of hospital acquired conditions and higher RN-to-LPN ratios were also found to be associated with a lower incidence of healthcare acquired conditions.
"Findings from the study indicated that higher registered nurse (RN) and licensed practical nurse hours per equivalent patient day and higher percentages of RNs in the skill mix predicted a lower number of adverse events and shorter lengths of stay, controlling for patient age and complications."
http://www.ncbi.nlm.nih.gov/pubmed/20351541

Imaging Safety Concerns – It has been reported that the medical profession takes an average of 17 years to adopt a new protocol. But when reports surface regarding concerns of supression of safety data by the FDA, one begins to understand the cautious approach taken by the medical profession.
http://www.washingtontimes.com/news/2010/mar/30/scientist-fda-suppressed-imaging-safety-concerns/

Leapfrog Group Releases the 2010 US Hospital Survey.

1244 hospitals participated in the study.

1) Research indicates that a patient's risk of dying is reduced approximately 2 to 4 times, depending on the high-risk procedure, if care is obtained in a hospital that meets Leapfrog standards

2) Over 3,000 deaths could be avoided each year if Leapfrog standards were implemented in all hospitals that electively perform these procedures.

In Kentucky only 8 hospitals participated. Only two, Greenview Regional Hospital and Frankfort Regional Medical Center, comply with Leapfrog's Management of Serious Medical Errors and adherence to Leapfrog Group's Never Events Policy which includes not billing for the National Quality Forum's Serious Adverse Healthcare Conditions.

The Leapfrog Group asks hospitals to agree to all of the following if a never event occurs within their facility:

- We will apologize to the patient and/or family affected by the never event
- We will report the event to at least one of the following agencies within 10 days of becoming aware that the never event has occurred:
    - Joint Commission, as part of its Sentinel Events policy*
    - State reporting program for medical errors
    - Patient Safety Organization (e.g. Maryland Patient Safety Center)
- We agree to perform a root cause analysis, consistent with instructions from the chosen reporting agency
- We will waive all costs directly related to a serious reportable adverse event
- We will make a copy of this policy available to patients, patients' family members, and payers upon request

http://www.leapfroggroup.org/media/file/Binder_Presentation_412310.pdf

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Wellpoint of California (CEO Angela Braly) Does it Again.

"U.S. Department of Health and Human Services (HHS) Secretary Kathleen Sebelius sent a letter to WellPoint urging them to immediately end their practice of dropping health insurance coverage for women with breast cancer"
http://www.hhs.gov/news/press/2010pres/04/20100423a.html

Health Watch USA 2010 Conference

2010 Conference Topic: Value Purchasing and Hospital Acquired Conditions. Date: Nov 19, 2010, Lexington Embassy Suites on Newtown Pike, Lexington, Kentucky.

Cofirmed Speakers Include:

1) Richard Wild, MD, JD, Chief Medical Officer, Atlanta Regional Office
   Centers for Medicare and Medicaid Services (CMS), will present on "CMS Perspectives on Value Based Purchasing, P4P, and Meaningful Use of a Electronic Health Records."
2) Dr Jim Battles, PhD, Center for Quality Improvement and Patient Safety, AHRQ - Presenting on Quality and Safety Provisions in the New Health Care Reform Law.
3) Jill Rosenthal, Program Director, National Academy for State Health Policy -- Presenting on State Medicaid Policy on Hospital Acquired Conditions.
4) Alicia Cole, Patient Advocate, Actress, and Necrotizing Fasciitis Survivor - A Hospital Acquired Condition.
5) Joycelyn Elders, MD, former US Surgeon General
6) Marvin Feit, PhD, Editor of the Journal of Health and Social Policy

Continuing education credits will be applied for RN, MD, JD, Social Work and Human Resource Managers.

To register go to www.healthconference.org

To register as an exhibitor go to http://healthconference.org/exhibits.htm

To submit papers for the conference please send them to:
contact-mail@healthwatchusa.org

Proposed Statue for Public Reporting of HAI for Kentucky.

This is posted as a resource to be modified and used as a basis for legislation.
This sample has been constructed from prior proposed Kentucky and Federal Legislation.

http://www.healthwatchusa.org/downloads/20100118-KY%20HAI%20bill.pdf