Of Note

Healthcare Workers Still Skeptical About Flu Vaccinations

Efforts to get more healthcare workers vaccinated are having little success, with results well below the nation's 90 percent goal, according to a report from the Centers for Disease Control and Prevention.

Less than two in three, or 63.5 percent of those surveyed in the nationwide study of health care providers, received influenza vaccines during the 2009-2010 season. However, rates at health care facilities that mandate vaccinations are 98.1 percent. Of those who refrained from getting immunized, only 66.2 percent said they believed the vaccines were safe.

Starting in 2013, the Centers for Medicaid & Medicare Services may require hospitals to report their worker vaccination coverage as part of its Hospital Inpatient Quality Reporting Program. (Cheryl Clark, *HealthLeaders Media,* Aug. 19, 2011).

Palliative Care Expert Sees Essential Role for Catholic Health Care

Catholic health care has a unique role to play in the nation's understanding and acceptance of end-of-life care, according to Dr. Ira Byock, a pioneer in palliative and hospice care and professor of anesthesiology and family medicine at Dartmouth-Hitchcock. He was a presenter at a conference entitled, "The Science of Compassion: Future Directions in End-of-Life and Palliative Care", sponsored by the National Institute of Nursing Research and other agencies of the National Institutes of Health.

Byock calls palliative care – which involves management of pain as well as care for the physical, emotional and spiritual needs of the patients and his or her loved ones – "ardently life-affirming." "If you are committed to affirming life, you have to affirm all of life, including that part we call dying," he said.

Once familiar to oncologists treating cancer patients, palliative care is now being suggested by physicians who work in intensive care, transplant surgeries, cardiac care, neurology and other specialties. (Nancy Frazier O'Brien, *Catholic News Service,* Aug. 12, 2011).

Chronic Pain Costs U.S. $635 Billion a Year

More than 116 million Americans struggle with chronic pain each year, and associated medical charges and lost productivity cost the nation as much as $635 billion annually, according to a report from the Institute of Medicine

called "Relieving Pain in America: A Blueprint for Transforming Prevention, Care, Education and Research.

"That's a conservative estimate of the overall economic impact because it excludes children, members of the military and individuals in nursing homes or chronic care facilities," said Philip A. Pizzo, MD, chair of the IOM panel and dean of the Stanford University School of Medicine.

The panel, mandated under the Patient Protection and Affordable Care Act, includes 16 recommendations for action. In addition to creating a population-level strategy for pain prevention, management, treatment and research, these include developing strategies for reducing barriers to pain care and supporting collaboration between pain specialists and primary care physicians. (Kevin B. O'Reilly, *admednews,* July 1, 2011).

Thomson Reuters Identifies Most-and Least-Expensive Health Care Markets in the U.S.

Ogden-Clearfield, Utah has the lowest health care spending for the commercially insured at $2,623 per person of 382 metropolitan statistical areas (MSAs) in the country that were measured in the study. The highest spending was in Anderson, Indiana at $7,231 per person. The data appear in a study by the Healthcare business of Thomson Reuters, which assessed the use and cost of health care services for 23.5 million Americans in numerous MSAs.

"Studying these geographic variations can help us identify locations where healthcare costs are less, yet the quality of care and outcomes are not compromised," said Ray Fabius, MD, chief medical officer for the Healthcare business of Thomson Reuters and a study author. "Understanding where, why and how medical care costs less can provide solutions to control our nation's health care spending," he said. (Thomson Reuters Healthcare, *PRNewswire*, Aug, 10, 2011).

Delays Are Frequent When Surrogates Make DNR Decisions

Delays often occur when a surrogate has to make decisions about do-not-resuscitate orders for a loved one, according to a study conducted by researchers at Indiana University and the Regenstrief Institute published in the July issue of the *Journal of the American Geriatrics Society.*

Findings showed that a surrogate took longer to decide whether or not to sign a DNR than when patients decide for themselves. That's important because the patients who had designated a surrogate were sicker and the decision regarding whether to resuscitate might arise sooner.

Surrogates may have difficulties making decisions for several reasons, including not being sure of what the patient would want. "This really points to the need to support family members who have to make these kinds of decisions, because it's a different process to come to in terms of one's own death than to come to terms with it for someone else," said Alexia

Torke, MD, lead author of the study and assistant professor of medicine at Indiana University's School of Medicine. (Health Blog, *WSJ.com*, July 11, 2011).

Students from the Center for Health Law Studies at Saint Louis University School of Law contributed the following items to this column. Amy N. Sanders, assistant director, Center for Health Law Studies, supervised the contributions of health law students Chelsea Mortimer (JD anticipated '12) and Ann Schunicht (JD anticipated '12).

11th Circuit Strikes Down Section of Health Care Law

In an August 2011 ruling, the 11th Circuit Court of Appeals struck down the portion of President Obama's healthcare law that mandated all Americans to purchase insurance, but upheld the remainder of the law. The case, Florida et al v. Dept. of Health and Human Services et al, was filed jointly by 26 states. State petitioners contended that constitutionally, the federal government lacked authority to impose an individual mandate on Americans. The majority in Florida stated, "This economic mandate represents a wholly novel and potentially unbounded assertion of congressional authority: the ability to compel Americans to purchase an expensive health insurance product they have elected not to buy, and to make them re-purchase that insurance product every month for their entire lives." So far, three courts have ruled against that portion of the law and three have ruled for it. (*Yahoo! News*, August 12, 2011).

A Call to the Supreme Court of the United States: Correct 11th Circuit's Mistake

Professor Robert Gatter, co-director of the Center for Health Law Studies and a law professor at Saint Louis University School of Law, presents an argument that the 11th Circuit Court's opinion striking down the individual mandate for health insurance is based on flawed reasoning. Professor Gatter's main contention is that the court was erroneous in stating individuals that forego care do "not affect the insurance market and medical care markets". He cites several key pieces of evidence that suggest these individuals actually are affecting the market in a major way. One of the reasons is that uninsured patients often use the emergency room as the first instance in which they seek treatment for a condition. Emergency room care is expensive and without means to pay their bills, the uninsured pass the debt through the doctors and hospitals and onto the insured population in the form of higher premiums. According to FamiliesUSA, this "cost-sharing" results in each insured individual's payment to increase by $370 and each family's payment to increase by $1,000 annually. Professor Gatter suggests that in fact it is within the federal government's power to regulate health insurance in this manner via the Commerce Clause. If "conduct substantially affects interstate commerce, Congress is empowered to take any rational regulatory steps", according to Professor Gatter. (*STLtoday.com*, August 23, 2011).

Evidence that Medical Malpractice Caps Do Not Reduce Lawsuits

Recent tort reform legislation, like the Help Efficient, Accessible, Low-Cost, Timely Healthcare (HEALTH) Act of 2011, has been touted as a means to reduce health care costs and prevent the abuse of medical lawsuits by supporters. The HEALTH Act is attempting to limit non-economic damages in medical malpractice claims, shorten statute of limitations, among other provisions. The Court of Appeals of the State of California recently upheld a $250,000 non-economic damages cap. The lawsuit ensued after a widow was awarded $1 million in economic damages and $6 million in non-economic damages. However, according to Michael Kataf of Nexus Insurance Services, "…there has not been conclusive evidence that malpractice caps have driven down the cost of health care." Kataf contends that his insurance system focuses on training physicians to prevent medical malpractice lawsuits by making personal connections with patients. Additionally, a program implemented at the University of Michigan Health System in 2001 encouraged health care providers to admit their mistakes. As a result of the program, the institution saw a reduction in malpractice lawsuits and a faster resolution of disputes. (*dBusiness News*, New York, October 2011).

Government Predicts an 85% Rise in Federal Health Care Fraud Prosecutions

As a result of increased enforcement efforts from the Obama administration, a dramatic number of prosecutions against health care fraud has already been filed this year. By the end of August, 903 prosecutions had been filed, a 24% increase over the total for the entire fiscal year of 2010. Justice Department officials point to big busts and private sector fraud as contributors to the large jump in prosecutions. The addition of two more health care fraud teams in February also added to the large number of prosecutions. The task force studies data from the Centers for Medicare and Medicaid Services to find people defrauding the system. (Kelly Kennedy, *USA Today*, August 29, 2011).

Survey Reports that One-Half of Hospitals Buy Drugs from a "Gray-Market"

In response to drug shortages and price-gouging, one-half of hospitals report they've bought medications from back-door suppliers. These back-door suppliers, also known as "gray-market suppliers," don't exist in official channels. One hospital association's report found an average mark-up of 650 percent. These "gray-market suppliers" take advantage of drug shortages and exploit the weakest supply chains with outrageous prices. Policy groups are calling for a stronger response from the FDA to address the problem, yet many point to drug

shortages as the root cause that must be addressed. (JoNel Aleccia, MSNBC, August 26, 2011).

Missouri Halts Plans to Begin Work on Health Insurance Exchange

Missouri has delayed plans to begin spending the $21 million federal grant received in August 2011 to begin work on the state's health insurance exchange. PPACA gives states until 2014 to set up their own health insurance exchanges or have the federal government implement one for them. Several Missouri Republican senators raised concerns over beginning the project and the state has not yet decided how to proceed. The state insurance director, John Huff, said, "We will continue to work with the Legislature to weigh the pros and cons of establishing a state exchange or defaulting to the federal government." Senator Jane Cunningham has voiced concerns that a state created insurance exchange may run opposite to the Missouri voters that approved a law that attempts to reject the part of PPACA requiring most Americans to have health insurance by 2014 or be penalized. (David A. Lieb, *Bloomberg Businessweek*, September 15, 2011).

Senator Grassley Fights Removal of Doctor Data Online

The Obama administration decided to take down a database of doctor malpractice and disciplinary cases from the Internet. Senator Grassley (R, Iowa), often a leader in investigations of fraud and waste in government health programs, joined with other academic researchers, consumer groups, and journalism organizations in their disapproval of the administration's actions. The National Practitioner Data Bank was created to make sure bad doctors were held accountable.

After journalists were able to match complaints against unidentified doctors in the National Practitioner Data Bank to other public information, thereby revealing doctors' names, the government removed the file. After the decision, twenty-three academic researchers protested in a letter, saying, the government "took a large step in the direction of the 'bad old days' when secrecy prevailed and providers' interests took precedence over patients' safety and well-being."(Duff Wilson, *The New York Times*, October 7, 2011).