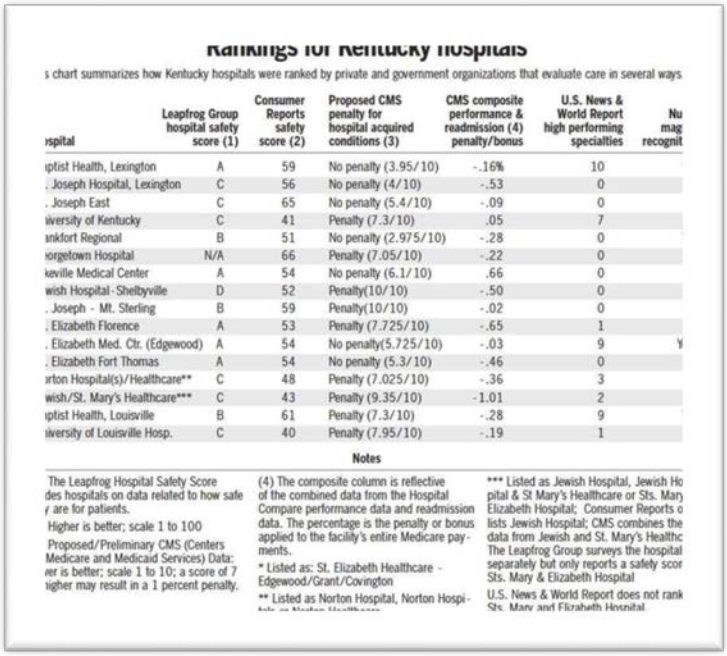
Health Watch USA[sm] Newsletter

www.healthwatchusa.org **Aug 20, 2014**

Member of the National Quality Forum and a designated "Community Leader" for Value-Driven Healthcare by the U.S. Dept. of Health and Human Services

Op-Ed on Kentucky Hospital Performance on National Ranking Systems



Rankings for Kentucky hospitals

s chart summarizes how Kentucky hospitals were ranked by private and government organizations that evaluate care in several ways.

ıspital	Leapfrog Group hospital safety score (1)	Consumer Reports safety score (2)	Proposed CMS penalty for hospital acquired conditions (3)	CMS composite performance & readmission (4) penalty/bonus	U.S. News & World Report high performing specialties	Nu mag recognit
ıptist Health, Lexington	A	59	No penalty (3.95/10)	-.16%	10	
. Joseph Hospital, Lexington	C	56	No penalty (4/10)	-.53	0	
. Joseph East	C	65	No penalty (5.4/10)	-.09	0	
ıiversity of Kentucky	C	41	Penalty (7.3/10)	.05	7	
ınkfort Regional	B	51	No penalty (2.975/10)	-.28	0	
ıorgetown Hospital	N/A	66	Penalty (7.05/10)	-.22	0	
ıeville Medical Center	A	54	No penalty (6.1/10)	.66	0	
ıish Hospital - Shelbyville	D	52	Penalty(10/10)	-.50	0	
. Joseph - Mt. Sterling	B	59	Penalty(10/10)	-.02	0	
. Elizabeth Florence	A	53	Penalty (7.725/10)	-.65	1	
. Elizabeth Med. Ctr. (Edgewood)	A	54	No penalty(5.725/10)	-.03	9	Y
. Elizabeth Fort Thomas	A	54	No penalty (5.3/10)	-.46	0	
ırton Hospital(s)/Healthcare**	C	48	Penalty (7.025/10)	-.36	3	
ıish/St. Mary's Healthcare***	C	43	Penalty (9.35/10)	-1.01	2	
ıptist Health, Louisville	B	61	Penalty (7.3/10)	-.28	9	
ıiversity of Louisville Hosp.	C	40	Penalty (7.95/10)	-.19	1	

Notes

The Leapfrog Hospital Safety Score des hospitals on data related to how safe r are for patients.
Higher is better; scale 1 to 100

Proposed/Preliminary CMS (Centers Medicare and Medicaid Services) Data: er is better; scale 1 to 10; a score of 7 igher may result in a 1 percent penalty.

(4) The composite column is reflective of the combined data from the Hospital Compare performance data and readmission data. The percentage is the penalty or bonus applied to the facility's entire Medicare payments.

* Listed as: St. Elizabeth Healthcare - Edgewood/Grant/Covington

** Listed as Norton Hospital, Norton Hospi-

*** Listed as Jewish Hospital, Jewish Ho pital & St Mary's Healthcare or Sts. Mary Elizabeth Hospital; Consumer Reports d lists Jewish Hospital; CMS combines the data from Jewish and St. Mary's Healthc The Leapfrog Group surveys the hospital separately but only reports a safety scor Sts. Mary & Elizabeth Hospital

U.S. News & World Report does not rank Sts. Mary and Elizabeth Hospital

Lexington Herald Leader - Aug. 10, 2014: "One in 25 hospital patients develops an infection and one in eight Medicare patients develops a potentially avoidable complication, according to federal estimates. Major hospital ranking organizations include: U.S. News & World Report; The Leapfrog Group, a business purchasing alliance, and Consumer Reports, a consumer-oriented non-profit. These ranking systems are still evolving. If you need a complex procedure requiring super specialization, without a doubt get your care at a large medical center and rely more heavily on the U.S. News rankings. If you are in good health and having a common procedure, consider all your options, ask questions and pay close attention to safety scores. Your local hospital may be your best choice." Click on picture to enlarge. **Download Complete Table**
http://www.kentucky.com/2014/08/10/3373440/use-hospital-rankings-to-stay.html

Hospital Rankings Systems and Its Validity Debated Regarding a New York Hospital

"While CEO Clare Haar repeatedly dismisses the survey results, others in the community, including the group of activists, elected officials and emergency personnel aligned against the planned restructuring, point to the scores as proof of poor leadership by the administration and directors of the hospital system."
http://www.lockportjournal.com/local/x1927931175/Surveys-show-low-grades-at-ENH-Lockport

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Healthcare Infections

NHSN Data Provides Support for MRSA Infection Reporting in Kentucky

Data Reported to the National Healthcare Safety Network (NHSN) on MRSA Bacteremia shows Kentucky has the fourth highest Standardized Infection Ratio (SIR) among the 50 States. The SIR is a risk adjusted value. The National average for accusation dates 1/1/2013 to 9/30/2013 was 0.834, Kentucky's was 1.194.

High Prevalence of Reduced Chlorhexidine Susceptibility in Organisms Causing Central Line–Associated Bloodstream Infections

"In units that bathe patients daily with chlorhexidine gluconate (CHG), organisms causing central line–associated bloodstream infections (CLABSIs) were more likely to have reduced CHG susceptibility than organisms causing CLABSIs in units that do not bathe patients daily with CHG (86% vs 64%; P = .028). Surveillance is needed to detect reduced CHG susceptibility with widespread CHG use." http://www.jstor.org/stable/10.1086/677628

Screening for methicillin-resistant Staphylococcus aureus - By Kalisvar Marimuthua and Stephan Harbarth

"Universal decolonization is an acceptable MRSA control strategy for intensive care units; however, close monitoring of chlorhexidine and mupirocin resistance is warranted. As a strategy, screening and contact precautions are suitable for hospital-wide MRSA control. Targeted decolonization is a proven measure for patients undergoing clean surgery. Enhancement of hand hygiene is a core measure regardless of the strategy." http://www.ncbi.nlm.nih.gov/pubmed/?term=25029612

MRSA Surveillance

The impact of a "search and destroy" strategy for the prevention of methicillin-resistant Staphylococcus aureus infections in an inpatient rehabilitation facility.

"The implementation of an all-admissions MRSA screening program with decolonization of positive carriers in an IRF affiliated with an acute care hospital resulted in decreased MRSA-HAI rates in the IRF. " http://www.ncbi.nlm.nih.gov/pubmed/24107426

Commentary in AAC Points Out Unfair Comparisons In Some Literature Recommendations.

"Our findings indicate that a widespread perception of efficacy of chlorhexidine had arisen that was in significant parts actually based on evidence for the chlorhexidine/alcohol combination." http://jac.oxfordjournals.org/content/69/8/2017.long

Healthcare Reform

Time Magazine 'How Kentucky Got Obamacare Right'

Time (dot) Com: "This is the story of how one state, led by Governor Steven Beshear and a team of smart, determined career civil servants, got it right–by preparing exhaustively, by dealing frontally with the system's challenges ..... " http://time.com/3062886/how-kentucky-got-obamacare-right/

Uninsured Rate in Kentucky Down 8.5 Percent

"Arkansas and Kentucky lead all other states in the sharpest reductions in their uninsured rate among adult residents since the healthcare law's requirement to have insurance took effect at the beginning of the year. Delaware, Washington, and Colorado round out the top five." http://www.gallup.com/poll/174290/arkansas-kentucky-report-sharpest-drops-uninsured-rate.aspx?utm_source=alert&utm_medium=email&utm_campaign=syndication&utm_content=morelink&utm_term=Healthcare

Hospitals May Lose Billions in States That Did Not Expand Medicaid

Robert Wood Johnson: "Hospitals in these 24 states are also slated to lose a $167.8 billion (31 percent) boost in Medicaid funding that was originally intended to offset major cuts to their Medicare and Medicaid reimbursement. " http://www.rwjf.org/content/dam/farm/reports/issue_briefs/2014/rwjf414946

Patient Safety

Data on Hospital Acquired Conditions are No Longer Available on Hospital Compare

Time (dot) Com: "As of this month, the Centers for Medicare and Medicaid Services (CMS) has removed data on many “never events” from its public website, Hospital Compare. “Never events” are just what they sound like: errors so egregious they should never happen. The term came into widespread use in 2006, when the National Quality Forum defined 28 serious healthcare errors. While CMS has never published data on all the never events until recently, it made public records of some of the worst and most preventable, such as foreign objects left in the body, air embolisms (a killer air bubble entirely preventable during surgery), giving the wrong blood type to a patient and bedsores allowed to develop into extremely painful and even deadly wounds. CMS now believes that continuing to publish this information is unfair to hospitals."
http://time.com/3066053/hospital-errors-never-events/

Maryland hospitals aren't reporting all errors and complications, experts say

Baltimore Sun: "Similarly, the number of bloodstream infections from central lines, or catheters, as reported to the Office of Health Care Quality appears low... But other agencies found higher numbers."
http://www.baltimoresun.com/news/maryland/sun-investigates/bs-hs-medical-errors-20140726,0,5079647.story

Have Faster FDA Drug Approvals Caused More Safety Problems?

Wall Street Journal: http://blogs.wsj.com/pharmalot/2014/08/05/have-faster-fda-drug-approvals-caused-more-safety-problems/

Feds stop public disclosure of many serious hospital errors.

"The federal government this month quietly stopped publicly reporting when hospitals leave foreign objects in patients' bodies or make a host of other life-threatening mistakes. The change, which the Centers for Medicare and Medicaid Services (CMS) denied last year that it was making, means people are out of luck if they want to search which hospitals cause high rates of problems such as air embolisms — air bubbles that can kill patients when they enter veins and hearts — or giving people the wrong blood type."
http://www.usatoday.com/story/news/nation/2014/08/05/foreign-objects-in-bodies-federal-hospital-reporting-changes/13467829/

The Most Shocking Mistakes Hospitals Don't Want You To Know About

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http://time.com/author/david-goldhill/

Power Morcellation to Remove Uterine Fibroids is Being Marginalized by

http://abcnews.go.com/Health/couple-fought-ban-medical-procedure-wifes-cancer-back/story?id=24797149

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Upcoming Events:

Aug 20, 2014 - 2:00 PM ET (Lexington, KY): Alicia Budd (CMS/CCSA) will discuss Over Adobe Connect the new Centers for Medicare and Medicaid Services (CMS) regulations on value purchasing and Hospital Acquired Conditions for the 2014 IPPS. In other words, what are the current financial incentives that Medicare is using to promote quality in our hospitals and to prevent unplanned adverse events from happening to patients. To attend please send an email to healthwatchusa@gmail.com

Sep. 9, 2014: Dr. Peter Pronovost on the Jack Pattie Show - WVLK am.
"Dr. Pronovost has earned several national awards, including the 2004 John Eisenberg Patient Safety Research Award and a coveted MacArthur Fellowship in 2008, known popularly as the "genius grant." He was named by Time magazine as one of the world's 100 "most influential people" for his work in patient safety. He regularly addresses Congress on the importance of patient safety, prompting a report by the U.S. House of Representatives' Committee on Oversight and Government Reform strongly endorsing his intensive care unit infection prevention program."

http://www.hopkinsmedicine.org/anesthesiology_critical_care_medicine/research/experts/research_faculty/bios/pronovost.html

When: Sep. 9, 2014, 9:00 to 10:00 Eastern Time. The program can be listened to by going to http://www.wvlkam.com/ and selecting the "Listen Live" button in the upper right hand corner of the page.

HW USA Annual Patient Safety Conference

Nov. 7, 2014: Health Watch USA's Annual Health Policy Conference, Lexington, KY. Continuing Education Credits for physicians, nurses, social workers and physical therapists will be offered. This year's conference will focus on patient safety, advocacy, healthcare associated infections and multi-resistant drug organisms. (A working agenda can be viewed at http://www.healthconference.org/agenda.htm

In the Conference's Patient Advocacy Section, we have a number of nationally renowned speakers, including Past Surgeon General Joycelyn Elders, MD, Kathy Day, RN, and Karen Meyers, JD. In addition, the following presentations will deal with full disclosure.

- Patient Advocate David Anton will present on how a lack of transparency can inhibit the correction of medical errors that are found on CMS Surveys. (David Anton is the patient advocate who was involved in the CMS, Cleveland Clinic, VA Secretary Appointment Issue.) http://www.modernhealthcare.com/article/20140607/MAGAZINE/306079939/-cleveland-clinic-cases-highlight-flaws-in-safety-oversight

- Dr. Steve Kraman, will give an update on the full disclosure initiative. Dr. Kraman was one of the first to start the full disclosure initiative back in the late 1990's. It has since been adopted by Stanford University and the University of Michigan and found to lower malpractice costs.

- James Anderson, will give the morning keynote address on disclosure of adverse events. Mr. Anderson is on the Board of Directors for the Institute for Healthcare Improvement (IHI) & Former President and Chief Executive Officer, Cincinnati Children's Hospital. About the James M. Anderson Center for Health Systems Excellence.

In the Conference's Adverse Events and Healthcare Associated Infections Section, Dr. Richard Wild, Chief Medical Officer CMS Atlanta Region will present on the CMS initiative on decreasing Hospital Acquired Conditions (HACs). Representative Tom Burch, Kentucky House Health and Welfare Committee Chairman and Dr. Kraig Humbaugh, Director of the Kentucky Department for Public Health (KDPH) Division of Epidemiology Planning will present on the revised Kentucky regulation for reportable diseases, including CRE. Dr. Kevin Kavanagh will present on the prevention of surgical site infections, and Dr. Raul Nakamatsu will present the Louisville, VA experience of universal surveillance to control MRSA.

Conference registration is $50. To register go to: http://www.healthconference.org/payment-fax-check.htm

Full conference agenda can be viewed at: http://www.healthconference.org/agenda.htm

For more information go to: www.healthconference.org Registration is now open

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