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(non)Profitability in Healthcare

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Cost Savings Through Zero Preventable Deaths

Instituting patient safety practices will save lives and healthcare dollars. We are proud of our healthcare experts; it is the system that needs to be fixed, and we can do that! We can create a system where safe, high-quality healthcare is delivered to every patient every time. Healthcare must become a high-reliability organisation, and this starts at the top by creating a culture of safety throughout the system. Other high-risk industries have done this, and we have the tools to do this in healthcare.

MICHAEL RAMSAY

Chief Executive Officer | Patient Safety Movement Foundation | California, United States

key points

- Complications are very expensive as well as potentially lethal. Surgical errors alone are estimated to cost $29 billion annually, and all medical errors may reach $958 billion annually in the U.S. alone.
- We all must reach zero harm, and to do this, we must create a safety culture in our healthcare system.
- Actionable, evidence-based best practices need to be instituted and followed.
- Now technology can help to identify abnormal data, and then a clinical team reviews the data. This is leading to more accurate and timely data, and what is exciting is that harm that was thought to be not preventable is now becoming preventable because of the early alerts given by this technology.
- Reimbursement in healthcare should be based on quality of results, not quantity.
- An independent National Patient Safety Team should be considered to investigate incidents of serious patient harm and develop recommendations to prevent them from happening again.

Introduction

Twenty-three years ago, the Institute of Medicine published a report, “To Err is Human”, which determined that 44,000 to 98,000 patients died each year in U.S. hospitals of preventable harm (Institute of Medicine 2000). Seven years ago, Professor Martin Makary from Johns Hopkins University estimated that the number was much higher in the region of 250,000 patient deaths a year (Makary and Daniel 2016). This would make it the third leading cause of death in the U.S. after heart disease and cancer!

Last year the Office of the Inspector General of the Department of Health and Human Services published a report on the state of the Federal government supported health systems, including the Centers for Medicare and Medicaid, that concluded that 25% of Medicare-funded patients had an adverse event during hospitalisation and 180,000 of these patients died (U.S. Department of Health and Human Services 2018). 43% of these adverse events were determined to be preventable, which calculates to 77,500 preventable deaths a year from hospitalised Medicare-funded patients.

Earlier this year, David Bates reviewed 11 hospitals in Massachusetts and found very similar results as were found in Medicare patients: adverse events were found in one in four admissions, approximately 22.7% of harm events were considered preventable, and 32.3% had a severity level of serious (Bates et al. 2023).

The U.S. has a dedicated team of well-trained healthcare workers, including clinicians, nurses, and pharmacists, that we can be proud of, so why are mistakes so common?

Patient harm frustrates the healthcare team. They, too, want a safe process for their patients. It is likely then that the process is faulty, not only for the members of the team. Some hospitals have managed the process to improve safety and have reached prolonged periods of zero hospital-acquired infections, zero pressure ulcers, zero ventilator-acquired pneumonias, and zero wrong-site surgeries.

We all must reach zero harm, and to do this, we must create a safety culture in our healthcare system. This comes from the top down, from the leadership of the country to the leadership in healthcare, to the hospital leadership, and then to every employee, every healthcare worker. Each must make a commitment to patient safety. We then need partnerships with patients, patient families, the med-tech industry, the legal system, other industry safety organisations, payors, and insurance companies. This will be a team effort, but we can do it.

Actionable, evidence-based best practices need to be instituted and followed (Patient Safety Movement 2023). These need to be "Living documents" so that new, proven improvements can be included.

Wrong-site surgery should be a "never event" Let's borrow from the airline industry the appropriate checklists, marking the site with the patient co-operating, appropriate consents and scans checked. The whole operating room team is in agreement on all parts of the procedure. Empower members of the team to speak out without fear if they see a step being missed or potential harm about to occur. This is often done already through the so-called 'time-out', where all the aforementioned steps are reviewed, and all can comment.

Near misses must all be reported without fear so that we can all learn from them. Everyone must feel safe reporting mistakes so that they can be investigated and not repeated. However, members of the team also have to be accountable if a safety measure agreed on in the evidence-based best practice is deliberately omitted without good reason.

Actionable, evidence-based best practices need to be instituted, followed and checked

Complications are very expensive as well as potentially lethal. Surgical errors alone are estimated to cost $29 billion annually, and all medical errors may reach $958 billion annually in the U.S. alone (Acevdo and Kuo 2021; National Quality Forum 2023; Goodman et al. 2023).

A precise accounting study from Dartmouth Hitchcock Medical Center demonstrated that instituting continuous monitoring of all patients with pulse oximetry saved lives and money. They were able to show an annual cost savings of $1,479,012 despite the cost of installing the surveillance technology because of a reduction in transfers to the ICU and a reduction in ICU stay (Taenzer et al. 2010). This was published in 2010, so inflation might represent even larger savings today.

When COVID-19 was rampant, many patients were kept out of hospital and managed by remote monitoring at home. This saved money and allowed other patients to be cared for in the overcrowded hospitals. The new monitoring systems would rely on transmitting their data to the patient's cell phone and the cell phone of the caregiver, and if a parameter such as oxygenation or pulse rate is aberrant, both cell phones would give an alert. This is an example of med tech companies working as a team with the healthcare force (Pronovost and Cole 2022).

Data should be very transparent, both to the healthcare team but also to the patient.

The healthcare team should all be apprised when wrong site surgery has occurred so that measures can be enforced to be sure it never happens again. Post-operative wound infections, central line infections, the incidence of pressure ulcers, urinary tract infections, diagnostic errors, medication errors, and the list goes on, but if we are going to prevent these complications and avoid patient harm and save the high cost of them, this would be progress. If we are all aware of when the error happens and the magnitude of the error, we will reach the solution much sooner. We are human, and we all are competitive, and if my data is not as good as yours, I will try and do better.

Hospitals used to rely on the adage "See something, say something" or billing and claims

We must make healthcare safer and save the millions of dollars that are spent on managing preventable complications

data to find errors. Now technology can help using artificial intelligence, electronic medical records can be scanned using "evidence-based trigger tools" that identify abnormal data, and then a clinical team reviews these data. This is leading to more accurate and timely data that will allow harm that was thought to be not preventable to become preventable because of the early alerts provided by this technology (Classen et al. 2018).

Another reason patient harm events may not be disclosed is the fear of malpractice litigation. The patient has a right to know if harm has occurred, and there should be open discussion on what happened and what will be done. There must be accountability if an error occurs, but equally, if the evidence-based best practice was followed and this was an unintended consequence, then full disclosure should still occur, but no admission of error should be made. The Agency for Healthcare Research and Quality developed the Communication and Optimal Resolution – CANDOR – tool kit in 2016. This is a strategy intent on honesty, transparency, and accountability (Boothman 2016).

An injured patient is the clinical responsibility of the caregiver and not the risk manager or hospital attorney.

Another barrier to the transparency of data is loss of reputation, loss of referrals, and loss of income, but this transparency is the fastest way to make healthcare safer and more affordable. Reimbursement in healthcare should be based on quality of results, not quantity. If evidence-based best practices were not followed and harm occurred, this should not be the payor's responsibility. If they were followed and unpreventable harm occurred, there should be full reimbursement. Evidence-based best practices should become standard everywhere.

Finally, a national patient safety team should be established to investigate causes of patient and healthcare worker harm and come up with recommendations. This team should include patients and representatives from the medical field, safety experts and lay experts.

We must make healthcare safer and save the millions of dollars spent on managing preventable complications. Excellence in healthcare is a result of good leadership.

Conflict of Interest

None. ■

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