Health Watch USA℠ Newsletter

www.healthwatchusa.org **Mar. 1, 2017**
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

Health Care Quality

INVITED COMMENTARY

Estimating Hospital-Related Deaths Due to Medical Error: A Perspective From Patient Advocates

Estimating Hospital-Related Deaths Due to Medical Error: A Perspective From Patient Advocates

Patient Advocates stress that the patient context should be dissociated from medical errors and preventable mortality. Our calculations of preventable hospital-related mortality are based upon two well controlled studies and are in line with other researchers. We calculated an annual rate of 163,156 preventable deaths and when combined with diagnostic errors, non-captured events and deaths after hospitalization can be projected to approximate 200,000 preventable deaths annually.

"Advocates are not calling to prevent problems for which solutions are not known but calling to implement known solutions to prevent all too common problems. What ties the occurrence of preventable adverse events and mortality together is the willingness and determination of facilities to adopt a culture of safety and invest in patient safety."

View Article (Journal of Patient Safety): http://journals.lww.com/journalpatientsafety/Abstract/2017/03000/Estimating_Hospital_Related_Deaths_Due_to_Medical.1.aspx

YouTube Video (6.5 mins): https://youtu.be/ktjh8EmO9QU

Kentucky Health News: Study analysis by Kentucky critic of hospital safety estimates more than 200,000 preventable hospital-associated deaths each year http://kyhealthnews.blogspot.com/2017/02/study-analysis-by-critic-of-hospital.html

News Release: View Document

Blog Post: https://medicalresearch.com/author-interviews/estimating-hospital-related-deaths-due-medical-error/32105/

AHRQ Report on Hospital Mortality - May 6, 2016

AHRQ: "Our report estimates the number of adverse events that happen each year in U.S. hospitals. According to the most recent data, nearly 4 million adverse events occurred in U.S. hospitals in 2013. Based on that estimate, we can project that about 170,000 people died in 2014 as a result of an adverse event or medical error. Of these, we estimate that about 44 percent—approximately 75,000—were preventable." https://www.ahrq.gov/news/blog/ahrqviews/strengthening-ahrqs-role-in-preventing-medical-errors.html

Lexington Herald Leader Op-Ed. Choosing a Hospital? Read This First.

"It needs to be stated on the front end that the hospital industry is not happy with the current quality measurements. However, the vast majority of these measures were derived from, or had extensive input from, the health-care industry. The industry criticizes these measures as not being accurate. Of course, the exception is when a facility scores No. 1; then there seems to be no limit to marketing the result."

"Scores on accreditation from The Joint Commission are also touted as the measurement of choice for quality. However, this accreditation organization was forged out of the health-care industry and all too often gives a gold star of approval. The accuracy of its accreditation process has also been brought into question by a recent CMS report which found for fiscal year 2014 (latest data available) a 42 percent "disparity rate" for The Joint Commission surveys. In other words, these surveys were out of compliance. By law, the compliance rate needs to be 80 percent or greater."

Read More LHL OpEd: http://www.kentucky.com/opinion/op-ed/article130669754.html

Association Between Hospital Penalty Status Under the Hospital Readmission Reduction Program and Readmission Rates for Target and Nontarget Conditions.

After HRRP (Hospital Readmission Reduction Program) implementation in October 2012, the rate of change for readmission rates plateaued ($P < .05$ for all except pneumonia at nonpenalty hospitals), with the greatest relative change observed among hospitals subject to financial penalty.
https://www.ncbi.nlm.nih.gov/pubmed/28027367

Nearly Half of Death Certificates List Inaccurate Causes

http://www.healthleadersmedia.com/quality/nearly-half-death-certificates-list-inaccurate-cause-death

Healthcare Infections

Should Hospitals Be Held Accountable for High Infection Rates?

Lisa McGiffert, Consumer Reports:

View YouTube Video:
https://youtu.be/ly4MzrJCvkw

San Diego Union-Tribune: "Consumers Union, the advocacy arm of product research magazine Consumer Reports, recently filed a petition with the California Department of Public Health that was highly critical of how the regulatory agency uses the data that is collected and reported every time a patient gets one of several types of hospital-acquired infections. The nonprofit decries what it says is a "firewall" between the department's infection-tracking and investigation divisions and calls for inspectors to start receiving prompt notification when infection rates spike." Read more at:
http://www.sandiegouniontribune.com/news/health/sd-me-hospital-infections-20170131-story.html

The Day the WIP (Dutch Working Party on Infection Prevention) Died

Andreas Voss: "I believe that only an independent, integrated and coordinated approach (by one organizational structure) can ensure the basics of effective and sound infection control."
https://reflectionsipc.com/author/vossandreas/

Effect of Detecting and Isolating Clostridium difficile Carriers at Hospital Admission on the Incidence of C difficile Infections

JAMA: "We estimated that the intervention had prevented 63 of the 101 (62.4%) expected cases. By contrast, no significant decrease in HA-CDI rates occurred in the control groups."
http://jamanetwork.com/journals/jamainternalmedicine/article-abstract/2516765

Eight years of decreased MRSA healthcare-associated infections associated with Veterans Affairs Prevention Initiative

"The VA program included having a dedicated MRSA prevention coordinator at each facility to oversee a bundle of interventions which included: universal active surveillance (screening) on admission, unit-to-unit transfer, and discharge; contact precautions for those colonized or infected with MRSA; adherence to hand hygiene; and institutional culture change where infection prevention became everyone's business." "... the Veterans Health Administration, found that between October 2007 and September 2015 monthly HAI rates dropped 87 percent in intensive care units (ICUs), 80.1 percent in non-ICUs, and 80.9 percent in spinal cord injury units (SCIUs). In long-term care facilities (LTCFs), rates fell 49.4 percent during the period of July 2009 to September 2015.

During September 2015, only two MRSA HAIs were reported in ICUs, 20 in non-ICUs (with three in SCIUs), and 31 in LTCFs nationwide." https://www.elsevier.com/about/press-releases/research-and-journals/eight-years-of-decreased-mrsa-healthcare-associated-infections-associated-with-veterans-affairs-prevention-initiative

Effects of control interventions on Clostridium difficile infection in England: An observational study

"National fluoroquinolone and cephalosporin prescribing correlated highly with incidence of C difficile infections (cross-correlations >0·88), by contrast with total antibiotic prescribing (cross-correlations <0·59). Regionally, C difficile decline was driven by elimination of fluoroquinolone-resistant isolates (approximately 67% of Oxfordshire infections in September, 2006, falling to approximately 3% in February, 2013; annual incidence rate ratio 0·52, 95% CI 0·48–0·56 vs fluoroquinolone-susceptible isolates: 1·02, 0·97–1·08). C difficile infections caused by fluoroquinolone-resistant isolates declined in four distinct genotypes (p<0·01)." http://www.thelancet.com/journals/laninf/article/PIIS1473-3099(16)30514-X/fulltext

Ebola 'super-spreaders' cause most cases

BBC News: "The majority of cases in the world's largest outbreak of Ebola were caused by a tiny handful of patients, research suggests. The analysis, published in Proceedings of the National Academy of Sciences, shows nearly two thirds of cases (61%) were caused by 3% of infected people. " http://www.bbc.com/news/health-38955871

Terminal Cleaning - Time to go shopping for a ultra violet cleaning system?

https://reflectionsipc.com/2017/01/19/time-to-go-shopping-for-a-uvc-system/

Medical Devices

Power Morcellators: New GAO Report

GAO: "Cancer Risk Led FDA to Warn Against Certain Uses of Power Morcellators and Recommend New Labeling:" http://www.gao.gov/assets/690/682574.pdf

Flaws in adverse event reporting kept power morcellators in use

"The FDA's passive adverse event reporting system depends on individuals to flag problems associated with medical devices. In the case of power morcellators, the GAO found, doctors and hospitals did not tell the FDA about the risk of spreading cancer via power morcellation." http://www.fiercebiotech.com/medical-devices/flaws-adverse-event-reporting-kept-power-morcellators-use

Dangers of the Essure Contraceptive Devices

Amanda Rusmisell, legislative Liaison for the Essure Problems Group presents on reported dangers of the Essure Contraceptive Device along with the activities and accomplishments of the Essure Problems.

Corrected Link to YouTube Video:
https://youtu.be/zSVe5MQLTeA

==========

Health Watch USA's Mar. 15th Meeting

7:00 PM ET -- Adobe Connect

Meeting Information: Dr. Gerald Hickson presenting on the dangers of disruptive behavior in the Operating Room.

Washington Top News: "Surgeons rude to patients may pose problem in OR, study says. Complications were most common in patients whose surgeons had received lots of earlier complaints about their behavior, researchers found. The complaints were typically unsolicited phone calls to hospitals from unhappy patients or their relatives." http://wtop.com/health/2017/02/surgeons-rude-to-patients-may-pose-problem-in-or-study-says/

To Join the meeting, send an email to healthwatchusa@gmail.com

Health Watch USA's 2016 Healthcare Quality & Patient Safety Conference

Ideas for patient safety: collaboration, transparency, more nurses in hospitals and nursing homes, surgical patients' risk awareness.

Kentucky Health News. Nov. 20, 2016: "Patient safety was the topic at the 2016 Health Watch USA conference this month in Lexington, with health advocates calling for a more collaborative and transparent health-care system to better prevent medical errors, improved nurse-to-patient ratios and a call for patients to become their own advocates to improve their safety in the operating room." http://kyhealthnews.blogspot.com/2016/11/ideas-to-improve-patient-safety.html

Presentations video for the 2016 Conference are now online.

To view the conference presentations: Go To:
https://www.youtube.com/playlist?list=PLKKV6p_etRmPhxndxzrvt7yeE-ICUmqzK

==========

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