IOM has it mostly right

Regarding "Right there all along," (Sept. 10, p. 6), I think for the most part, the Institute of Medicine got it right. I do, however, have a couple of concerns to share.

First is the over-emphasis on technology as the answer to health-industry ills. I have visited 116 hospitals in 11 countries in recent years and have found that leaders who have the latest and greatest bar-coding system or EMR or other technology think they are doing everything they can to deliver patient safety. That could not be further from the truth. Technology is only a tool. It must be supported by good-care processes. Most organizations don't have a system to identify and solve frontline problems on a daily basis. They lack standard work and haven't mapped out the full patient experience.

The report's second weakness is its lack of focus on the principle that 99% of the problem in healthcare today is faulty processes, not faulty people. In the 1960s, the FAA took the airline industry by the horns and mandated fail-safe processes that prevented human error. Aviation is now one of the safest industries. This is what we are fundamentally missing in healthcare.

Establishing standard work for care processes can virtually eliminate errors. Members of the Healthcare Value Network prove this every day. St. Jude has achieved this with ventilator-associated pneumonias for three years in a row, Mercy (Medical Center) North Iowa with lab specimen tube errors for two years and ThedaCare with admission medication reconciliation errors for five years running.

Overall, the IOM report is a welcome addition to the literature on the problems facing healthcare and includes a good set of recommendations. I am particularly happy with the clear focus on building a continuous improvement culture. As the report points out, we have so much to do to make healthcare safe, but we also have a direction ahead.

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No tolerance for abusers

Regarding "Targeting hot spots," (Sept. 17, p. 14), the National Association for Home Care & Hospice has no tolerance for those who would abuse or defraud the Medicare and Medicaid programs on which so many depend. The NAHC believes that patients and providers alike have the duty to help maintain the fiscal integrity of government programs.

The NAHC also maintains that Medicare home health care, which was a $19 billion program, has been cut disproportionately since 2009. The program has already been cut by $77 billion, jeopardizing the ability of NAHC's members to serve Medicare patients. Accordingly, the NAHC is on record for doing just that—opposing any additional cuts in the Medicare home health benefit. Instead, the NAHC argues that vigorous steps to fight fraud can conserve precious public funds.

The NAHC's opposition extends to cuts aimed either at providers, as noted above, or at beneficiaries. On this score, the idea of requiring Medicare patients to make copayments before they can access home health services might sound as if it would save money, but history tells a different story. The original Medicare program, as enacted in 1965, included copayments with the intent of controlling costs. Congress removed the copayments in 1972 because of clear evidence that it cost the government more to collect them than it saved the Medicare program. Moreover, it was proven in reports of the Senate Committee on Aging that such cost sharing became a "sick tax" falling heaviest on those who could least afford it, discouraging the use of home care and therefore forcing patients to either go without needed care or seek it in a more expensive setting. The view of many experts was that copayments were a mistake and every effort should be made not to repeat the error.

The NAHC has called on Congress not to make any further across-the-board cuts to Medicare, which is a very inefficient way of punishing the few who dare to abuse the program. Instead, the NAHC has called for strict enforcement of the anti-fraud laws that are on the books. There is no need for additional laws. What is needed is the will to enforce them. There is no question that such notorious practices are localized in some 25 counties, according to the MedPAC. Targeted investigations, where there is just cause, and prosecutions, where the evidence warrants, will do much to reduce the incidence of fraud and abuse. This would also result in a return of substantial sums to the federal treasury.

Prosecuting those who break the law takes time, but it also brings a very high return on the investment. More than that, it is the right and fair course for the nation to take. The NAHC believes we should not discourage the thousands who are struggling to do a great job in caring for the ill, infirm and people with disabilities, and who will need to provide home-care services to the large percentage of the 78 million baby boomers. The NAHC is on record in encouraging Congress not to make any further across-the-board cuts in Medicare, which would hurt everyone—patients and providers alike—but rather to "fight fraud first" by encouraging the prosecution of those who may be tempted to steal from the public purse.

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Editorial's accuracy questioned

Regarding "An authentic call for compromise?" (Sept. 3, p. 16), David May's editorial is neither accurate nor helpful! He is entitled to believe whatever Democratic Party talking points he prefers, but he should not think that sharing his biased, slanted and ill-informed views is welcome or helpful. Massachusetts just passed governmental health cost-controls because Romneycare could not slow the growth of healthcare costs, after more than five years. Romneycare is similar to Obamacare and provides a reliable predictor of how Obamacare will affect healthcare delivery nationwide. Perhaps May forgot about the absence of bipartisanship in passing Obamacare. He might discuss the heavy-handed governmental response to out-of-control costs in Massachusetts and analyze what it may predict for the future of Obamacare.

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