

HealthGrades Quality Study

The highly regarded HealthGrades, Inc. study, representing the Second Annual Patient Safety in American Hospitals Report, was released in May of 2005.

HealthGrades identified the patient safety incident rates for nearly every hospital in the country by applying uniform Patient Safety Indicator methodology to three years of Medicare data (2001-2003). HealthGrades then identified the best-performing hospitals to establish a best-practice benchmark against which other hospitals can be evaluated.

Efforts by hospitals have not achieved the report's goal of reducing medical errors by 50 percent within five years. Based on the Institute of Medicine estimates, the United States loses more American lives to patient safety incidents every six months than it did in the entire Vietnam War. "This also equates to three fully loaded jumbo jets crashing every other day for the last five years. If medical errors were recognized by the Centers for Disease & Prevention (CDC) in its annual National Vital Statistics Report, they would be ranked as the sixth leading cause of death in the United States."

The March 2005 MedPAC Report to the Congress on Medicare Payment Policy found that not only are hundreds of thousands of Medicare beneficiaries experiencing adverse events every year, but they are doing so at increasing rates. In last year's *Patient Safety in American Hospitals Report*, HealthGrades found that for every Medicare patient that developed one or more patient safety incidents, he or she had a one-in-four chance of dying. The excess cost identified because of these safety problems is \$8.5 billion.

Approximately 1.18 million total patient safety incidents occurred among the nearly 39 million hospitalizations in the Medicare population during 2001 through 2003. The Patient Safety Indicators with the highest incidents rates were postoperative respiratory failure, decubitus ulcer, and postoperative sepsis. Of the total 298,865 deaths among patients who developed one or more Patient Safety Indicators during 2001 through 2003, 81 percent of these deaths were attributable to the patient safety incidents.

Hospital-acquired infections worsened by approximately 20 percent from 2000 to 2003, and accounted for 9,552 deaths and \$2.60 billion, almost 30 percent of the total excess cost related to the patient safety incidents. These costs are, of course, for additional medical care required by the events.

Patients in the top 10% of hospitals had, on average, an almost 50 percent lower occurrence of experiencing one or more PSIs, compared to patients at the bottom 10% hospitals. The 16 PSIs studied accounted for \$8.73 billion in excess

inpatient costs to the Medicare system over the three-year study, or roughly \$2.91 billion annually. The costs break down as follows:

- Decubitus ulcer - \$2.77 billion
- Selected infections due to medical care - \$1.90 billion
- Postoperative pulmonary embolism (PE) or deep vein thrombosis (DVT) - \$1.21 billion

The report concluded, “If American hospitals were to implement what we know works, many costly complications could be avoided and lives would be saved. For example, we know that washing hands before patient contact is a simple and effective process that has proven to reduce hospital-acquired infection rates. However, in a recent study, 57 percent of physicians do not wash their hands after patient contact, and 67 percent of those that did not thought it was ‘too difficult’.”

Other campaigns have been launched to reduce errors.

The data from the well-documented study by HealthGrades is consistent with the annual report released in May by Pennsylvania’s Patient Safety Authority to the legislature, showing that in six months there were approximately 70,000 reports of serious events and incidents. Extrapolated to a year, that would mean that in 2004, there were over 7,000 serious events. The Pennsylvania Supreme Court reports there were approximately 1,800 medical malpractice lawsuits. The lawsuit number represents some over-counting, since it includes data from multiple party and multiple count litigation.

The Pennsylvania Supreme Court also indicated that there has been an almost one-third drop in the filing of lawsuits due to tight new restrictions such as the Certificate of Merit and venue rules.

We can now conclusively conclude that while serious patient errors are increasing with HealthGrades referring to an “epidemic” of patient safety problems, the number of people seeking compensation for legitimate, serious and valid claims has been reduced by the effective lobbying and public message of the medical healthcare industry.

What is needed is a vast reduction in the number of medical errors in this country, and an increase in identifying and properly compensating those who suffer at the hands of negligent conduct which causes harm.

Now that very solid data is coming in concerning the safety of the healthcare system and compensation for those harmed by it, it is time to aggressively level the playing field.

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