Patient Safety and High Performance Leadership Summit
Issues in Governance, National Collaboratives, and H.I.T.:
New Horizons: Imaging, Pain Management, Rural and Vulnerable Populations

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Webinar Transcript

Charles Denham: All right. We're starting our next panel, and we're so pleased that everybody has hung in so long today. We've got a terrific panel here, and what we'll be doing is we'll be shortening the end of the day just to give everyone a little bit of planning time.

Those [who] were in the Discovery movie: what we're going to do is take some photographs of you all together with your families and we'd like to have you kind of separate from the crowd at 5:00 o'clock and we'll go into a part of the ballroom [inaudible] so we can take some pictures and get some nice shots of everybody because you're all here, and so many of you are in the program. And what we're going to do is, you know, we want to be really respectful that we have a lot of folks in government and we know that we want to be very respectful of resources. We're having hors d'oeuvres. We have a host bar. We've moved the movie to 6:00 [inaudible]; it always has been, but this allows people to go on and to have their dinner, and it allows us to manage our resources properly and that kind of thing, just for planning purposes.

So I think we'll be pretty prompt at starting the premiere at 6:30, and we'll have a reception outside between 5:30 and 6:30; but those [who] are in the film and your families, we'd like to have you kind of go into the ballroom off to the side and we'll take some pictures in front of the posters and that will be kind of fun to get everybody involved.

So those [who] have remained on our WebEx and on our global streaming, we are starting our new panel, our next panel, "New Horizons, imaging, pain management, rural and vulnerable populations." We've got a really great group here to address this issue, and we just want to remind everyone that we are filming this segment. We think this is a really important segment in our future films. We're going to ask our panelists to kind of keep your comments to about 20-25 seconds so we can give you the best chance of being in the next documentary, because these are really important topics, and then we'll come back to you.

And then for the rest of the evening, for those [who] are here at the press club, we'll go for pictures and drinks for everybody [who was] in the film. Everyone else, we've got a reception outside for you, and we'll start the film at 6:30, and we'll get out at 7:30, and you can go off to dinner and have your evening. We love the fact that everybody has hung in here with the great energy that they have.

This is really an exciting area. We know that – we had Dr. McDowell speak in the last panel – that pain management is an absolutely greenfield opportunity. It has now moved up to the No. 1 reason that we see a primary care doctor. We know that 40% of cancer patients die with intractable pain in America today. In America, where we spend more money than anybody on healthcare, 4 out of 10 cancer patients don't have their pain controlled. That's crazy. And I think as we put in the film, everyone owns it and no one owns it. Does everyone really have the skills to really practice good pain management, and the answer is we really haven't.

So, Gladstone, as we go down, I think the first three of our panelists, we have Dr. McDowell, who's cross-trained as a urologic oncologist, urologic surgeon, as well as anesthesia and pain management; goes all over the country and teaches people how to do procedures because he's a great surgeon, in addition to understanding oncology for cancer, in addition to understanding pain; but the other issue is that vulnerable populations are the most vulnerable to pain, the most vulnerable to get addicted, and we had

15,000-16,000 deaths last year from narcotics that we really didn't need to because of how [poorly] we managed pain.

We'll ask Dr. Bechtle to talk about recent experience of reaching out to rural hospitals in Florida and what your read is and what you're seeing, and again a former flight surgeon with the Blue Angels, and frankly, we have so much to thank you for, Perry. You know, just like I mentioned Dr. Swensen being a servant leader, if it hadn't been for Dr. Bechtle, we wouldn't have been flying with the Blue Angels and that wouldn't have been in our film.

Dr. Zeltner is going to address how they have managed their vulnerable populations, but also almost all of the hospitals in Switzerland we would classify almost to be rural. So we're talking about rural because they're smaller and they have small hospitals closer to people and what insights that we can have there.

And then as we move down, we know David Hunt has a real passion for vulnerable populations and would like both [him] and Regina to talk about that, and we have latest data on star, we've got Paul Moore from HRSA, and he's going to join us, Health Resources and Services Administration, to tell us about the focus of rural and a real champion for rural with the Partnership for Patients, but I think we've got a great panel.

Gladstone, lead us off on this issue of pain, a little deeper dive, and how big the opportunity really is in this area.

Gladstone McDowell, II: So we have a major healthcare crisis. We have an epidemic that is unrecognized. Of a population of, say, 311 million, at least 100 million people at any one time are in chronic pain. I should tell you that we spend $100 billion treating back pain. It's $650 billion in terms of lost productivity and healthcare costs, and access is poor. I mean there is one pain doctor for about every 33,000 patients. If you're older, if you're a child, or if you're female or a minority, you have less chance of getting the best pain control. So it's a huge problem. Prescription deaths of 15,000-16,000 a year from prescription overdoses. Three of four people who die from prescription overdoses weren't prescribed the medicine. They got it from a friend, they got it from a family member; so just a huge opportunity to make a big difference if we set up a system and use technologies to really manage patients.

Charles Denham: Perry, reaching out into the rural environment as we kind of talk about, and I think rural is another, especially, a pain issue, and you're an anesthesiologist, a neuroanesthesiologist; so you also kind of see that overlap between those things. But are rural hospitals vulnerable populations by definition?

Perry Bechtle: Yeah, I've tried to make connections between the pain problem and the rural problem. I went to, earlier this week, actually on Tuesday, to a hospital in a very rural area of Georgia. As most people know, many areas in southern Georgia are very rural and have been exceptionally adversely affected by the economy with increasing levels of poverty, five percent over what they were even 10 years ago.

I met with an ER doc, pharmacist, head of anesthesiology, several nurses, the head of nursing; and the head of the pharmacy said they had told them what I was coming up for and this was such an important topic for her. She said, "I knew you were coming up to talk about some of the prescription drug addiction issues and that sort of thing," and she said, "I went to two patients randomly selected in each of our 12 units, for a total of 24 patients, and on admission looked at their admission drugs, and I think 18 out of the 24 were on prescription narcotic medications from somewhere, and all but one was on some sort of adjunctive therapy for pain." And that's the degree of the problem, and that's their baseline coming in, ever-growing problem in their population.

The emergency room physician said he believes that prescription narcotic overdose may be the leading cause of death in young people in his county. He didn't have any data, but he said from his experience working there, that may be a leading cause of death. A combination of morbid obesity and narcotic abuse with obstructive sleep apnea issues may be one of the leading causes.

Charles Denham: So we have a pandemic. This is a pandemic.

Now when you think about just the basics on medication management, and we have some of the leaders in the world, and in this room, Dr. David Bates and Dr. David Classen, and they'll tell you that the frequency of adverse drug events both in the ambulatory space and the acute-care space is just staggering, and these medications are always in the top five. So we still have this problem. We've been talking about it for years.

And for those [who] have just logged on or have come in recently, we are really honored to have Dr. Zeltner as part of our TMIT team. He is the new assistant editor of the *Journal of Patient Safety* and the director of the Global Programs and we're really reaching out globally. We're learning a lot more.

One of the things that most people don't realize is the research money and innovation, because the FDA is so stalled, has moved offshore. So the innovation is being done now in Europe and in Asia, not here. Our FDA is so slow now that everything is moving offshore, so a lot of the new technologies and approaches aren't here, although procedurally we're recognized as being the best. So they want to come over and learn how to do what we do, but then people will go back to Europe and study a drug or procedure or new device, which is really a shame, but that isn't our issue today.

Dr. Zeltner, in Switzerland, took care of 7 million people for 19 years at 60% of our cost and better outcome. By the way, they take care of their vulnerable populations, and every one of their hospitals we could almost classify as rural, about an average 180 beds, right, and so forth. So tell us what we could learn from Switzerland that we could apply today.

Thomas Zeltner: Well, two things. I think a healthcare system should really be measured on how well it serves vulnerable populations and that, I think, is the key indicator. And coming to Switzerland, the most vulnerable population we have are illegal immigrants, and we have really focused very much on looking what can we do to serve illegal immigrants, and actually a lot of enormous problems and the problems are that the doctors who serve them, whether they can get the names or not the names because they are not known so they need to get the names to the police and we solved, I would say 95% of that. In Switzerland, by now, illegal immigrants even can get a health insurance plan and the government will pay for it, but the government is split such that you don't get the names to those who then want to prosecute and expel them. And so I think it makes sense to look into the most vulnerable population and to say, "Is our system such that we can really serve them?" I'm glad to talk about the small hospitals in a minute**.**

Charles Denham: Great. And I know we have Sharon Rossmark here from one of our safety-net hospitals, and they take care of our vulnerable populations, and David and I have had numerous conversations about the fact that the majority of minorities in America [who] are becoming the majority are treated at only 300 hospitals out of almost 6,000. So we know where they are, we know they're in urban communities, and we know that they have unique patient safety issues.

David, thoughts there about the uniqueness of that vulnerable population group, and then Regina will talk about, from the consumer perspective, vulnerabilities of the poor who can't have access.

David Hunt: Well, health outcome disparity among the poor and underserved in our country is absolutely a huge issue, and it really has become a focus now at HHS. Why? There are a number of reasons. There's a moral responsibility, an ethical responsibility, but there's also a fiduciary responsibility. When you look at the cost of providing disparate care, it actually accounts for about one-third of the increase in healthcare spending that we have every year. So there are a lot of aspects to it that we really have to address.

When you look at the care of those for whom the least common denominator is the best possible care that they can expect to see, we see there are a number of opportunities for improvement, and those opportunities are very often facilitated, on sort of a one-trick-pony, to health IT. That is to say that we've been able to see time and time again when you drive performance level to maximal levels, often using

health IT, healthcare disparities start to melt away. That's one big thing that we really want to try to promote, and one reason I'm so passionate about health IT is that it provides finally a path that we can actually use to eliminate healthcare disparity.

Charles Denham: When we talk about vulnerable populations and we talk about the poor being a vulnerable population, you know, I hark back to one of the great programs, and I think Dennis Wagner is here, I talk about him being one of the greatest social entrepreneurs on the planet, and when I first met him, he was working with the hundred-zero program, 100% Access/Zero Disparity. And I was asked by the administration that came in to look at the work they were doing thinking that this was a grant that shouldn't go on, and my gosh, what did we find out? That if we take care of the poor in a community, Asheville, North Carolina, when the doctors took care of the poor in agreement with the hospitals admitting them and not pushing back, in agreement with the pharmacies taking care of their meds, and the government kicked in what they could, what happened? People [who] were working 70% of the time could work 100% of the time and they got healthcare insurance, and the community turned around.

And so I came up with this mathematical metric called Return to Community, and all I did was roll up the ROI of each one of them and showed the numbers to that presidential administration, and they said, "That works." And so there's a return on taking care of the vulnerable populations because we don't allow them to get to the emergency department, they don't get a Stage 2 cancer, or metastases in time.

So the vulnerable – and Regina, I've heard you speak about this, so share your thoughts, and again in a 25-second byte so I can make sure they get you in the next documentary.

Regina Holliday: Have you ever heard of green drop? They were made in the 1930s. They were this medicine that would cure everything. You could mix it with sugar and you could put it in your mouth or you could put it in your ear if you warmed it up, or you could rub it on your body. And when I was a child, my mom still had her bottle of green drop, and when I was sick, she would pour it and put the sugar in and she would give it to me when my throat was hurting or when my ear was infected because we couldn't afford to go to the doctor. And if we became very, very sick to the point that she was worried that something might happen to us, and what happened to us meant we might die, then she would take us to the doctor.

When I was in older elementary school, I broke my arm on the playground -- well, part of it; it was like a fracture -- and the principal was in the office and my dad came to pick me up, "I don't ever want you to do sports again because we can't afford it," and I never did do sports again. I sprained my ankle wearing a sandal when I was 10, and I was told never, ever wear sandals ever again, and to this day I never have.

See, we're taught how to live under an uninsured system. We're taught to only go to the doctor when we become so sick that we're about to die, and when we become adults, those lessons ingrained in our childhood stay with us for the rest of our life. So I can't help but wonder if I'd been raised differently, would I have pushed my husband harder to find out what was wrong with him rather than let him get so sick that he died.

We must have an equal appreciation for all populations. I've gone into meetings like this one and I've heard people say at the table, "You know, they're not smart enough to understand. We can't give them the imaging results so they can understand it. They're not college-educated like us." And that's when I slam my hand down on the table and say, "I only have a high school degree, but I can understand this." So please don't assume that a person who is uneducated is unintelligent.

Finally, when we talk about disparity, you must get on the ground with us to find out what's wrong with us. I've been in meetings like this one where they say, "Why aren't the poor people eating better?" And I said, "Hey, have you thought about redesigning the food pushcart that we push 10 blocks down the street to get our food home? When those wheels fall off after you bought it and it cost $20, $20 you didn't have, you probably stopped buying fruit because fruit is too heavy. You probably go to ramen noodles because ramen noodles are light, and you can hold a child in one arm and push a cart and take ramen noodles home." So we must look at the entire web of what we're doing to address disparity. Thank you.

Charles Denham: So, Paul, with HRSA, and we've talked about the vulnerable populations and the rural populations, and it turns out that there's a big overlap, isn't there?

Paul Moore: There is. As you talk about quality care, you have to say that the first part of inequality care is access to care, and as my colleague mentioned that IT brings, technology brings a great possibility for that, and, you know, access also includes being able to afford it even if it's there. You don't have access to it if you can't afford it. But even if that's fixed, where, you know, insurance, more folks have coverage and insurance takes care of the cost, insurance is not access, it's coverage, and there still needs to be the folks there to provide the care.

In rural America, about 20% of the population lives there, but only about 10 percent of the providers, and I'm not just talking about physicians. I'm talking about physicians, pharmacists, nurses, the entire resource that's there, and so that creates an access problem. Sometimes it's geographical, sometimes it's economic. It can be any number of things, but the first thing to any quality program is to have access to it. That's why I hold out great hope for telemedicine and other technologies. It is the key, it is a key to leveraging the resources there. This nation cannot afford to have haves and have nots based on poverty.

Moderator: Dr. Zeltner?

Thomas Zeltner: In Switzerland, we have 7 million, as he said, we have, 47 million and have 350 hospitals, which for everyone who organizes the health system says it's crazy, and our economists said that we need 80 to 100 so let's close 250. We started doing that and stopped because what we realized is what is a comfort in one way is from each home in Switzerland to the next hospital is something like three to five miles. For an old population, that's a wonderful thing to have.

And so I think the response of the system must be, let it be such that the access, even for one vulnerable group, is given and with the new technologies – and we have them – let's organize the system that even small units can deliver good service and that can be done. And I think the whole notion of too-small hospitals needs to be rethought and we need to be really very close to the patient and to their family and it can be done.

Charles Denham: Gladstone, back to the New Horizons and pain management: so if we were looking at the intersection of the vulnerable populations and poor, pain, New Horizons, and know that we have to be responsible with our resources, what insights can you give us because this is our next wave of research that we're going to be focusing on is pain management and we're going to pull together. What are the high-impact, high-volume scenarios and cases that we can help the fastest? And it sounds like back pain is a major issue. Is that a fair category of where the problem is?

Gladstone McDowell, II: Absolutely. Major issue, major problem, and not everybody needs surgery, not everybody can have surgery, so a lot of people are on pain medicine. The problem is that you guys are familiar with Vicodin and Lortab, that's hydrocodone. Ninety-nine percent of the world's supply of hydrocodone is prescribed in the United States, 99%. It's cheap and patients can get this. They can't get some long-acting medications from their healthcare insurance companies because they're a little bit more expensive. Controlled substances may be more costly than the cheaper medicines. And so patients who have financial disincentive, i.e., it costs you a $75 co-pay versus a $3 co-pay, are often pushed towards the cheaper substances because there's more margin for the healthcare for the insurance companies. That just promulgates the whole issue of short-acting opioids leading to some people making money off of them, some people overusing them because that's all they have.

So I think we need to really look at this and redesign our healthcare delivery systems. We need to redesign what types of drugs are covered for patients. We need to think about targeted drug delivery. You know, taking somebody who's on 1200 milligrams of OxyContin every day, and I work a lot with companies like Medtronic that are looking for targeted drug delivery, where we can use devices to deliver less medicine in a safer mode or use digital technologies, use pacemaking devices to treat chronic pain rather than continuing to prescribe high-dose opioids. But we really have this paradox between untreated

or undertreated pain and substance abuse, and we're not doing very well with either one of them. We are trying to treat pain better, but we're giving more of the wrong kinds of medicine that are going out and leading to prescription drug deaths. And then we are undertreating pain because people are worried about legal issues, regulatory issues, and then there's just a lot of lack of knowledge. We need to get back to educating our medical students, our nursing students, and then really setting up systems to protect patients. So I think Partnership for Patients and health information technologies are really crucial.

Charles Denham: Well, we're going to wrap up this panel, but one of the things that has become very clear working with the purchasing community is that we really need to get into a mode of "expect it, ask for it, demand it," and we need to really work with our employers because we've worked with employers for a long time. The Leapfrog Group is one of the areas that we've worked with them, but we've worked with them in other ways. And when you talk to a major employer [who] has 10,000; 50,000; 20,000; or 25,000 employees, and you start to tell them the benefits of better pain management to put people back to work and not have them go down the path of rehab and destroy their family and be able to use of these new technologies and look at it in a fully loaded cost.

I mean, we talk about the wonderful things of leadership and everything else, but actually there's a great return on investment by leading. There really is. There's a return on investment by properly taking care of your employees. Bob told us that it's important to take care of our employees as if they were our children. Well, would you want your child to get addicted because the insurance company figures it's cheaper to give them pain medicine than it is a neurostimulator or a pain pump or whatever? And the answer is no, but we just don't know it.

So I think an educated and informed population about pain is a wonderful opportunity, and as we look at what to do with WHO and as we expand the five rights, we got a five-rights-for-pain trajectory that we want to take with us, and it's a low-hanging-fruit opportunity. And I think that what I learned about this actually by working with Gladstone, and I put a project together at Harvard when I was a senior fellow at Harvard. And I'm a cancer doctor, and I don't know whether Dave Parda is still here, but I was shocked to find out that 40% of cancer patients die with intractable pain, and I've spent half of my life taking care of pain and I didn't know that. So if I didn't know it, a lot of people didn't know it. I had a huge practice.

So I think there's a great opportunity. Thank you guys so much. I think it's a great opportunity. Thanks for keeping us focused on it and the vulnerable populations and rural populations.

As we go after an election, if we get a major cut in reimbursement, they're going to be more vulnerable, because our small communities, they're the No. 1 or No. 2 employer in small communities. You shut down small hospitals, you shut down a community, and you have an even more vulnerable population. I'm not sure we've really thought that through, and I think that's why our trustees need to step up and say, "Let's take some of that endowment funding and put it to work in safety and quality and clean up our act so that we'll be able to be viable at a later time," and I think that's one of our messages.

Yeah? Or go ahead.

Gladstone McDowell, II: Bob Chapman, what he's taught us about this loving concept, taking care of each other, I think we need to have this convent concept. You know, convent is a solemn or sometimes sacred agreement between two people to either do something or refrain from it. I think we need to go back to that covenant concept of I'm going to take better care of you than I take care of myself, but I expect you to take better care of me; and so we get away from this "me" society and get back to the "we" society where we're all-inclusive because if we take care of everybody, all the voices rise.

Charles Denham: Great. So that we stick to our time, we are going to wrap up with an abbreviated session, but we'd like to talk about some of the next steps that …

And I see that we have Dennis Wagner here. We talked a little bit about the Partnership for Patients and integrating across some of these activities that we've talked about.

David Bates, maybe what we could do is come up and have an abbreviated kind of “next steps” and talk about a little bit of a wrap-up of some of the topics that we’ve covered during the day. And I think the Partnership is a reconciling force of a lot of the activities that we see, and give you a chance maybe to articulate where that’s going, to just leave us with that and tell us the trajectory that we’re following.

I’d like to address the wrap-up on the IOM report and some of the recommendations that we had there, so if Dr. Classen is here, and what we’ll do is we’re going to finish in about a 20-minute sort of timeframe. We have a reception outside. We’ll be turning off the WebEx and our global streaming.

We want to thank this panel, and we’ll wrap up with one more, kind of talking about what we learned today and what are the action steps that we can take.

Thank you very much, you all.