Is Patient Safety Something You Think About in Your Practice?

In 2001, the **Institute of Medicine** (IOM) published *Crossing the Quality Chasm: A New Health System for the 21st Century*, which outlined fundamental changes that must be made in order to improve healthcare in the United States. Here is a quote from the book:

> *"The U.S. health care delivery system does not provide consistent, high-quality medical care to all people. Americans should be able to count on receiving care that meets their needs and is based on the best scientific knowledge—yet there is strong evidence that this frequently is not the case. Health care harms patients too frequently and routinely fails to deliver its potential benefits. Indeed, between the health care that we now have and the health care that we could have lies not just a gap, but a chasm."*

Although the concepts in the books have been widely implemented in the inpatient setting (**100,000 Lives Campaign** and now **5 Million Lives Campaign**), not as much has been done in the outpatient setting, predominantly because inpatient safety has been (rightfully) highlighted by needless deaths and injury (**The Josie King Story**, **The Dennis Quaid Story.**) These same concepts must be applied in the outpatient setting to achieve improved patient care and patient satisfaction. Ultimately, patients will **demand** to know what medical practices are doing to provide safe, effective, patient-centered, timely, efficient and equitable care. This is a great book to read (you can read it online) and think about in preparation for the changes coming with healthcare reform,

“Payment for Performance” (P4P) and electronic medical records promulgation.

Aim #1: Care should be **SAFE:** Patients should not be harmed by the care that is intended to help them. Current estimates from the **Agency for Healthcare Research and Quality** place medical errors as the eighth leading cause of death in this country. About 7,000 ”” people per year are estimated to die from medication errors alone ”” about 16 percent more deaths than the number attributable to work-related injuries.

Aim #2: Care should be **EFFECTIVE:** providing services based on scientific knowledge to all who could benefit and refraining from providing services to those not likely to benefit. Estimates are that about half of all physicians rely on clinical experience rather than evidence to make decisions. But should they? Experts say that physicians in most practices do not see enough patients with the same conditions over long enough time to draw scientifically valid conclusions about their treatment.

Aim #3: Care should be **PATIENT-CENTERED**, respectful of and responsive to individual patient preferences, needs, and values and ensuring that patient values guide all clinical decisions. One study of physician-patient interactions showed that physicians listen to patients’ concerns for an average of 18 seconds before interrupting. Medical schools are beginning to place greater emphasis on the development of good patient-interaction skills.

Aim #4: Care should be **TIMELY:** reducing waits and sometimes harmful delays for both those who receive care and those who give care. Many hospital Emergency Departments (EDs) are symptomatic of a system that cannot reliably give timely care. One recent survey revealed the average wait at “crowded” EDs was one hour. One third of U.S. EDs report they must periodically divert ambulances to other facilities.

Aim #5: Care should be **EFFICIENT:** avoiding waste, including waste of equipment, supplies, ideas and energy. Some experts estimate that most physicians are productive only 50% of their time, in part because the system works against them. Working smarter, not harder, can reduce non-clinical work and increase "face time" with patients.

Aim #6: Care should be **EQUITABLE:** care that does not vary in quality because of personal characteristics such as gender, ethnicity, geographic location, and socioeconomic status. There is a growing number of studies showing disparities in care and treatment for some population groups. The implications can be dramatic: for example, the life expectancy of a black child is seven years shorter than that of a white child in Baltimore, Maryland, USA.

You can download a PowerPoint program from the Institute for Healthcare Improvement (IHI) that cover the concepts in the book for free **here**. Registration is required, but it is free and gives you access to lots of tools and resources.

You can also read the book for free online by clicking on the "READ" icon below. No registration is required.

What books, websites, blogs, organizations or people would you add to the list of resources to prepare us for the changes of the future?

The Healthcare Bill, Rage,

Concierge Practices, Cuts, Claims and Don Berwick (Yes!)

HEALTHCARE BILL IMPACT ON INDIVIDUALS AND RAGE

A number of people asked me about the impact of health reform on them as individuals. Here is a **great story from the Atlanta Journal-Constitution** that takes specific examples of individuals and families and speculates on how the new bill(s) will impact them.

For 2010, the changes are minimal:

- Dependent children may be covered by their parents' health insurance policies until age 26.
- A high-risk insurance pool will open for people with pre-existing conditions who have been uninsured for six months.
- In 2011 Medicare will pay for an annual checkup, and deductibles and co-payments for many preventive services and screenings will be eliminated. The Medicare prescription drug doughnut hole will gradually narrow every year until it is eliminated in 2020. People in the "doughnut hole" could receive a $250 rebate this year.

I have to say that I've been dumbfounded by the fury raised over the passage of the new healthcare legislation. I realize that the bills separate people into winners (uninsured, providers with uncompensated charity care, patients with pre-existing conditions, Medicare patients, providers who see Medicaid patients, families with adult children, etc.) and losers (companies who have to pony up more money for their retired employees, insurance companies, illegal immigrants, high wage earners, etc.), but **this story placed the fury into a different perspective for me**. It's a good read.

CONCIERGE PRACTICES

What does healthcare reform mean for the physician practice? Many are predicting the rise of concierge practices (also called boutique medicine, retainer practices, VIP medicine and cash practices) as physicians find they cannot survive if their patient population is predominantly Medicare, Medicaid and uninsured patients. Concierge practices fall into two categories:

- The first operates on an insurance+ model, which means that the practice accepts and files the insurance for the patient, but also requires an additional out-of-pocket fee of anywhere from $1500 to $1800 per year to be a patient of the practice. The fee is to cover services that Medicare and commercial insurance do not, such as physicals, phone consultations, wellness counseling and patient education.
- The second operates on a strictly cash basis and the practice does not accept or file any insurance for the patient. The patient pays a flat fee per year for care (usually in the $5,000 to $15,000 range) and all primary care is provided for that amount. The patient still needs to carry insurance for prescriptions, hospital services and sub-specialist services. *Imagine being a manager in this type of practice – no pre-authorizations, no insurance department, no eligibility checking, no refunds…*

Concierge medicine has not been around that long, but it is growing in popularity by leaps and bounds. The first acknowledged concierge practice was formed in 1996 in the Pacific Northwest. In 2002, CMS (Centers for Medicare and Medicaid) published a memo stating that physicians may enter into retainer agreements with their patients as long as these agreements do not violate any Medicare requirements. In 2003, the Department of Health and Human Services ruled that concierge medical practices are not illegal. Today, there are

approximately 5,000 physicians using the concierge model in the United States today.

MEDICARE CUTS, MEDICARE CLAIMS AND DON BERWICK

Shortly after all the shouting and voting on healthcare reform was over, Congress recessed for two weeks leaving the controversy over the 21.5% cuts required by the SGR formula still unsettled. CMS has advised the MACs to again **hold claims for services provided from April 1 to April 10** to give Congress a chance to get back to work and back to voting for an additional delay (or not) for the cuts. If the cuts are allowed to stand, many physicians will start making their own cuts by minimizing the number of Medicare and Medicaid patients they will see.

Amidst this craziness, a voice of sanity is heard and it is Donald Berwick, MD, current President of the Institute for Healthcare Improvement (IHI) and **probable Obama pick for the head of CMS.** If you don't know Don Berwick or the IHI, click **here** to read an interview with him about the IHI's "100,000 Lives Campaign" or watch the video below of him speaking about the dimensions of quality. Good stuff!