National Business Group on Health

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Creative Health Benefits Solutions for Today, Strong Policy for Tomorrow

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. A more recent study in the *Journal of Patient Safety* states that medical errors leading to patient death are much higher than previously thought, and may be as high as 400,000 deaths a year. 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.
- A Massachusetts Technology and New England Health Care Institute study found that inpatient preventable medication errors cost approximately $16.4 billion annually.

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.

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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. Many commercial health plans followed soon after with similar targets, measures and policies to align their payment policies with CMS to not pay for treatments that fix errors made by hospitals and health care facilities.

In 2010, the President signed the Affordable Care Act (ACA) into law that:

- Reduced payments to Medicare hospitals in the top 25th percentile of healthcare-acquired infection (HAI) rates in 2015;
- Reduced 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 (NQF);
- Prohibited federal payments to states for Medicaid services related to health care acquired conditions; and
- Established 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 394 large employers (including 67 of the Fortune 100) who voluntarily 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.

Public and private payers should assure that payment mechanisms increasingly reward providers who are better performers on both quality and safety, adjusting for relevant factors.

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;and
- Actively participate in the Partnership for Patients and 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.

Partnership for Patients

The Partnership brings together leaders from major hospitals, employers, physicians, nurses, and patient advocates in a shared effort to make hospital care safer, more reliable, and less costly. The two goals of the Partnership for Patients are to decrease preventable hospital-acquired conditions by 40% and preventable hospital readmissions by 20% compared to 2010.

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 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. 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.