

THE ADVISORY BOARD

Daily Briefing

“Nation’s news in
five minutes”

News for Health Care Executives • Wednesday, February 13, 2008

SPOTLIGHT

Spine care spending increasing but not producing results, study says

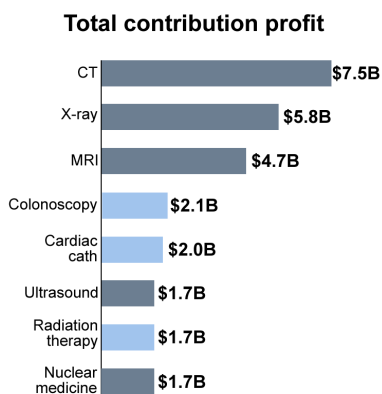
U.S. spending on back and neck ailments rose by 65% from 1997 to 2005, but that increase was not accompanied by an improvement in patients’ self-assessed health status, according to a study in today’s *JAMA*.

See story #1

RESEARCH HIGHLIGHT

Imaging still the leading player in outpatient business

Building on the strong growth experienced across the last decade, diagnostic imaging continues to represent the largest source of hospital outpatient profits, contributing more than \$21 billion in 2006. At the procedure level, imaging exams—CT, X-ray, and MRI—provide the three leading contributors to overall profitability. To learn more, please see the Innovations Center’s *Future of Diagnostic Imaging* brief.



Source: Advisory Board research, 2007

THIS DAY IN BRIEF

HHS publishes proposal to establish Patient Safety Organizations

HHS yesterday announced a proposed regulation that would establish Patient Safety Organizations in an effort to create a voluntary, non-punitive national patient safety reporting system.

See story #2

GAO testimony highlights problems with domestic PCP supply

Testifying before the Senate Health, Education, Labor, and Pensions Committee this week, officials from the U.S. Government Accountability Office cautioned that waning interest among U.S. medical graduates in primary care careers has narrowed the domestic pipeline of primary care physicians.

See story #3

USA Today says certain pharmacy policies may increase error risk

Although pharmacy chains say that technology and training improvements have enabled them to hold prescription-error rates to just a fraction of 1%, corporate policies emphasizing speed at some of the nation’s largest pharmacy chains may contribute to medication safety gaps, according to a *USA Today* investigation.

See story #4

FROM THE ADVISORY BOARD

Finance Watch: Recent OIG gainsharing approvals shed light on model

HHS’s Office of Inspector General last month approved two proposals allowing hospitals to pay physicians a portion of the cost savings achieved through the introduction of procedural efficiencies.

See story #5

NAMES IN THE NEWS

Akron Children’s (Ohio) (#8) ■ University of Cincinnati (Ohio) (#4)
University of Massachusetts-Lowell (#8) ■ University of the Sciences (Pa.) (#4)
University of Texas (#8) ■ University of Washington (#1)



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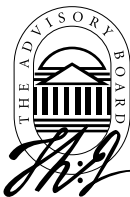
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► Today's Headlines

1 Spine care spending increasing but not producing results, study says

U.S. spending on back and neck ailments rose by 65% from 1997 to 2005, but that increase was not accompanied by an improvement in patients' self-assessed health status, according to a study in today's *JAMA*. Using data from the **Agency for Healthcare Research and Quality's** annual Medical Expenditure Panel Survey, researchers from the **University of Washington** studied spending and treatment practices for nearly 23,000 people annually during an eight-year period. After adjusting for age and gender, researchers found that patients with spine problems spent an average of \$6,096 on treatment in 2005, compared with an average of \$3,516 for those without spine problems; inflation-adjusted U.S. spending on spinal treatments in the United States, meanwhile, totaled almost \$86 billion that year, marking a 65% increase over 1997 expenditures and outpacing overall health expenditure growth. Despite this trend, the percentage of people with spine problems reporting physical, social, and mental limitations from back and neck pain increased from 20.7% in 1997 to 24.7% in 2005.

The researchers note that medication use showed the greatest relative increase among expenditure categories during the study period, as Americans in 2005 spent roughly \$20 billion on drugs for spine problems, an increase of 171% over 1997 numbers; spending on narcotic pain relievers rose more than 400% during this timeframe. Outpatient spine treatment spending also increased by 74% to \$31 billion during the study period, while spending on spine-related ED visits increased by 46% to \$2.6 billion and spending on surgical and other inpatient costs for back and neck conditions rose by 25% to about \$24 billion. The researchers attribute the growing expenditures to a variety of factors, including the availability of new and costly drugs and the greater use of medical imaging, diagnostic tests, spinal injections, and spinal fusion surgery and instrumentation. And although it remains unclear why more people report suffering from spinal pain, the researchers suggest the trend could stem in part from rising obesity rates or the side effects of excessive treatment. Given their findings, the authors conclude that "spine problems may offer opportunities to reduce expenditures without associated worsening of clinical outcomes" (Martin et al., *JAMA*, 2/13 [subscription required]; Parker-Pope, *New York Times*, 2/13 [registration required]).

2 HHS publishes proposal to establish Patient Safety Organizations

HHS yesterday announced a proposed regulation that would establish Patient Safety Organizations (PSOs) in an effort to create a voluntary, non-punitive national patient safety reporting system. The announcement comes more than two years after the program was authorized by the Patient Safety and Quality Improvement Act of 2005; since the act's passage, several organizations—including the **Institute of Medicine** and **American Hospital Association (AHA)**—have called for implementation of the data collection groups as a way to improve health care safety and quality. Under the proposed rule, public, private, and not-for-profit organizations—including hospitals—could be certified as PSOs through the **Agency for Healthcare Research and Quality (AHRQ)**. Once certified, PSOs would have the authority to aggregate patient safety information from providers, consult with them about patient safety events, and help identify areas for quality improvement. The rule also outlines how PSOs could share information with others involved in patient safety work, how that information would remain confidential and privileged, and how clinicians would receive feedback from the PSOs.

HHS says that by establishing confidentiality provisions, the proposed regulation seeks to ease providers' fear of liability or sanctions resulting from the discussion or analysis of patient safety

events—a critical barrier to voluntary participation in patient safety event reporting. Commenting on the proposal—published in the Feb. 12 Federal Register and open for public comment through April 14—the director of AHRQ says the regulation provides the framework for a “shared-learning approach” that will ultimately reduce the risk of harm to patients. The president and CEO of AHA, meanwhile, says that hospitals are “extremely pleased” that HHS has released the rule, adding that hospitals will rely on PSOs to “help identify the underlying causes of errors so that all health care providers can implement strategies to prevent harm to patients” (HHS [release](#), 2/12; [AHA News Now](#), 2/12). For more information on the proposed regulation, please access the Feb. 12 [Federal Register](#).

3 GAO testimony highlights problems with domestic PCP supply

Testifying before the Senate Health, Education, Labor, and Pensions Committee this week, officials from the U.S. **Government Accountability Office** (GAO) cautioned that waning interest among U.S. medical graduates in primary care careers has narrowed the domestic pipeline of primary care physicians (PCPs) but said that supply has been bolstered somewhat in recent years by an influx of international medical graduates (IMGs) pursuing primary care residencies, the Associated Press reports. For its report to Congress, the GAO examined data from **HRSA’s** Area Resource File, the **American Academy of Physician Assistants** (AAPA), the **American Medical Association**, and the **American Academy of Nurse Practitioners** to uncover recent and projected PCP supply trends and assess the influence of current health care payment models on the valuation of primary care services. While noting that the number of U.S. PCPs increased from 208,187 in 1995 to 264,086 in 2005, the GAO reports that there were 22,146 American physicians in primary care residency programs in 2006, down from 23,801 in 1995; moreover, the number of U.S. primary care residency programs fell from 1,184 to 1,145 programs across that period. Offsetting that trend, however, the number of IMGs entering primary care residencies rose from 13,025 in 1995 to 15,565 in 2006. Meanwhile the number of American medical graduates in specialty residency programs increased from 45,300 to 47,575 between 1995 and 2006, while the number of IMGs in specialty training also rose from 11,957 to 12,611.

Saying that “health care marketplace signals suggest an undervaluing of primary care medicine,” the GAO voices concern about the future supply of PCPs, physician assistants, nurse practitioners, other primary care professionals, and dentists. Given primary care providers’ role in the management of chronic conditions and delivery of preventive services, the GAO adds that an “over reliance on specialty care services at the expense of primary care” is likely creating a less efficient health care system. The GAO recommends that the nation move toward payment systems that appropriately reward care coordination. Calling the decrease in primary care trainees troubling, Sen. Bernie Sanders (I-Vt.) has urged Congress to double funds for the National Health Service Corps—which provides scholarships to students who provide primary care in underserved communities—to \$250 million next year (GAO [testimony](#), 2/12; [Associated Press](#), 2/12).

4 USA Today says certain pharmacy policies may increase error risk

While pharmacy chains report that technology and training improvements have enabled them to hold prescription-error rates to just a fraction of 1%, corporate policies emphasizing speed at some of the nation’s largest pharmacy chains may contribute to medication safety gaps, according to a *USA Today* investigation. For its analysis, the newspaper reviewed policies and alleged errors at both Walgreens and CVS—which together fill nearly one-third of all retail prescriptions nationwide—and examined “scores of lawsuits” and pharmacy board disciplinary actions in 10 states. *USA Today* notes that the investigation surfaced several common gaps, including a reliance on technicians, who have

less training than pharmacists; a failure to offer or provide face-to-face counseling to most customers, which is required in all but two states; and inadequate pharmacist staffing to accommodate high prescription volumes. In addition, the paper highlights policies at both chains that emphasize speed and prescription volume growth. *USA Today* reports that Walgreens' budget guidelines for work hours, for instance, suggest that pharmacists may have as little as two minutes to fill a prescription, and the company ties a portion of pharmacists' and pharmacy managers' bonuses to prescription volumes. CVS, meanwhile, tracks pharmacists' performance against three corporate goals: ensuring phones are answered within 20 seconds, filling prescriptions by the promised time, and ensuring walk-in customers wait no more than 15 minutes for pharmacists to fill their prescriptions.

In response to the investigation, both pharmacy chains called attention to their safety systems, and Walgreens noted that it has spent almost \$1 billion in last decade on safety training and technology. CVS added that error rates run well below 1% and said that number is "continuing to decline." The companies also have referenced a **University of Cincinnati** study—partially funded by the National Association of Chain Drug Stores—indicating that workload was just one factor contributing to medication errors at 36 chain pharmacy sites and that pharmacists were most prone to errors during dips in prescription volume. However, a pharmacy professor at **University of the Sciences** in Philadelphia maintains that pharmacy policies that increase workplace stress and emphasize speed are "an invitation for error," and *USA Today* adds that there are currently few standards dictating "how much [prescription] volume is too much" (McCoy/Brady, *USA Today*, 2/12).

► From the Advisory Board

5 Finance Watch: Recent OIG gainsharing approvals shed light on model

The following is an excerpt from the Finance Watch, a monthly publication that provides timely perspectives on the major events and trends that shape hospital finance, offering actionable information to assist chief financial officers with the management of their institutions and workforce.

HHS's Office of Inspector General last month approved two proposals allowing hospitals to pay physicians a portion of the cost savings achieved through the introduction of procedural efficiencies, offering insight into hospital efforts to avoid violating anti-kickback laws. However, while the regulatory body continues to approve gainsharing arrangements on a case-by-case basis—having now granted 10 total approvals—it still adopts a cautionary approach to the cost-savings model.

For more information

To read more about gainsharing arrangements and the new advisory opinions, please see the February issue of the [Finance Watch](#).

6 New online cardiovascular research compendium

Across the past 15 years, the Cardiovascular Roundtable has published hundreds of best practices and management tools for enhancing cardiovascular clinical and economic performance. To improve member access to its work, the Roundtable is pleased to introduce a next-generation online research library. Moving forward, members may search the archive by research study or through the new online Research Compendium. Organized by topic, the compendium enables members to find in one place all the published practices, implementation tools, technology assessments, and forecasts

addressing any one of a host of cardiovascular-specific topics—as well as to download all relevant materials in real time. Categories of searchable research include:

- Clinical Quality
- Finance
- Operations
- Strategic Planning
- Technologies & Therapies
- Medical Populations

For more information

All components of the research library are accessible to Cardiovascular Roundtable members through the program's home page at www.advisory.com/cr. Should you have any questions about this new service or the Cardiovascular Roundtable in general, please contact Mollie Reed at reedm@advisory.com.

7 Acquire Joint Commission Primary Stroke Center Certification

Since its inception in 2003, the Joint Commission stroke center certification program has designated more than 440 hospitals as Primary Stroke Centers. Due to this industry trend, the Advisory Board Company is pleased to announce the formation of a consulting initiative to help hospitals pursue Joint Commission Primary Stroke Center Certification. This program will assist our members as they look to formalize their stroke programs and improve clinical care of their stroke patients.

H*Works, the consulting division of the Advisory Board Company, actively partners with hospitals to help them achieve lasting results by implementing those best practices that address their greatest operational, financial, and strategic issues. By addressing only those problems for which the Advisory Board has already amassed a substantial body of best practices, tools, and case study experience, H*Works offers an answers-first advantage installing known, proven practices and processes quickly and with sustained results.

For more information

To learn more about how this engagement or other offerings in the H*Works portfolio can assist your hospital, please contact Neha Sharma at sharman@advisory.com or 202-266-6463.

► Regional Round-up

8 Around the nation: Bite-sized hospital and health industry news



- **Iowa:** State legislators are currently considering a health reform bill that would require hospitals and nursing homes to obtain permission from the Iowa Health Facilities Council prior to building replacement facilities outside of their current site. While proponents of the provision—which would end a current exemption to the state's certificate of need (CON) process—say it would help control costs, the vice president of the Iowa Hospital Association says the measure is unnecessary, given that replacement facilities do not add to overall capacity (Leys, [Des Moines Register](#), 2/11).

- **Ohio: Akron Children’s Hospital** recently launched its on-demand Children’s Room Service Dining Program, which gives pediatric patients their choice of kid-friendly comfort foods such as chicken tenders, grilled cheese, macaroni and cheese, and milkshakes and delivers the meals within 45 minutes of a request. The hospital, which spent roughly \$50,000 on new kitchen equipment and software for the dining program, expects the new system to reduce costs by limiting the amount of wasted food (Powell, [Akron Beacon Journal](#), 2/12).
- **Massachusetts:** The state will provide \$4 million to assist the **University of Massachusetts–Lowell** (UMass-Lowell) in building an “innovation center” that will help entrepreneurs develop, test, and commercialize medical devices. Approximately 40 faculty members from UMass-Lowell and UMass Medical School in Worcester will participate in the innovation center, which could open within a year, according to its co-director. To supplement the state support, the university will raise up to \$3 million in additional funding from federal and private sources (Gavin, [Boston Globe](#), 2/13 [registration required]).
- **Texas:** A study released by the Austin Chamber of Commerce concludes that a university-backed medical school in Austin would generate \$2.38 billion in yearly spending, create 19,307 jobs, and “be a central factor in positioning Texas as a competitor for the bioscience cluster.” Specifically, the study examines the potential for a medical school linked to the **University of Texas**, estimating that if such a program could drive at least a 1% improvement in the outcomes of patients with major diseases, it would generate \$11.17 billion in longevity and productivity benefit annually (Harrington, [Austin Business Journal](#), 2/11 [registration required]).

► Endnotes

9 Et cetera

Nifty navigation: GPS may enable assessment of peripheral artery disease severity

Global Positioning System (GPS) devices may help physicians determine the severity of peripheral artery disease (PAD), according to a study published in this week’s *Circulation*. Noting that walking capacity often varies from one day to the next for PAD patients, French researchers decided to forego the treadmill assessments typically used to measure maximal walking distance (MWD)—the maximum distance a PAD patient can walk at a normal pace before leg pain forces them to stop—and instead tapped GPS devices to assess the severity of PAD-related disability. After using GPS technology to test the MWD of 24 PAD patients strolling through a public park at a normal pace, the researchers found that measuring “MWD obtained at a person’s usual pace is largely superior to the MWD measured on a treadmill” and may offer a cheaper and less time-consuming alternative to traditional tests performed in vascular laboratories. They note, however, that GPS devices could not entirely replace treadmills for measuring MWD because treadmill tests are standardized and concurrently measure patients’ blood pressure, oxygen consumption, and heart rate.

—[HealthDay](#), 2/5