FurstGroup
Thought Leadership For The Healthcare Industry

Daniel Levinson of the HHS estimates that errors cost U.S. taxpayers more than $4 billion per year.

Dollars and sense

Does patient safety have staying power in the cost-conscious era of reform?

With the success of books like "Safe Patients, Smart Hospitals" and "The Checklist Manifesto," not to mention the Dennis Quaid-hosted documentary "Chasing Zero," public awareness of patient safety has reached its zenith, spurring even mainstream newspapers to run Page One stories dedicated to unsexy topics like central-line infections.

But as the Patient Protection and Affordable Care Act is implemented, some question whether the gains in quality and safety can continue in the new era of healthcare, in which funding and the number of physicians are both expected to decrease.

Whatever happens, the topic is unlikely to disappear soon.

A month ago, Inspector General Daniel R. Levinson of the U.S. Department of Health and Human Services released a report on safety and quality. Levinson summarized the report, "Adverse Events in Hospitals: National Incidence Among Medicare Beneficiaries," for USA Today and included these sobering statistics:

"Physicians determined that about one in seven patients (13.5%) experienced at least one serious instance of harm from medical care that prolonged their hospital stay, caused permanent harm, required life-sustaining intervention, or contributed to their deaths. Projected to the entire Medicare population, this rate means an estimated 134,000 hospitalized Medicare beneficiaries experienced harm from medical care in one

Patient safety in the age of reform

(Continued from Previous Page)

month, with the event contributing to death for 1.5%, or approximately 15,000 patients."

Other measures remain worrisome as well:

** The Commonwealth Foundation, which gets its data from providers and patients, has been measuring the healthcare of seven industrialized nations. In 2010, the U.S. is dead-last, as it has been in 4 of the last 7 years, despite spending astronomically more on healthcare than any off the other countries in the study.

** HealthGrades, a healthcare ratings company based in the Denver area, also studies Medicare patients. In its most recent report, released Oct. 30, its researchers found that "one in nine patients developed a hospital-acquired complication, across the nine procedures evaluated for inhospital complications, from 2007 to 2009." But if all hospitals performed on a level as what HealthGrades calls a "five-star hospital," the report concluded that "185,875 Medicare inhospital complications may have been avoided."

** Despite some controversial methodologies, the World Health Organization ranks U.S.' healthcare 37th among countries.

In light of the recent political changes in the U.S., the question that lingers is this: Does patient safety have staying power in the era of reform? Will it be seen as a luxury or actually a money-saving tool?

"It's going to be both," opined Charles Denham, M.D., executive producer of the "Chasing Zero" documentary and the president of the Texas Medical Institute of Technology (*safetyleaders.org*). "There are going to be costs related to unreliable care that are huge waste generators, and there are going to be safety investments we should make for the future that won't give us an immediate return on investment. Wise leaders will know how to choose."

Denham made his mark as an oncologist.

"As a cancer doctor, I worked really hard at trying to save a life," he said. "But then I saw how many more lives we could save if we worked at preventing a harmful death."

Denham and his team have worked hard to avoid finger-pointing. "We don't have bad people; we have bad systems," he said. Because of that attitude, Denham's work has been welcomed by healthcare executives and his fellow physicians. His involvement with Dennis Quaid and his family began when Quaid's father-in-law showed the actor an article Denham had written for the Journal of Patient Safety that mentioned the inadvertent overdose that had been administered to Quaid's twins.

"We met and found out we both were jet pilots and flew the same airplanes," Denham said. "He really wants to make a difference but wants to be sure he doesn't overstep his bounds. But he believes that, since his babies were spared, his babies could help to save the lives of other babies."

Denham and Quaid are at work on two follow-up documentaries that will include a look at the lessons in safety gleaned from astronauts and Formula One racing.

From the executive suite at Allina Hospitals and Clinics in Minnesota, chief clinical officer Penny Wheeler, M.D., sees the positive strides in safety and quality advancing in the years to come, even as PPACA is implemented.

"I think safety has more staying power under these conditions," said Wheeler, who speaks regularly on patient safety. "Greater costs occur when there is an error. If something happens and a patient develops a hospital-acquired condition, Medicare is no longer footing the bill."

Levinson of the HHS agrees, noting that: "Obviously, this situation is unacceptable – and expensive, costing taxpayers more than $4 billion a year due to the need for additional treatment or longer hospitalizations (and even more if you add costs for follow-up care)."

In fact, HealthGrades pegged the price at $8.9 billion.

Errors don't just affect patients, Wheeler added. "We had a surgeon who was terrific. Then, one day, he performed the wrong procedure on a patient. He was ready to quit. These events are devastating to all the people who go through them," she said.

Part of the problem, Wheeler observes, is that healthcare is not a simple process. She likes to quote Sir Cyril Chandler, who said: "Medicine used to be simple, ineffective, and relatively safe. Now it is complex, effective and potentially dangerous."

Patient safety in the age of reform

(Continued from Previous Page)

That perspective resonates with Peter Pronovost, the Johns Hopkins professor and anesthesiologist whose book, "Safe Patients, Smart Hospitals," has attracted a following inside and outside medicine.

He argues that the sheer complexity of modern medicine makes a mundane thing like a checklist a must-have in a hospital room or an operating room.

"I think society has benefited greatly from physicians' autonomy – we have new drugs and new procedures to show for it. The problem is, we haven't evolved culturally. So now we have this most complex healthcare system that makes it impossible for any one physician to do it all. And as physicians, we have often crossed the line from autonomy to arrogance."

Pronovost has been unafraid to ruffle, nay, blister any feathers.

"The Toyota CEO had to make a public apology when their mistake killed 4 people a year for 5 years," he said. "Medical errors have been killing a hell of a lot more people and there's no public outcry."

Pronovost sees his role – and the success his model of care at preventing bloodstream infection – as "the canary in the coal mine of learning how to be accountable for outcomes. Most hospitals rely on the physicians to police themselves – that doesn't work."

He admits that other areas have to be addressed to change the healthcare culture – everything from tort reform to physicians' too-long shifts ("we're not immune to biological laws"). But Pronovost has been careful to frame his argument with scientific method, backing up his arguments with peer-reviewed studies, and noting that he is not an outsider, that he is in fact part of the physician "tribe."

He says he is hopeful that hospitals will learn from the dramatic reduction in infections that is possible by following some simple rules. That, he said, would enable safety to become something more than the flavor of the month in the era of reform.

"The bloodstream infection project could be a fad if we don't make the right investments as hospitals," he said. "But safety saves money. And under healthcare reform, I'm optimistic we'll make those investments."

Dan Ford, FACHE, a Furst Group vice president, has spoken on patient safety in conference venues ranging from Harvard to Europe. His viewpoint not only includes his decades as an executive recruiter, but as a family member who has gone through a tragic accident due to medical error. (*See related story, "Putting a face on safety"*) He sees signs that the industry is slowly coming around on this issue.

"Since the report 'To Err Is Human' came out in 1999, I have done a handful of informal survey of CEOs over the last 10 years," he said. "These are people who trust me and know whatever they tell me is confidential. These CEOs are in the trenches, and they have really become champions of safety and quality. "

When he first started surveying them about patient safety 10 years ago, a number of them were in denial, Ford said. A couple years later, they would say, "Well, the guy down the street has a problem, but we don't."

When Ford checked with them again a few years later, they'd say, "We've got more problems than I thought. I asked my CMO or my CNO to take care of this." A couple years later, they'd tell him, "You know, this problem is a whole lot worse than I thought it was. I'm going to take personal responsibility for this and get it fixed."

From an ethical and practical standpoint, Ford said he believes "we've just got to keep plugging away. The partnership that is being developed between providers and patients and families has still got a long way to go. But there's also the marketing benefit to hospitals and a reassurance to the public of doing the right thing.

"Over time, a hospital that is visible because of a poor reputation on safety and quality is going to suffer for that. Insurance companies are getting into this – and so is the government."

Putting a face on safety

The Ford family learns that errors don't carry an expiration date

A decade ago, "To Err Is Human" rocked the medical world with its report of how many lives were ended and how many people were injured by human error in the healthcare field. A 2010 report by the inspector general of the U.S. Department of Health and Human Services confirmed that the problem remained widespread.

'The cost to a family when an error occurs can last a lifetime.' **Dan Ford**

But 20 years after a medical error upended everything they knew, the Ford family still must try to cope with what happened.

Today, Dan Ford, FACHE, is a Furst Group vice president. In 1991, he was enjoying the success of the search firm he co-founded, Witt/Kieffer, Ford, Hadelman & Lloyd. His wife Diane was working on her second master's degree, this one in theology. Their marriage was good and they were raising three kids.

Then, Diane went in for a routine hysterectomy at 47. But nothing turned out to be routine. Her colon was accidentally cut in the surgery, which was then followed by a temporary colostomy. In her hospital room, she overdosed on morphine that was given to her through a PCA pump. A student nurse walking by her room heard a sound "like an elephant snoring," Dan Ford said.

It took over 20 minutes to intubate her," he added. "That time frame caused a respiratory arrest, which caused permanent brain damage."

Her personality changed completely, from warm and pleasant to suspicious and accusatory. Her short-term memory vanished. One of her sons watched her in the hospital as she read a get-well card, put it down, then picked it up and read it again, not knowing it was the same card. At the time of the tragedy, the Fords' sons were 17 and 14 and their daughter was 11.

Diane didn't look different. But she was.

"Today, memory loss is only the tip of the iceberg," said Jonathan, their middle child. "She is very irrational and has been diagnosed with dementia. I have not had a mom since that day in 1991. My mom didn't call me when I was going to college. She didn't send me cookies. How could she? She didn't know what state I was in."

Several years after the medical error, Diane divorced her husband. Today, she resides in an assisted living facility and her daughter is her legal conservator.

"When somebody becomes disabled, the cost to the healthcare system and the family is amazingly large," said Dan Ford, who became active in the patient safety movement in 2002 to help prevent other families from experiencing a similar tragedy. "The reality is we still have a long way to go to really reduce deaths and injuries caused by medical error. It has to be a partnership among all providers as well as between patients/families and providers. It has to be a top priority in the boardroom as well as at the bedside."

The costs, say Ford and his children, go beyond dollars and cents.

"The cost to a family when an error occurs can last a lifetime," he said. "The emotional and financial cost can be devastating even when there is a settlement."