Health Watch USA Newsletter

www.healthwatchusa.org **Aug 24, 2010**

News from the 9th Annual Quality Colloquium

-- Harvard University, Cambridge, Mass.

(Click on Pictures to Enlarge)

Policy Points From Keynote Speaker Atul Gawande, MD

Twenty percent of our economy directly or indirectly goes to healthcare. Our system has over 13,600 diagnostic codes which is indicative of the many service lines needed in medicine. No other industry comes close. Quality suffers. For example, 40% of people with heart disease or pneumonia receive inadequate care, and there is an explosion in costs.

For example, two communities with the same demographics in the same state (Texas) differed as much as 50% in costs. However, the bell curve for quality does not match that for costs. High quality hospitals tend to be in the middle or lower half for costs. See The Cost Conundrum - June 1sh, 2010, New Yorker

Checklists are used in other industries but are not commonly found in the medical industry. We are seeing a transition from the world of artisans to a world of systems in healthcare.

In the US, there are 150,000 deaths from surgery (within the first 30 days) and half of these are preventable. Introducing a surgical checklist with items such as giving a preoperative antibiotic and the surgeon discussing the procedure, goals, length, expected blood loss and complications is associated with a 35% reduction in complications and deaths -- See NPR story below: http://www.npr.org/templates/story/story.php?storyId=122226184

The final Keynote Address was from Dr. Carolyn Clancey, MD, Director or AHRQ.

She stressed that the major goals of AHRQ in 2010 are to reduce readmissions and to reduce Healthcare Associated Infections. AHRQ has had a 53% increase in their budget with an influx of over $350 million dollars.

AHRQ will focus on transparency. Hospital Acquired Infections are still a major problem, there have been some improvement -- but in most areas they "REMAIN A PERVASIVE CHALLENGE"

Dr. Barry Straube, MD, the chief medical officer of CMS, also stressed that the US healthcare system spends more per capita on healthcare than any other country in the world with little benefit and often inferior quality. In addition, there was often an inverse relationship between quality and costs. (Thus, higher costs often creates an inferior quality of care.)

CMS strongly supports public reporting. Dr Straube stated that CMS "believe(s) we have valuable evidence that public reporting is a powerful tool."

Other Policy Bites:

A new OIG report is going to be published soon on Serious Adverse Events in hospitals.

If a doctor reads 2 articles per day he would be 400 years behind in a year (actually it was then restated as 3000 years behind) -- Attributed to Dr. Donald Lindberg on why need e-medicine.

Death by Googling: There have been no reported cases of patients dying because of information obtained over the internet. The presenter felt it was more dangerous not to Google.

Accountable Care Organizations are going to play a major role in healthcare. They are needed as illustrated by the data in the Dartmouth Atlas which reports a threefold variation in spending and an inverse relationship between quality and costs. The underlying principle of Accountable Care Organizations is that the insurance company takes the insurance risk and the provider takes the performance risk. Details are

not fully worked out but payment per episode or event will have a role. This payment will include complications and readmissions. -- Vinod K. Sahney, PhD.

Why is healthcare change so hard to implement? "One person's waste is another person's income."

Definition of an EVENT in healthcare - taken from the Joint Commission: If it is part of the natural course of the disease, it is not an event. If it is not part of the natural course of the disease, it is an event.

Few ADVERSE EVENTS are reported because of facility legal concerns. Reports to Patient Safety Organizations are not discoverable by Federal Law, but facility participation in these organizations is poor.

Hospital Acquired Infections

Clostricium Difficile Infections are reviewed by the Washington Post in a large analytic news article which Health Watch USA participated in.
http://www.washingtonpost.com/wp-dyn/content/article/2010/08/23/AR2010082303562.html

Stop HAI - Courier Journal - Louisville KY

A Letter to the Editor Regarding the High Cost and Death of her Husband from Hospital Acquired Infections. http://www.courier-journal.com/article/20100824/OPINION02/308240008/1018/OPINION/Reader+Letters+|+Prevent+infections

A New Study Shows MRSA Rates May Be Improving

A recent article published in JAMA shows improvement in MRSA infection rates. HW USA feels this can be viewed as a huge win for consumer advocates since all reporting metropolitan areas (except Atlanta) are in states that have public reporting laws. Atlanta is the home of the CDC and one would expect good results from this area. If it is measured it will be managed. If the measurement is made public it will be managed well. http://jama.ama-assn.org/cgi/content/full/304/6/641 (Note: Kentucky does not report Hospital Acquired Infections)

AHRQ Draft Report on the Effectiveness of Screening and Treatment for C Difficile infections

http://effectivehealthcare.ahrq.gov/index.cfm/search-for-guides-reviews-and-reports/?pageaction=displayProduct&productID=505

New 'superbug' found in UK hospitals http://www.bbc.co.uk/news/health-10925411

Malpractice Claim Costs and New Medical Disclosure Program

Kachalia, et al., reported that a newly implemented program of full disclosure of medical errors with offers of compensation did not increase total claims and liability costs. Annals of Internal Medicine. Vol. 153 p 213-221 http://www.annals.org/content/153/4/213.abstract

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The Economic Measurement of Medical Errors

A new report "analyzed a large claims database of more than 24 million patients to identify errors, deaths, and costs, and found that more than 1.5 million preventable adverse events occur in hospitalized patients yearly, resulting in $19.5 billion in excess costs and 2500 excess deaths yearly" http://www.soa.org/research/health/research-econ-measurement.aspx

Google Technology Identifying Sanctioned Doctors

William Heisel is using Google Technology to post and identify doctors that have been sanctioned by their medical boards. http://www.reportingonhealth.org/blogs/doctors-behaving-badly-medical-boards-should-drop-stone-tools-join-digital-age

Department of Health and Human Services Recommends Patients Have Health Advocates When They Obtain Healthcare http://www.hhs.gov/news/healthbeat/2010/08/20100816a.html

Visits to Emergency Departments Up 23% Over Past Decade

This may be a sign of poor access to healthcare to the dwindling supply of primary care physicians. http://www.cdc.gov/nchs/data/nhsr/nhsr026.pdf

More patients are seeing medical and surgical specialists at an ever increasing number. http://www.cdc.gov/nchs/data/databriefs/db41.htm

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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

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2010 HW USA Conference – Nov. 19th, 2010

Agenda and speakers are finalized and conference brochure is available.

Download Brochure:
www.healthconference.org/2010conference_downloads/HCTPA_Brochure.pdf

To Register: www.healthconference.org

Helen Haskell to Speak at the September Health Watch USA Meeting

Health Watch USA meeting on Saturday September 11th to have Helen Haskell, founder of Mothers Against Medical Error to present live over SKYPE. If you wish to attend the meeting please call Kevin Kavanagh at 606-875-3642.