UNACCOUNTABLE

What Hospitals Won’t Tell You and How Transparency Can Revolutionize Health Care

MARTY MAKARY, MD
How Many Die From Medical Mistakes In U.S. Hospitals?

by MARSHALL ALLEN, PROPUBLICA

September 20, 2013  4:52 PM

210,000 deaths

Sometimes the care that's supposed to help winds up hurting instead.
Causes of Death in the U.S.

1. Heart disease: 597,689
2. Cancer: 574,743
3. Variation
4. Chronic lower respiratory diseases: 138,080

Makary MA, unpublished data
Laparoscopic Hysterectomy

Cooper M, et al., BMJ 201
Safety Attitudes Questionnaire (SAQ)

It is easy to speak up if I perceive a problem in the OR

I would feel comfortable having my own care here

I would feel safe being operated upon here as a patient.

Rates of PE/DVT

- S.S.I.: $p < 0.05$
- Postop Sepsis: $p < 0.05$
- Postop Bleeding: $p > 0.05$

Unpublished data
# Operating Room Teamwork among Physicians and Nurses: Teamwork in the Eye of the Beholder

Martin A Makary, MD, MPH, J Bryan Sexton, PhD, Julie A Freischlag, MD, FACS, Christine L. Poon, PhD

<table>
<thead>
<tr>
<th>Caregiver Position Performing Rating</th>
<th>Surgeon</th>
<th>Anesthesiologist</th>
<th>Nurse</th>
<th>CRNA</th>
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<tr>
<td>Surgeon</td>
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<td>87</td>
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<tr>
<td>Anesthesiologist</td>
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<tr>
<td>CRNA</td>
<td>58</td>
<td>75</td>
<td>76</td>
<td><strong>93</strong></td>
</tr>
</tbody>
</table>

*B*
The Pre-Op Checklist

“Briefing”

- What are the names and roles of the members of the team?
- Has the patient & procedure been confirmed?
- Have antibiotics been administered?
- What is the plan for DVT Prophylaxis?
- Are there any instruments and equiplt. issues?

Patient Satisfaction as a Possible Indicator of Quality Surgical Care

Heather Lyu, BA; Elizabeth C. Wick, MD; Michael Housman, PhD; Julie Ann Freischlag, MD; Martin A. Makary, MD, MPH

**Importance:** In 2010, national payers announced they would begin using patient satisfaction scores to adjust reimbursements for surgical care.

**Objective:** To determine whether patient satisfaction is independent from surgical process measures and hospital safety.

**Design:** We compared the performance of hospitals that participated in the Patient Satisfaction Survey, the Centers for Medicare & Medicaid Services Surgical Care Improvement Program, and the employee Safety Attitudes Questionnaire.

**Setting:** Thirty-one US hospitals.

**Participants:** Patients and hospital employees.

**Interventions:** There were no interventions for this study.

**Main Outcomes and Measures:** Hospital patient satisfaction scores were compared with hospital Surgical Care Improvement Program compliance and hospital employee safety attitudes (safety culture) scores during a 2-year period (2009-2010). Secondary outcomes were individual domains of the safety culture survey.

**Results:** Patient satisfaction was not associated with performance on process measures (antibiotic prophylaxis, $R = -0.216$ [P = .24]; appropriate hair removal, $R = -0.012$ [P = .95]; Foley catheter removal, $R = -0.089$ [P = .63]; deep vein thrombosis prophylaxis, $R = 0.101$ [P = .59]). In addition, patient satisfaction was not associated with a hospital’s overall safety culture score ($R = 0.295$ [P = .11]). We found no association between patient satisfaction and the individual culture domains of job satisfaction ($R = 0.327$ [P = .07]), working conditions ($R = 0.191$ [P = .30]), or perceptions of management ($R = 0.223$ [P = .23]); however, patient satisfaction was associated with the individual culture domains of employee teamwork climate ($R = 0.439$ [P = .01]), safety climate ($R = 0.395$ [P = .03]), and stress recognition ($R = -0.462$ [P = .008]).

**Conclusions and Relevance:** Patient satisfaction was independent of hospital compliance with surgical processes of quality care and with overall hospital employee safety culture, although a few individual domains of culture were associated. Patient satisfaction may provide information about a hospital’s ability to provide good service as a part of the patient experience; however, further study is needed before it is applied widely to surgeons as a quality indicator.

What percent of Medical Care is Unnecessary?

Lyu H et al, Unpublished data, Johns Hopkins University School of Medicine
Measure Weight vs. Preventable Harm

HAC

Patient Satisf

AHRQ PSI-90

SCIP

CLABSI

Unpublished data, Johns Hopkins University School of Medicine
The Impact of Videorecording on the Quality of Colonoscopy Performance: A Pilot Study

Douglas K. Rex, MD¹, David G. Hewett, MBBS, FRACP¹, Meghna Raghavendra, MD¹ and Naga Chalasani, MD¹

| Table 2. Mean pre- and post-awareness inspection quality scores for all physicians |
|---------------------------------------------------------------|-----------------|-----------------|
|                                                               | Pre-awareness score | Post-awareness score |
|                                                               | Mean (s.d.)        | Mean (s.d.)        |
| Overall quality index (1 to 5)                               | 2.9 (0.9)          | 3.8 (0.7)          |
| Fold examination (1 to 5)                                    | 2.5 (1.0)          | 3.5 (0.8)          |
| Luminal distention (1 to 5)                                  | 3.4 (1.0)          | 4.2 (0.7)          |
| Cleanup (1 to 5)                                             | 3.0 (0.8)          | 3.9 (0.7)          |
| Adequacy of inspection time (1 to 5)                         | 2.6 (1.0)          | 3.7 (0.8)          |
| Measured inspection time (min)                               | 4.9 (2.2)          | 7.3 (1.8)          |

Am J Gastroenterol 2010;105:2312–2317; doi:10.1038/ajg.2010.245
Percentage of Covered Workers Enrolled in a High Deductible Health Plan or Savings Account, 2006-12

Note: HDHP/SOs are defined as (1) health plans with a deductible of at least $1,000 for single coverage and $2,000 for family coverage offered with an HRA (referred to as HDHP/HRAs); or (2) high-deductible health plans that meet the federal legal requirements to permit an enrollee to establish and contribute to an HSA (referred to as HSA-qualified HDHPs)

Hello New York, We're Oscar, A new kind of health insurance company

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Just click and a board-certified doctor will call you within an hour.

YOUR PERKS

Stay healthy with our free perks

Free Generic Drugs
Don't choose between your medications and your wallet. Most plans provide free generic drugs.

Free Doctor Visits
Most plans provide a few free primary care visits each year so you don’t need to think twice about visiting your doctor.

Smart Technology
Intuitive web tools guide you where to get care and how to save money.
You Can & Should Know the Price

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Read More

Surgery Pricing
Click on an area of the body where a surgery or procedure is needed. Use this tool to find a price and request a specialist to contact you.

ADDITIONAL PROCEDURES
Maryland’s All-Payer Approach to Delivery-System Reform

Rahul Rajkumar, M.D., J.D., Ankit Patel, J.D., Karen Murphy, Ph.D., John M. Colmers, M.P.H., Jonathan D. Blum, M.P.P., Patrick H. Conway, M.D., and Joshua M. Sharfstein, M.D.

On January 10, 2014, the Centers for Medicare and Medicaid Services (CMS) and the State of Maryland jointly announced the launch of a statewide model that will transform Maryland’s health care delivery system. Although some aspects of the new approach may be unique to Maryland and not applicable elsewhere, both the principles of this model and the process that led to its development may serve as a guide for future federal–state partnership efforts authorized by the Social Security Act and is tied to a growth limit in Medicare payment per hospital admission.

This system has eliminated cost shifting among payers, more equitably spread the costs of uncompensated care and medical pressure, combined with the fact that Medicare pays higher rates for hospital services in Maryland than it does under the national prospective payment systems for inpatient and outpatient care, has resulted in per capita Medicare hospital costs in Maryland that are among the country’s highest.

The new model, which is made possible by the authority granted to the Center for Medicare and Medicaid Innovation under the Affordable Care Act, will change
153 U.S. clinical registries

- 16.2% (19/117) AMA specialty societies
- 26% Funded by government
- 18% Audit data
- 23% Risk-adjust

Lyu H et al, Unpublished data, Johns Hopkins University School of Medicine
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