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BURDA ON HEALTHCARE

Scared Healthy

By David Burda

April 27, 2023

We all know there is one, surefire patient safety strategy: Stay healthy so you never have to go to the doctor or the hospital. Zero chance of a medication mixup. Zero chance of the surgeon taking out the wrong organ. Zero chance of a central line infection. Zero chance of falling out of a hospital bed.

But no matter how hard you try to stay healthy and execute that perfect patient safety strategy, there are times when you can't avoid seeing your doctor or going to the hospital. Things happen.

That's too bad because it's not getting any safer out there in the healthcare delivery system for patients, who through no fault of their own, may get sick or hurt. If you don't believe me, here's my evidence.

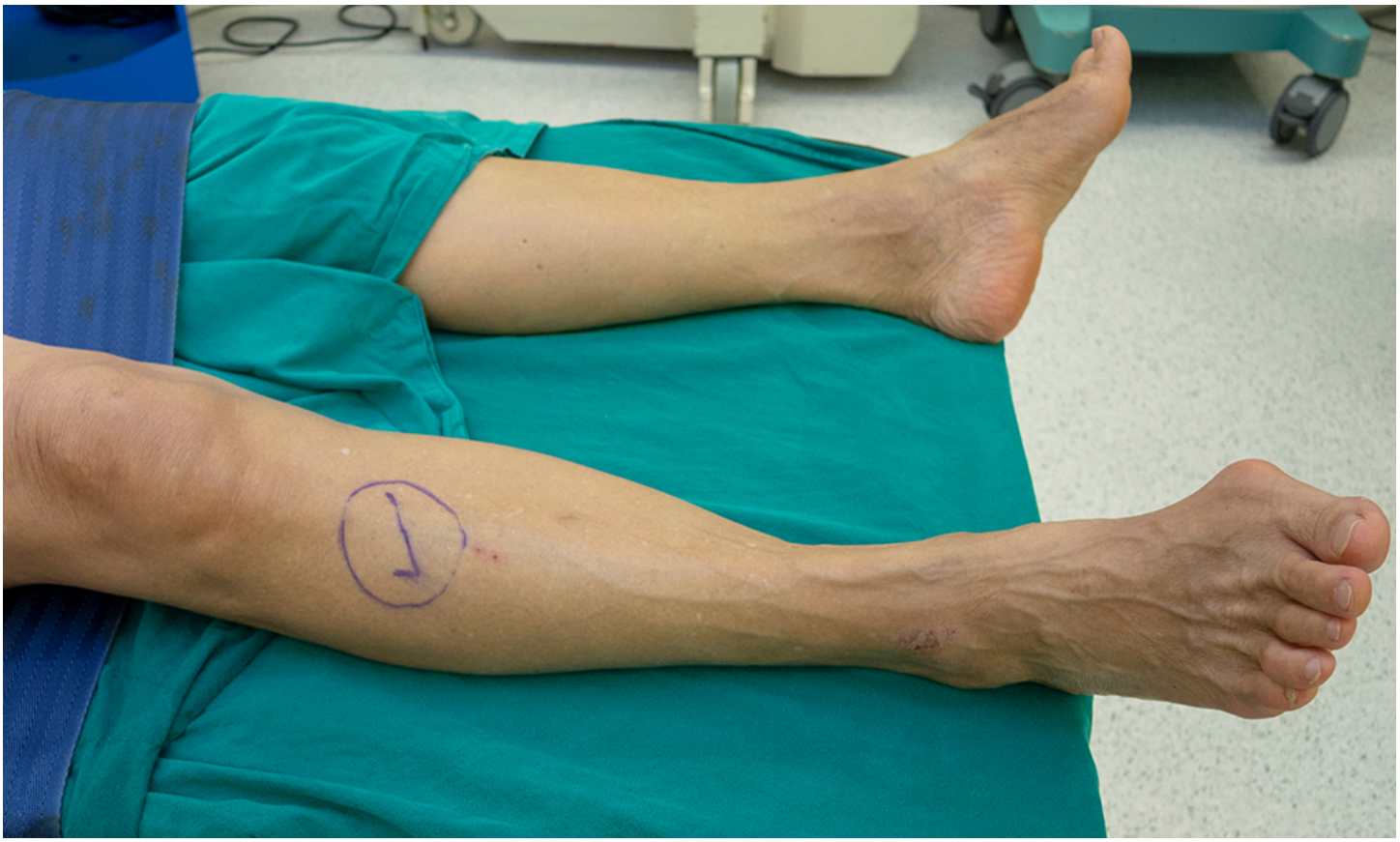
MALPRACTICE INSURANCE PREMIUMS GOING UP

In April, the American Medical Association (AMA) released a 10-page policy research paper on medical liability insurance premiums. The research paper tracked premium changes over a 10-year period, 2013 through 2022, using data from major liability insurance carriers in the U.S. According to the report, 36.2% of the carriers raised their premiums for medical liability insurance with 10.2% of them raising their premiums by 10% or more. Five years earlier — in 2017 — only 13.3% of carriers raised their premiums with virtually no carrier raising them 10% or more.

I'm not an actuary, but the insurance business model is pretty basic and hard to screw up: Take in more premium dollars than you pay out in claim dollars. If you're paying out more in claims for mistakes by doctors, for example, you raise your premiums to cover the higher losses and stay highly profitable. The fact that premiums are going up is a signal that patient safety is going down.

"If current trends continue ... this medical liability pressure could have detrimental effects on health care markets, such as an increase in defensive medicine, lower physician supply and thus reduced access to care," the AMA said.

More defensive medicine? Fewer doctors to pick from? Less access to care? Scary stuff. That's a recipe to make care even less safe for patients.



REPORTED ADVERSE PATIENT SAFETY EVENTS ARE GOING UP

Also in April, The Joint Commission released its annual report on "sentinel events" at hospitals, nursing homes or other facilities accredited by The Joint Commission. Sentinel events are patient safety breaches that cause severe harm, permanent harm or death. The number of reported sentinel events rose 19.3% in 2022 to 1,441 from 1,208 in 2021. That's also a 78.1% jump from the 809 reported in 2020.

Eighty-eight percent of the sentinel events in 2022 happened at accredited hospitals, and 90% were self-reported by accredited organizations. Patients, patients' families or current/former employees reported 10% of the sentinel events to The Joint Commission.

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The top 10 sentinel events, in ranked order by percent of the 1,441 total sentinel events last year were:

1. Falls (42%)
2. Delays in treatment (6%)
3. Unintended retention of a foreign object (6%)
4. Wrong site, wrong procedure, wrong patient or wrong implant surgery (6%)
5. Suicide (5%)
6. Assault/rape/sexual assault/homicide (4%)
7. Fire/burns (3%)
8. Perinatal event (2%)
9. Self-harm (2%)
10. Medication management (2%)

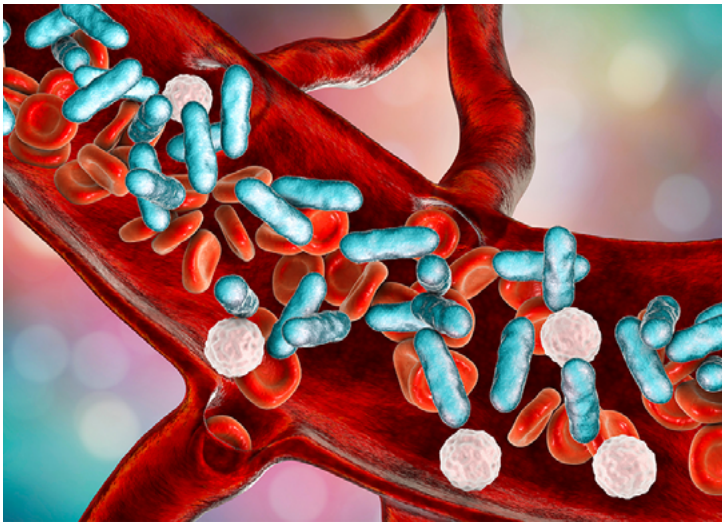
Two things scared me from this eight-page report. First, The Joint Commission is publishing statistics and trends in *reported* sentinel events. How many go *unreported*? Second, surgeons still are performing the right procedure on the wrong patient or the wrong procedure on the right patient? Isn't there a checklist to prevent this? The stuff of nightmares.

10 MORE PATIENT SAFETY RISKS TO WORRY ABOUT

In March, ECRI, the independent not-for-profit patient safety organization, released its latest annual list of the Top 10 "most pressing patient safety concerns." ECRI said many of the concerns that made the list this year are "exacerbated by ongoing staffing shortages." So, if the AMA is right, and higher malpractice insurance premiums force more physicians out of business, it's only going to get worse for patients.

Here are ECRI's Top 10 patient safety risks, verbatim, for 2023, from its 28-page report:

1. The pediatric mental health crisis.
2. Physical and verbal violence against healthcare staff.
3. Clinician needs in times of uncertainty surrounding maternal-fetal medicine.
4. Impact on clinicians expected to work outside their scope of practice and competencies.
5. Delayed identification and treatment of sepsis.
6. Consequences of poor care coordination for patients with complex medical conditions.
7. Risks of not looking beyond the "five rights" to achieve medication safety.
8. Medication errors resulting from inaccurate patient medication lists.
9. Accidental administration of neuromuscular blocking agents.
10. Preventable harm due to omitted care or treatment.



What hit me about this list is the fact that most of the risks on it are structure or process problems. I personally knew the moms of two good friends of mine who died from sepsis because their doctors were too slow in diagnosing and treating their urinary tract infections. Things can go south pretty quickly for an elderly woman with a UTI. There are clinical protocols for that, right?

These problems are fixable with better structures and processes. The fact that hospitals and doctors aren't fixing fixable problems scares me.

And it should scare you, too.

SPINNING OUR PATIENT SAFETY WHEELS

Also in March, the U.S. Agency for Healthcare Research and Quality, or AHRQ, published its most recent Chartbook on Patient Safety. Using its own data supplemented by data from a variety of sources like the CDC and CMS, the 116-page Chartbook tracks changes in 440 measures of quality and disparities over a 20-year period, 2000 through 2020, in four settings: ambulatory care, home health, hospitals and nursing homes. Of the 440 measures, 29 are patient safety measures — 20 outcome measures and nine process measures. AHRQ then reveals whether those measures are improving, not changing or worsening.

Overall, 17, or 59%, of the measures improved over 20 years. Eleven, or 38%, stayed the same over 20 years. One measure, or 3%, got worse over 20 years. At hospitals specifically, nine measures improved and five stayed the same. The five that stayed the same, verbatim from AHRQ, were:

- Perioperative hemorrhage or hematoma with surgical drainage or evacuation per 1,000 surgical admissions, age 18 and over.
- Postoperative hip fracture per 1,000 surgical admissions who were not susceptible to falling, age 18 and over.
- Reclosure of postoperative abdominal wound dehiscence per 1,000 abdominopelvic-surgery admissions of length 2 or more days, age 18 and over.
- Accidental puncture or laceration during a procedure per 1,000 medical and surgical admissions, age 18 and over.
- Birth trauma — injury to neonate per 1,000 live births.

Hemorrhage? Fractures? Wounds? Punctures? Lacerations? Trauma? Sounds more like scenes from the 1978 classic horror movie "Halloween" than it does scenes during a hospital stay. The fact that hospitals didn't move the needle on these five measures over two decades scares me, and it should scare you, too. (FWIW, my wife and I saw Halloween on our first date in 1979. Make of that what you will.)

The bottom line is this, and I said this at the top: The most effective patient safety strategy is to stay or get healthy. If you don't, there's a real chance that you could end up a data point in a report published by the AMA, The Joint Commission, ECRI or AHRQ.

No one wants that.

AUTHOR

David Burda began covering healthcare in 1983 and hasn't stopped since. Dave writes this monthly column "Burda on Healthcare," contributes weekly blog posts, manages our weekly newsletter 4sight Friday, and hosts our weekly Roundup podcast. Dave believes that healthcare is a business like any other business, and customers—patients—are king. If you do what's right for patients, good business results will follow.

Dave's personnel experiences with the healthcare system both as a patient and family caregiver have shaped his point of view. It's also been shaped by covering the industry for 35 years as a reporter and editor. He worked at Modern Healthcare for 25 years, the last 11 as editor.

Prior to Modern Healthcare, he did stints at the American Medical Record Association (now AHIMA) and the American Hospital Association. After Modern Healthcare, he wrote a monthly column for Twin Cities Business explaining healthcare trends to a business audience, and he developed and executed content marketing plans for leading healthcare corporations as the editorial director for healthcare strategies at MSP Communications.

When he's not reading and writing about healthcare, Dave spends his time riding the trails of DuPage County, IL, on his bike, tending his vegetable garden and daydreaming about being a lobster fisherman in Maine. He lives in Wheaton, IL, with his lovely wife of 35 years and his three children, none of whom want to be journalists or lobster fishermen.

Visit **4sight.com/insights** to read more from David Burda.