



Improving the Quality and Safety of Health Care Will Lead to Healthier Employees, Lower Costs and a More Productive Workforce

Issue: Health care quality and patient safety remain at unacceptably low levels. Preventable adverse events (AE) contribute to rising health care costs and often result in extended hospital stays, as well as lost productivity.

- Every day, more than 250 Americans die because of preventable medical errors in hospitals.
- The Institute of Medicine (IOM) estimated that between 44,000 and 98,000 deaths occur in hospitals alone each year as a result of preventable adverse events, making medical errors the eighth leading cause of death. Countless more are injured as a result of preventable medical mistakes.
- Preventable events such as hospital-acquired infections can increase patients' stays in the hospital significantly. The excess length of stay can vary from 9 days for ventilator-associated pneumonia to 26 days for mediastinitis after coronary artery bypass grafting.
- Thomson Reuters suggests the national annual cost for 20 adverse inpatient events is approximately \$5.4 billion.

Fear of malpractice litigation and adverse employment consequences encourage physicians and other health professionals to keep silent about medical errors. Similarly, some hospitals resist reporting certain adverse outcomes, because they fear the information will be used in court.

In 2005, the Patient Safety and Quality Improvement Act created a voluntary, confidential system for reporting medical errors and "near misses"; prohibited adverse job actions against those who report information; kept the reports to Patient Safety Organizations (PSOs) and PSO analyses of errors from use in court, without changing the rights or ability for injured patients to sue and promoted the examination of reporting and dissemination of findings and recommendations to hospitals, doctors, and others in the health care system so that they can make systemic changes to reduce future occurrences of the same mistakes.

In 2008, CMS, followed by a number of insurers, stopped paying for "never events," including wrong-side surgeries, objects left inside a patient during surgery, air embolisms, use of the wrong blood type during transfusions, pressure ulcers and hospital-acquired injuries.

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In 2010, the President signed the Patient Protection and Affordable Care Act (Affordable Care Act) into law that:

- Reduces payments to Medicare hospitals in the top 25th percentile of healthcare-acquired infection rates in 2015;
- Reduces Medicare payments to hospitals based on the dollar value of each hospital's percentage of potentially preventable Medicare readmissions for the conditions endorsed by the National Quality Forum or a similar entity, beginning in 2012;
- Prohibits federal payments to states for Medicaid services related to health care acquired conditions, beginning July 1, 2011;
- Requires the Department of Health and Human Services (HHS) to submit a study to Congress in 2012 on expanding an infection prevention policy to nursing homes, inpatient rehabilitation facilities, long-term care hospitals, outpatient hospital departments, ambulatory surgical centers, and health clinics; and
- Establishes a program at the Agency for Health Research and Quality (AHRQ) to give grants to academic institutions to develop and implement academic curricula that integrate quality improvement and patient safety into health professionals' clinical education.

Position: The National Business Group on Health, representing approximately 300 large employers who provide coverage for 55 million Americans, believes that increases in patient safety and health care quality will lead to lower costs and direct improvements in the health and productivity of the U.S. workforce.

The National Business Group on Health supports legislation to establish a mandatory reporting system for medical errors as the next step toward a better health care system.

As purchasers of care and business leaders with expertise in quality improvement in their own companies, employers have much to contribute. *Hospital and health system boards* are the most important agents of change—and employers play a critical role in driving this change. Working with the Institute for Healthcare Improvement (IHI) and other organizations, the National Business Group on Health assists members' company executives become more effective in their roles on hospital Boards.

Recognizing that significant progress in patient safety occurs when there is evidence of the strong commitment of the leadership team, and the Board of Directors, employers should require either that all hospitals and health care systems in their preferred networks satisfy the following conditions, or provide special financial incentives (e.g. lower deductibles) to employees and other participants in employers' plans who use hospitals and health care systems that satisfy the following conditions*:

- Obtain the commitment of the CEO, the Board, and other senior leadership team members to a culture of safety and the reduction of avoidable medical errors;
- Actively participate in the Protect 5 Million Lives Campaign and work aggressively to sharply reduce the number of health care acquired infections; and

- Actively participate in the Surgical Care Improvement Project.

The Culture of Safety

There is a need to promote a culture that overtly encourages and supports the reporting of any situation or circumstance that threatens, or potentially threatens, the safety of patients or caregivers and that views the occurrence of errors and adverse events as opportunities to make the health care system better. To create this culture, buy in needs to come from the top—the CEO, the Board, and the administrators of each health care organization.

Protect 5 Million Lives Campaign

Launched in December 2004 by the Institute for Healthcare Improvement (IHI), the campaign has enlisted over 3,000 hospitals in the United States, (representing over 80% of all hospital discharges). The campaign's original aim was to avoid 100,000 unnecessary deaths in US hospitals by the end of the first phase in June 2006. The campaign aimed to do this by encouraging hospitals to adopt the following six interventions that have proved to significantly reduce serious disability and death when implemented properly:

- Deploy rapid response teams to patients with early warning signals of cardiac or respiratory arrest;
- Deliver reliable, evidence-based care for heart attacks, or acute myocardial infarction (AMI);
- Prevent medication errors through drug reconciliation (reliable documentation of changes in drug orders);
- Prevent IV catheter, or central line, infections; and
- Prevent surgical site infections.

Prevent Respirator, or Ventilator Associated Pneumonia

Since December 2006, the expanded campaign, called Protecting 5 Million Lives from Harm, aims to also reduce non-fatal harms in hospitals. Specifically, the campaign aims to protect patients from 5 million incidents of medical harm before December 2008. In addition to the six interventions above, the campaign has added the following:

- Prevent harm from high-alert medications;
- Reduce surgical complications;
- Prevent pressure ulcers;
- Reduce methicillin-resistant staphylococcus aureus infection;
- Deliver reliable, evidence-based care for congestive heart failure; and
- Convince hospitals boards to support the expanded campaign.

Surgical Care Improvement Project (SCIP)

The SCIP is a partnership of the American College of Surgeons, the American Hospital Association, JCAHO, the American Society of Anesthesiologists, the American Society

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of Perioperative Nurses, the IHI, and several federal agencies dedicated to improving the safety of surgery. The goal is to reduce the incidence of surgical complications and mortality by 25% by 2010. The SCIP is focusing on the following high incidence/high cost areas:

- Reducing surgical site infections;
- Reducing adverse cardiac events after surgery;
- Reducing deep vein thrombosis (DVT) after surgery; and
- Reducing pneumonia after surgery.

Each participating organization reports their performance on several process and outcome measures related to each of these four areas. Participation is voluntary.

* Hospitals and health systems should have appropriate measures in place to encourage the reporting of adverse events, including confidentiality policies, protections against adverse career consequences for those reporting, and penalties for failing to report.