Patient Safety America Newsletter

October 2010 http://PatientSafetyAmerica.com John T. James, Ph.D.

Question: Until very recently the Joint Commission, a consortium of 80% of all U.S. hospitals was the only body accrediting hospitals. This is a classic example of self regulation. Sentinel events are serious adverse events that harm patients. The Joint Commission has a voluntary Sentinel Event Reporting System. By its own estimate what fraction of sentinel events are actually reported to the Joint Commission by accredited hospitals? a) 1/1000 b) 1/500 c) 1/100 d) 1/50 e) 1/10

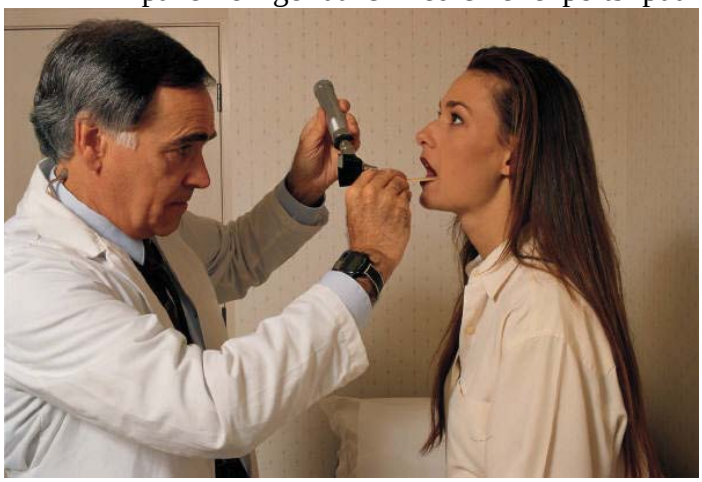
While you are in the Hospital

No doubt all of you have been in the hospital for treatment or there to look after the care of someone else. Hospitals are sometimes frightening places where fantastic cures and needless failures occur daily. Three articles were published this past month dealing with problems in hospitals, but also with good news on improvements in quality measures.

The first article deals with communication discrepancies as viewed by doctors and patients in a not-for-profit, teaching hospital in Connecticut.[1] The opinions of 43 doctors and 89 patients (age range 18-95 years old) were studied through questionnaires administered on the day of discharge after a hospital stay of at least 2 days in 2008-9. Patients with impaired reasoning capacity or those treated by a secondary intern on weekends were excluded. Only 18% of the patients could name the main physician caring for them, but 2/3 of the doctors thought their patients knew their name. Seventy-seven percent of the doctors thought the patient knew his diagnosis, but only 57% actually did know it. Interestingly, a slight majority of patients felt that doctors had given them a comprehensive explanation of what was going on, but only 1/5 of the doctors thought they always provided explanations at appropriate times. About 2/3 of the patients received new medications while in the hospital, but 90% said that they were not told about any adverse effects that could result from use of the medication.

Communication is a two way process. When you are in the hospital know who is in charge of your care and ask until you are certain of your diagnosis, your treatment plan and whether you have been given the information you need to make informed decisions. Ask if a new medication you are prescribed has any side effects. That brings us to the second article, which is about inappropriate prescribing in hospitals.

A panel of geriatric medicine experts put



together a list of drugs that should be avoided in older persons. This is called the "Beers medications" list and is based on criteria first proposed by Mark H. Beers http://en.wikipedia.org/wiki/Mark_H._Beers. The investigators asked the question: would there be fewer of the potentially dangerous medications prescribed if physicians used a computerized order entry warning system.[2] They targeted only drugs for which legitimate alternatives existed for older patients. The investigators compared the rate of potentially dangerous drugs prescribed to older patients in a large urban hospital in 2004 when no warning system was in use to ordering rates in 2005-

2008 when the system was in use. They found that without the warning system 11.6 % of the patients were prescribed potentially dangerous medications, but this dropped to 9.9 % once the warning system was in use.

If you are looking after an older patient in a hospital and a new medication is being prescribed to her, then ask if someone has done a literature search to determine if there are precautions for its use in older patients. Ask if there could be safer alternatives. If you want to appear informed, you could ask if it is on the Beer's list. In my opinion, it seems disconcerting that 10% of the time potentially dangerous medications are being prescribed to hospitalized older people. You may recall last month that I summarized an article showing that a large fraction of hospital admissions was directly due to adverse reactions to inappropriately prescribed medications in older patients.[3] **Recklessness prescribing to older Americans has to stop.**

That is a sufficient dose of scary news. A "sounding board" article in the *New England Journal of Medicine* described the improvements in quality measures achieved by hospitals in the past few years.[4] In 2002 hospitals accredited by the Joint Commission were required to report a few quality measures and these were made public in 2004. In that same year the Centers for Medicare and Medicaid Services insisted that it receive the same information, and this was publically reported in 2005. Now there are 57 quality measures of which 31 are publically reported. The "success" story the authors cite is the use of beta-blockers for patients who have had a heart attack. The defining study on the value of beta-blockers was published in 1981 in the *JAMA*; however, as late as 2002 only 87% of the patients who should have received these drugs actually got a prescription. Now this percentage is just over 98 %. One might count this as a success if it were not for the hundreds of thousands of people who died early because they did not receive beta-blockers in the years after 1981. The overall quality accountability of hospitals has improved from 82% in 2002 to 95% in 2009. The authors do call for continuous improvement of these quality measures, including robustness so that clinicians cannot just check boxes in discharge instruction forms and avoid giving thorough instructions.

If you want to check out some quality measures on specific hospitals, try this link: http://www.hospitalcompare.hhs.gov/hospital-search.aspx, but do not get your hopes up too much. Here is what I found if I wanted to know where to go within 5 miles of my zip code if I had a heart attack. Which hospital would you choose? I do like the idea that patient's opinions are being compiled.

Hospital→ Measure↓	A	B	C
30-day death rate after treatment of heart attack	No data reported	About the national average	Better than the national average
Patients who would recommend this hospital	87%	75%	63%

How to Give Birth

I am the proud grandfather of a beautiful baby boy born to my daughter three months ago by the natural method on a Saturday afternoon in a very non-busy labor-and-delivery floor of a major hospital in Dallas. Why was this floor so empty on a Saturday afternoon? Don't babies come into the world when they please? Cesarean deliveries now constitute 1/3 of all births in the United States, and many of these are *scheduled* deliveries. No one is going to schedule a Cesarean delivery for Saturday afternoon. If you would like to see how this procedure is done go to: http://www.ahrq.gov/research/jul10/0710RA1.htm (click on the second screen). Of 25 countries listed in the Organization for Economic Cooperation and Development (OECD) the U.S. has the 4th highest rate of C-sections.[5] The cost of an uncomplicated C-section is about $5-7,000 more than an uncomplicated vaginal delivery.

According to a perspective article in the *JAMA*, the guidelines for trial of labor after a C-section for a woman who has had a previous C-section have just been relaxed.[6] This could be an important step toward reducing the frequency of C-sections. The guidelines, which come from the American College of Obstetrics and Gynecology, emphasize better counseling of women

about their choices and the fact that most women who have had one C-section can deliver without surgery the second time. The downside is that an emergency C-section is required if the trial of labor fails. The guidelines emphasize that the birthing facility must be prepared to act if a trial of labor fails. If a facility does not offer a trial of labor after a C-section, then that facility cannot force a woman to have a C-section simply because their policy does not allow trial of labor. All options and risks must be discussed carefully with the woman's obstetrician. Do not buy an unnecessary C-section.

Cheers to Your Liver

Roughly 4 million Americans suffer from a liver infected with hepatitis C virus. This condition can lead to liver cancer, cirrhosis of the liver, and early death. A team of investigators asked the question: What portion of these victims actually received recommended care for their illness?[7] The team started with more than 10,000 patients enrolled in a private insurance plan from 2003-2006 and asked if their claims records showed that their care included 7 quality indicators listed in Medicare's 2009 physician quality indicator initiative. Less than 1/5th of the patients received all the recommended care that they should have gotten. Of the 7 indicators, the most neglected was hepatitis A vaccination. The authors conclude that "the quality of care given to patients with hepatitis C virus infection falls far short of that recommended by practice guidelines." Care was best when a generalist and a specialist were part of the patient's caregiver team. If you or someone you know is being treated for this serious illness, ask if guidelines are being followed, and ask that the care team include a generalist and a specialist.

Say What?

As the parent or past parent of any teenager can attest, their hearing becomes very selective. There may be more than just psychological reasons for this apparent loss of hearing. Four MDs asked if the prevalence of hearing loss in adolescents (age 12 to 19 years) changed in the years 2005-2006 as compared to 1988-1994.[8] The groups they studied were selected to be representative of this adolescent age group throughout the U. S. They studied

audiograms from a group of 2900 subjects examined in the earlier years and compared these with audiograms from 1800 adolescents from the later period. The rate of hearing loss in the early group was 15%, whereas in the later group it was about 20%.

The cause of increased hearing loss is unclear, but the rate of hearing loss was surprising to me. In the later group girls had less hearing loss than boys. The investigators adjusted the data for frequency of ear infections, so that is not thought to be the cause. Genetic factors are known to affect hearing loss, but that alone should not have changed between the groups. A higher likelihood of hearing loss with increased poverty has been observed previously and was apparent in this study, but it is uncertain if this might have produced the increased loss because there is more poverty. Markers of noise exposure, which were not especially robust, did not seem to explain the change. The authors conclude that association between noise exposure and hearing loss needs further investigation. Understanding the cause of hearing loss matters since such losses are associated with poorer performance in school.

The implications of this report and others on teenage hearing loss are obvious. If you have a teenager in your life, then encourage them to avoid excessively loud noises. Unfortunately, we all know how well teenagers listen to the advice of their elders.

Patient and Physician Compensation

Two articles on compensation caught my eye this month. The first was an editorial in *Annals of Internal Medicine* on compensation of patients without litigation after they have been harmed by healthcare[9] and the second was a commentary in the *JAMA* on physician compensation based on cost and quality measures.[10] The first article, written by a lawyer, surveys the "severe dysfunction" in the present system of litigation-based compensation.

The editorialist describes the landscape as follows: many patients are injured, a tiny fraction of those file claims, there is widespread disagreement on the cause of medical errors, and there are strong disincentives for admission of error. The author describes the plan adopted at the University of Michigan Health System in which errors are identified, admitted, and compensation offered – all without legal mandates. The jury, so to speak, is not in on the true effectiveness of such a plan. The author points out that the Michigan system is integrated (physicians and hospitals are a single enterprise), whereas in most of the country patients are treated by physicians who are paid and insured separately from hospitals. In a previous newsletter (November 2009) I reviewed a book called "High Performance Healthcare" in which the lack of integrated patient care is a product of this separation of doctor and hospital.

The second article, which is called "Physician compensation, cost, and quality" paints a troubling portrait of the interplay of these three factors in the U.S.[10] Physicians can be paid by salary, capitation (volume of patients seen), or fee for service. Salary payment may lead to low productivity of physicians. Capitation payment may lead to underuse or insufficient time to adequately treat patients. Fee for service may lead to overuse of services. The author states that "there has been enough experience to date with pay for performance and transparency to argue convincingly that neither of these additional mechanisms for compensating physicians will achieve the goal of most patients to receive high-quality, humane, and affordable care unless the mechanisms are substantially improved." The author argues that innovative ways of compensating physicians to achieve the goals patients want must have specific objectives. He speaks to a list of parameters that a primary-care physician should know about his patient-care population. One of these is to know how many patients have died and whether death was due to "medical care that could have been better."

I dislike ending this newsletter on a negative note, but to me it is clear that the U.S. healthcare industry has a long way to go before it can deliver high-quality, humane, and affordable healthcare. News reports last night noted that 51 million Americans have no health insurance. There's an old song by Bob Dylan called "Blowin' in the Wind" in which he asks, "How many years can some people exist before they're allowed to be free?" I ask: How much longer will you stand by and watch as your neighbors suffer entrapment between their need for healthcare and their ability to pay for it?

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Answer to question this month: a) unbelievably, only 1/1000 is thought to be reported[11]

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