A Message for Every Governor Regarding Health Care Transformation

The need for Health Care Transformation is abundantly clear. The methodology necessary for that task continues to escape recognition. The reason why an effective solution continues to elude recognition is due to the failure of every source of activity seeking to contribute to those efforts during the past quarter century having failed to recognize, or appreciate two critical understandings necessary for meaningful health care transformation to take place.

First Understanding: the word *System*. The current health care system is, and has always been devoid of any systematic characteristics! Furthermore, that structural malformation was recognized in IOM To Err Is Human 2000, and a Rand Corporation study in 2004. But the failure to fully appreciate the critical importance of that structural malformation continues to elude every source seeking to improve the quality of health care and patient safety throughout the past quarter century.

Second Understanding: each state's responsibility to create, and maintain an effective health care delivery system. Two fundamental facts; all medical care is local, and states license doctors create, or should create, as undeniable fact, each state is responsible for their health care delivery system contribution to the whole system. But again, every source of effort to improving the quality of health care, and patient safety for the past quarter century have failed to recognize, and factor in, the importance of those two fundamental facts. A word to the wise, focus on the facts!

Test: include the above Understandings; the current health care delivery system is devoid of any systematic characteristics, and each state's responsibility to create, and maintain, an effective health care delivery system into every quality of health care, and patient safety study during the past 25 years. The results would clearly illustrate why every new estimate of needless hospital deaths has been significantly greater than all previous estimates during the past quarter century.

National Governors Association (NGA) is anticipating that most, if not all, state governors will meet in Nashville July 10-13.
The NGA Center for Best Practices Health Division provides information, research, policy analysis, technical assistance and resource development for governors and their staff across a range of policy issues. The health division covers issues in the areas of health care service delivery and reform, including payment reform, health workforce planning, quality improvement, and public health and behavioral health integration within the medical delivery system. Other focus areas include Medicaid cost containment, state employee and retiree health benefits, maternal and child health, prescription drug abuse prevention and health insurance exchange planning. (NGA web site)

Two specific projects underway within the division include:
Transforming State Health Systems to Improve Quality and Efficiency
Payment and Delivery System Reform

Good News: NGA recognizes each state's responsibility to create, and maintain an effective health care delivery system.

Bad News: Neither NGA, or seemingly any state governor has ever recognized that this "thing" they all refer to as a system is, and has always been, devoid of any systematic characteristics.

In Find The Black Box I go to great lengths early in the book to describe how the current health care "system" has two equally important, and equally flawed aspects;
Cost & Access (how to pay for health care after the fact)
Delivery System (where sick or injured people go for medical care)

Unfortunately, the Cost & Access aspect of health care clearly dominates considerations for how to "transform health care" while at the same time the latest estimate of needless hospital deaths (quality of care) is 4X the original 1990 estimate of NHDs used in IOM To Err Is Human. How can so many NHDs remain so unrecognized, and unreported?

Health care is a PRODUCT! Health care, whenever provided, is the work product provided by highly trained professionals, but unfortunately, too much of the patient care provided results in patient harm, i.e., the quality of care.

The Transformation of Health Care Conundrum
The vast majority of all efforts to create transformation of the current health care system is, and long been, focused on how to improve the quality of care through improving the control of the cost of providing that care. Successful producers of products, however, would not attempt to improve the quality of their product by instituting cost-saving measures, particularly as the principle attempt.

What's Really Missing in Every Discussion About the Transformation of Health Care?
We, our nation, and more importantly its Leaders, have never created, never attempted to create, or ever even thought about creating a true Health Care System with all of the characteristics of a true "system" with clearly defined points of authority, delegated authority, and the mechanisms for meaningful accountability.

All of the so-called experts talking about how to "Transform Health Care" lack the ability to describe, in detail, the current non-system they seek to change.

Quality of Health Care Track Record (see references)
1990 Original estimate of needless hospital deaths annually - 98,000.
2013 Latest estimate of needless hospital deaths is 4X that number.
A True System would never have tolerated such an inexcusable track record, but that track record comes straight from the quality of health care literature.

A Brief Description of Our Current Health Care Delivery System
- Approximately 5,500 acute care hospitals, and a like number of surgery centers.
- Over 800,000 doctors. (some estimate closer to one million)

- 50 state medical examining boards, all over 100 years old, and each with a mission statement containing the phrase, “to regulate the practice of medicine” in their state.
- Each state has created multiple agencies mandated to “regulate” portions of their state’s health care delivery system.

South Carolina (where I live) has 68 acute care hospitals, 65 surgery centers, and approximately 10,000 doctors. I have identified 16 different components that contribute, in some manner, to that state’s health care delivery system, and there is no evidence of systematic collaboration between those components, and no mechanism for acceptable accountability at the point of questionable patient care.

Example: “Even if you cured cancer you couldn’t get it to the people because the medical system is broken.” Dr. Spence Taylor, Greenville Memorial Hospital, April 2010. Both Governor Haley, and SC Legislature ignored, and continue to ignore that all-too-true assessment of SC, and all 49 other current state health care delivery systems. Time will tell if NGA Health Division will be open minded toward new considerations.

Excerpts from UNACCOUNTABLE Marty Makary, M.D., Johns Hopkins Surgeon and Patient Safety Expert, and contained in Find The Black Box by consent.

A hospital is no longer the community pillar I knew growing up, with its altruistic mission guiding its decisions. Hospitals have merged and transformed into giant corporations with little accountability – and they like it that way.

In 2010, a Harvard study published in the prestigious New England Journal of Medicine reported a finding well-known to medical professionals: as many as 25% of all patients are harmed by medical mistakes. What's even less known to the public is that over the past ten years, error rates have not come down, despite numerous efforts to make medical care safer.

Dr. Lucian Leape, at a national surgeon’s conference opened the gathering's keynote speech by looking out over the audience of thousands and asking the doctors to “raise your hand if you know of a physician you work with who should not be practicing because he or she is dangerous.” Every hand went up. Incredulous at this response, I took to asking the same question when ever I spoke at conferences. And I always got the same response. Every doctor knows about this problem – but few talk about it. Every day, people are injured or killed by medical mistake that might have been prevented with a modicum of adherence to standardize guidelines. The silence about the problem has paralyzed efforts to address it – until now. Medicine is its own culture. It has its own language, ethos, and code of justice. Doctors swear to do no harm. But on the job they soon absorb another unspoken rule: to overlook malpractice in their colleagues.

We all know the health care system is broken, burdening our families, businesses, and national debt. It needs common-sense reform. Seeking accurate ways to measure patient outcomes has long been the holy grail of health care reform, the starting point for fixing our broken health care system.

As I listen to Dr. Leape talk about secret addictions and other common impairments, I realized that he wasn't just talking about doctors who simply have poor skills or bad judgment. This was an entirely different problem. He was talking about doctors affected by dependence problems and other physical and mental impairments. That's when the problem of impaired physicians struck me as nothing less than a public health crisis. I did some more math. If, say, only 2% of the nation's one million doctors are seriously impaired by drugs, alcohol abuse, or other major impairments (and most experts agree that 2% is a low estimate), that means twenty thousand impaired doctors are practicing medicine. I asked, "What can be done about these few bad apples affecting so many people?" Dr. Leape smiled, and said, "The state medical boards take care of that."

Yet there are also grossly impaired physicians, doctors with horrible skills, hazardous judgment, ulterior your motive motives, or who suffer from substance abuse or other problems that make them dangerous. Society ought to be able to deal with this better, not sweep it all under the rug. Doctoring is a stressful profession with easy access to drugs, so it's no mystery why doctors have substance abuse problems. In fact, rates of serious substance abuse and psychiatric disease among doctors are actually higher than that of other professions with similar educational background in socio-economic status.
So who is in charge of policing medical care in America?

Every organization, institution, medical Association, and hospital administrator that I have asked has told me that policing physicians is the real responsibility of state medical boards.

My Challenge to Every Governor and NGA Health Division
Identify even one person in any state that can claim the ability to describe in detail that state's current health care delivery system by naming each component that contributes, and describe the presumed systematic characteristics of that system.

I can provide a plan for a 21st century health care delivery system that will incorporate all of the aspects for patient care accountability that have always been missing in the current non-system. Is anyone interested?

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