Health Watch USAsm Newsletter

www.healthwatchusa.org Feb. 1, 2016
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

Healthcare Quality

Buyer beware: no return, redo in hospital care.

Lexington Herald Leader Op-Ed: Obtaining the safest health care should be a top priority for everyone. A number of different rating systems act as a guide; but by the time you are sick, it is often too late to undertake a thoughtful search. All these systems rate hospitals differently and invariably give different results, making it all but impossible to select a provider on the day of an emergency.

Substantial quality improvements are needed in our health-care system in Kentucky and nationwide. Until this takes place, one should preemptively study and evaluate treatment options. As the old saying goes, “Let the buyer beware,” for in health care, there is little opportunity to return or redo the service.

Read more here: http://www.kentucky.com/opinion/op-ed/article54997560.html

For References and Resources Used In This Op-Ed, please go to:
http://www.healthwatchusa.org/HWUSA-References/editorial/20160117-Hospital-Rankings.htm

For Expanded Hospital Ranking Data, please go to:
http://www.healthwatchusa.org/HWUSA-Publications/PDF-Downloads/20160106-Web-Table-20160113-KY-Hospitals.com.pdf

Only 5% of Surgeons use the Most Efficacious Techniques to Prevent Transmission of Infections During Surgery

Dr. Mark S. Davis presents on methods of reducing the exposure to dangerous pathogens such as HIV and Hepatitis C in patients undergoing surgery. Health Watch USA Meeting Jan. 20, 2016.
https://youtu.be/muFNnUHN4I0

Massachusetts Acts To Stop Simultaneous Surgeries By The Same Surgeon

Boston Globe: "Surgeons would have to document each time they enter and leave the operating room under a new regulation that the state medical board overwhelmingly approved Thursday amid heightened scrutiny of doctors who do more than one operation at a time. The Massachusetts

Board of Registration in Medicine approved the new rule, which appears to be one of the first of its kind nationally, with relatively little debate. The move comes in the wake of a series of reports by the Globe Spotlight Team about double-booked operations."
https://www.bostonglobe.com/metro/2016/01/07/massachusetts-require-surgeons-document-operating-room-comings-and-goings/2uIu1IDhmz4K8CRaJtL1vL/story.html

Incomplete Disclosure of Potential Conflicts of Interest on A Paper Studying Chlorhexidine for Skin Antisepsis

New potential conflicts of interest were disclosed from Sage Products, CareFusion, Irrimax Corporation and Ethicon, Inc. See article correction in JAMA Surgery:
http://archsurg.jamanetwork.com/article.aspx?articleid=2484558
http://archsurg.jamanetwork.com/article.aspx?articleid=2484563

Healthcare Overuse

Price Tag for Delivery Varies Widely

MedicineNet.com: "California women were charged between $3,296 and $37,227 for an uncomplicated vaginal delivery, depending on which hospital they visited, researchers report."
http://www.medicinenet.com/script/main/art.asp?articlekey=176223

Healthcare Finance

The Profitability (Or Not) Of Harming Patients.

Forbes: "As another physician noted in a journal article that same year, “a tacit but potentially significant barrier” to hospital management support was “a widespread but unsubstantiated belief” that serious infections substantially raised reimbursement."
http://www.forbes.com/sites/michaelmillenson/2015/12/06/the-profitability-or-not-of-harming-patients/

50 Hospitals Charge Uninsured More Than 10 Times Cost of Care, Study Finds

The Washington Post: https://www.washingtonpost.com/national/health-science/why-some-hospitals-can-get-away-with-price-gouging-patients-study-finds/2015/06/08/b7f5118c-0aeb-11e5-9e39-0db921c47b93_story.html

Healthcare Infections

Preventable Tragedies: Superbugs and How Ineffective Monitoring of Medical Device Safety Fails Patients

Senator Patty Murray, United States Senate Minority Staff Report: Excerpts from the report are below:

- The investigation found that by early 2013, Olympus, the manufacturer of 85 percent of the duodenoscopes used in the United States, knew of two independent lab reports finding that

the closed-channel model duodenoscope could harbor and spread bacteria even after cleaning according to the manufacturer's instructions. Olympus never brought this information to FDA, and did not alert hospitals, physicians or patients in the U.S. to the risk of infection until February 2015.

- Additionally, although at least 16 separate U.S. hospitals traced antibiotic-resistant infections directly to duodenoscopes, the hospitals generally did not raise alarms about these infections with federal regulators. It appears that not a single hospital that experienced infection outbreaks tied to the duodenoscopes sent the required adverse event form to the device manufacturers.

- Problems with FDA's outmoded adverse event device database, as well as slow and incomplete reporting by manufacturers and hospitals, appear to have left FDA staff unable to develop an accurate sense of the frequency and severity of the infection outbreaks.

- The failure of FDA's current device safety reporting system to rapidly identify duodenoscope-related, antibiotic-resistant infections, including superbug infections, should serve as warning that without a comprehensive postmarket device surveillance system that supplements self-reporting from hospitals and manufacturers, future device issues are likely to go undetected for far too long and with life-threatening consequences.

Download the Full Report at: http://www.healthwatchusa.org/downloads/20160113-Duodenoscope_Investigation_FINAL_Report.pdf

Olympus to recall and redesign medical scope linked to superbug outbreaks.

"The company, which sells about 85% of the duodenoscopes used in the United States, said it would revamp an internal mechanism inside the reusable device that had been almost impossible to disinfect before being used in the next patient."
http://www.latimes.com/business/la-fi-olympus-scopes-20160115-story.html

New Test May Differentiate Between a Cold (Viral) and a Bacterial Infection

http://www.forbes.com/sites/judystone/2016/01/20/under-the-weather-a-drop-of-blood-can-tell-if-antibiotics-are-needed/

Nurse Compliance With Standard Precautions

Fewer than one-fifth (17.4%) of respondents reported compliance with all 9 standard precaution items. Mean score for correct responses to the HCV knowledge test was 81%.
Yahoo Health: "That means more than 80 percent of the nurses you see at your doctor's office, dentist office, ER, and more aren't doing everything they can to prevent the spread of infection — to you, other patients, and themselves."
http://www.ajicjournal.org/article/S0196-6553%2815%2901035-4/abstract
https://www.yahoo.com/health/only-1-in-5-nurses-follow-the-right-safety-150255556.html

HW USA - Nov. 13, 2015 Patient Safety Conference

To view presentations and download slides & handouts go to:
http://www.healthwatchusa.org/conference2015/index.html

Follow Health Watch USA on Twitter !
The link is https://twitter.com/healthwatchusa

==

Future Health Watch USA Meetings:

Feb. 17, 2016. Eili Klein., PhD from the CDDEP on Antibiotic Stewardship and Reportable Disease Surveillance.
To attend send an email to healthwatchusa@gmail.com
http://www.cddep.org/profile/eili_klein#sthash.uPyzLrzj.dpbs

===

To subscribe to Health Watch USA^{sm} newsletter go to:
http://www.hwusa-newsletter.org/lists/?p=subscribe&id=1

Visit and "Like" HW USA's Facebook Page at:
https://www.facebook.com/HealthWatchUsa