Op-Ed

A Picture of Progress on Hospital Errors

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GOING TO THE HOSPITAL HAS BECOME LESS DANGEROUS IN THE last few years. That's a big deal, although it also raises a big question: Who is responsible for the progress? Has it been the influence of government policies or innovation by the private sector?

The answer, most likely, is both. Therein lies a parable of how, with public-private cooperation, the United States might solve some of its other, vexing health care problems.

Most of us think of hospitals as places of healing, and usually they are. But hospitals are also places where people get sick or are injured, thanks to medical errors. Sometimes patients are given the wrong medication or contract an infection because an intravenous line was inserted improperly. These mistakes cost money because the complications are expensive to treat. They also cost lives. According to several credible estimates from independent researchers, every year hundreds of thousands of people die because of medical errors.¹

Since 2010, however, those errors appear to have become significantly less common. Data that the Department of Health and Human Services released in December 2014 showed that the number of "hospital-acquired conditions" in the United States fell by 17% over 3 years. And while that's an average for many different medical errors, the declines occurred in virtually every subcategory. Bloodstream infections from intravenous lines were down by nearly 50%. Pressure ulcers, the bedsores that afflict disabled patients who aren't moved frequently enough, fell by 20%. Drug errors dropped by 19%. Those numbers are too big, and too widespread among categories of medical errors, to be a fluke.²

The time frame for these data, 2010 through 2013, is significant because it corresponds to the introduction of quality incentives associated with the Affordable Care Act. Researchers have been documenting the impact of medical errors, as well as promoting ways to avoid them, for more than a decade—going all the way back to 1999, when the Institute of Medicine published its landmark study of the topic: *To Err Is Human*,

which warned that errors could be killing as many as 98,000 people a year. (Subsequent estimates suggested the number was much higher.) The challenge has always been getting hospitals to change their ways, something that was difficult as long as insurers, both public and private, paid by the procedure.

Simply put, hospitals had few financial incentives to reduce errors. If anything, costly medical errors meant that they could generate more revenue, since patients with complications needed more tests and treatments—giving doctors and hospitals opportunities to charge, and to collect, even more money. Although companies eager to cut employee benefit costs called for improved care, they rarely made it a big enough priority to effect real changes in hospital practices.

The architects of “Obamacare” introduced payment reforms designed to change the financial incentives. They introduced a program called the “Partnership for Patients,” through which government provides funding for large hospitals that prioritize the reduction of errors. In all, 3,700 hospitals volunteered to be part of this program. In addition, the Affordable Care Act pushed through changes in Medicare payments, penalizing hospitals with high rates of readmission for certain conditions. In so doing, they were following the lead of the Bush administration, whose officials had begun introducing such incentives as part of their efforts to modernize Medicare.

The shift in readmission was discernible. At the end of 2010, the rate was above 19.5%, which is roughly where it had been stuck for several years. Then the rate started to drop—slowly and then, over time, more quickly. By early 2014, it had fallen to below 18%. The timing couldn’t be a coincidence, most experts say; instead, hospitals were finding ways to reduce readmissions.

Anecdotal evidence backs this up. In 2010, Mount Sinai Hospital in New York City began employing workers to conduct follow-up visits with patients after they were discharged, to make sure they were following instructions and taking their prescribed medications, and also to alert doctors (or at least the hospital) to new complications. During the first 2 years of its pilot program, hospital officials said, they were able to cut readmissions by 43%.³

Not all the available evidence has suggested such a clear link between government reimbursement and improvement in health care quality. An article by Grace Lee and colleagues in the *New England Journal of*

Medicine in 2012 found no correlation between the introduction of earlier penalties and a decline in infections associated with central catheters. Instead, Dr. Lee and colleagues found the number of infections had been falling even before those penalties started to take effect. According to their research, hospitals and their professionals were taking better care of patients and sparing more of them from painful, dangerous illness. They didn't appear just to be responding to government incentives.⁴

Lee and colleagues' study is one reason that most experts think it's a combination of factors—in both the public and private sectors—driving hospitals to take better care of patients, during and after admission. After all, there have always been forward-thinking hospitals that have put a high priority on patient care, and forward-thinking corporations eager to support those efforts. An example of the latter was the formation of the Leapfrog Group, an independent organization that publishes quality ratings of hospitals. The problem has been getting the rest of the hospital industry and the business community to take the issue of medical errors just as seriously. Changing the way that Medicare pays for services has helped solve that problem. As Michael Millenson, the veteran health care journalist and researcher, explained, "Leapfrog deserves credit for helping push the federal government in that direction, but it was the government that eventually led the way for reasons that made eminent economic sense. . . . The big 'leaps' in patient safety came from government pressure."⁵

This kind of cooperation can be a model for other health care initiatives. The Affordable Care Act has made health insurance more affordable for literally millions of poor and middle-class Americans. But the new availability of coverage does no good unless somebody persuades the uninsured to sign up for those plans. That's a job for which private-sector institutions, such as nonprofit advocacy groups, hospitals, doctors, and other professionals, are perfectly suited. Similarly, reducing the overall cost of health care—not simply by reducing errors but also by finding other ways to be more efficient—requires doctors and hospitals to reengineer their delivery systems. Some are bound to do so on their own initiative. But others won't unless there is real money on the line.

High costs, poor quality, limited access: solving these familiar problems in American health care may not be as daunting as it seems. It just might require a little more cooperation.

References

1. Allen M. How many die from medical mistakes in U.S. hospitals? *ProPublica*. September 19, 2013. <http://www.propublica.org/article/how-many-die-from-medical-mistakes-in-us-hospitals>. Accessed December 17, 2014.
2. Agency for Healthcare Research and Quality. Interim update on 2013 annual hospital-acquired condition rate and estimates of cost savings and deaths averted from 2010 to 2013. December 2, 2014. <http://www.ahrq.gov/professionals/quality-patient-safety/pfp/interimhacrate2013.html>. Accessed December 17, 2014.
3. Pettypiece S. Obamacare incentives slow hospitals' revolving door. *Bloomberg News*. September 25, 2013. <http://www.bloomberg.com/news/2013-09-25/obamacare-keeps-patients-at-home-slowng-hospital-use.html>. Accessed December 17, 2014.
4. Lee G, Kleinman K, Soumerai SB, et al. Effect of non-payment for preventable infections in U.S. hospitals. *N Engl J Med*. October 11, 2012. <http://www.nejm.org/doi/pdf/10.1056/NEJMsa1202419>. Accessed December 17, 2014.
5. Millenson M. If you want to stop hospital harm, don't call a capitalist. *Forbes*. May 12, 2013. <http://www.forbes.com/sites/michaelmillenson/2013/05/12/if-you-want-to-stop-hospital-harm-don't-call-a-capitalist>. Accessed December 17, 2014.

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