

HEALTHGRADES 2007

This is the fourth year that HealthGrades has analyzed patient safety among Medicare patients in all United States hospitals. The highly respected research group has found that improvements in patient safety have only been modest.

Highlights of the study found the following:

1. Approximately 1.1 million total patient safety incidents occurred in over 40 million hospitalizations in the Medicare population which is almost a 3% incident rate. These incidents were associated with \$8.6 billion of excess costs during 2003-2005.

2. More than half of the patient safety rates studied worsened from 2003 to 2005. The total patient safety incident rate worsened by an additional 2.0 incidents per 1,000 hospitalizations in 2005 compared to 2003.

3. Both decubitus ulcer and post-operative respiratory failure worsened by almost 10% & 20%, respectively.

4. Of the 284,798 deaths that occurred among patients who developed one or more patient safety incidents, 247,662 were potentially preventable.

5. Medicare beneficiaries that developed one or more patient safety incidents had a one in four chance of dying during the hospitalization during 2003 to 2005.

Some of the most common patient safety incidents were also the most costly. Decubitus ulcer and post-operative respiratory failure accounted for 50.70% of all excessive attributable costs. Unfortunately there appears to be a large and growing safety gap between top and bottom performing hospitals. Those hospitals designated as distinguished represent less than 5% of all United States hospitals examined in the study. If all hospitals performed at the level of distinguished hospitals for patient safety, approximately 206,286

patient safety incidents and 34,393 Medicare deaths could have been avoided while saving the United States approximately \$1.74 billion from 2003 through 2005.

The HealthGrades' evaluations were initiated by the dramatic study "To Err is Human" issued by the Institute of Medicine at the end of 1999 indicating that preventable deaths in U.S. hospitals equal the loss of all occupants on two 747 jumbo jets per month. The patient safety movement was born in earnest thereafter, but to many has been more smoke and mirrors than progress. Unfortunately the HealthGrades report supports the former view.

It is unfortunate the during the same timeframe where there has been a dramatic increase in patient safety errors, most state legislatures have passed legislation so restrictive that it is becoming increasingly difficult to bring meritorious medical liability claims. The next issue to be studied by some worthy organization is whether restriction on legitimate lawsuits has created a more casual atmosphere towards patient safety actually increasing errors in hospitals. The tort system has always been a viable safeguard to careless behavior, but it cannot do its job when artificial restrictions are passed by the legislature or enforced by the courts.

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