Preventable Surgical Errors Cost $1.5 Billion

BY ALICIA AULT
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Preventable surgical errors are likely costing insurers more than $1 billion a year, according to a new study by the Agency for Healthcare Research and Quality.

The report provides a fuller accounting of the true cost of potentially preventable errors than had been previously published, according to the authors, William E. Encinosa, Ph.D., and Fred J. Hellinger, Ph.D., both with AHRQ's Center for Delivery, Organization, and Markets.

They looked at the comprehensive, per-episode cost of medical errors, including payments to hospitals for the initial admission and readmission, as well as payments for physicians, for outpatient services, and for prescription drugs. All cost data were included for 90 days after surgical admission.

The authors drew their analysis from the 2001-2002 MarketScan Commercial Claims and Encounter Database, which covers 5.6 million enrollees in private, employer-sponsored plans (Health Serv. Res. 2008 July 25 [doi: 10.1111/j.1475-6773.2008.00882.x]).

"Most papers that estimate the cost of medical errors only examine the initial hospitalization in which the medical error occurred," they wrote. But, they added, "we find that the death rate increases by 50% over 90 days once the patient leaves the hospital."

Postdischarge costs also are often higher than those for the initial admission, they noted. For infections, the excess payments during a 90-day episode were 28% higher.

By looking at an entire episode of care over 90 days, the researchers make a strong argument in favor of spending money on quality, Dr. Darrell A. Campbell, professor of surgery at the University of Michigan, Ann Arbor, said in an interview. "Complications and adverse events are expensive, and if you can avoid them, not only does quality go up, but costs go down."

The case-control study examined 14 potentially preventable adverse medical events, defined by AHRQ as patient safety indicators. In all 161,004 adult, nonelderly, major surgeries were analyzed; 2.6% (4,140) of cases had at least one of the 14 preventable events, and 5.6% of those cases had additional errors.

Acute respiratory failure was the most common preventable event, which occurred in 0.9% (1,392) of all surgeries. That also was the most expensive event, at $106,000 per instance, and patients who had respiratory failure also had the highest death rate, at about 12% over the 90-day period tracked.

For all patients who had at least one preventable event, the 90-day death rate was higher at 6%, compared with 0.6% for patients who did not have a preventable event. The 90-day readmission rate was 15% for patients with a preventable event, compared with 5.5% for those without.

Overall 23% of patients who experienced potentially preventable events were readmitted, compared with 10% of those without an event. Not surprisingly, overall costs were higher for those patients with events. The 90-day cost for a surgery that included a potentially preventable event was $66,800, compared with $18,200 for a procedure that did not involve such an event.

Lengths of stay were longer, as well, at 22 days for patients with events, compared with 5 days for those without.

By extrapolating the results to the entire population of insured nonelderly adults in the United States, the authors report that 11% of 90-day postdischarge deaths and 2% of 90-day readmissions are due to the 14 potentially preventable adverse events, as are 2% ($1.5 billion) of all 90-day expenses after surgery.

This estimate might be conservative, because there are many costs that could be incurred outside of the 14 preventable errors that were assessed in the report, Dr. Campbell noted.

Going forward, it will be possible to collect stronger data on errors because hospitals are now recording whether certain preventable conditions are present on admission, he said. ■

Additional Surgery Costs for Patients Resulting From Medical Errors

Event	Cost
Acute respiratory failure	$28,218
Infections	$19,480
Nursing-sensitive events	$12,196
Metabolic problems	$11,797
Pulmonary and vascular problems	$7,838
Wound problems	$1,426
Technical problems	$646

Note: Based on 2001-2002 data for 161,004 observations from MarketScan Commercial Claims and Encounters Database.
Source: Health Services Research

ELSEVIER GLOBAL MEDICAL NEWS

Joint Commission Now Under CMS Oversight

The Joint Commission, which provides the standard in hospital accreditation in the United States, will soon be subjected to greater federal oversight.

Congress recently eliminated the Joint Commission's "unique deeming authority" for hospitals as part of the Medicare Improvements for Patients and Providers Act of 2008 (H.R. 6331), which was enacted in July. That means that the Joint Commission, like other accrediting bodies, will need to apply to the Centers for Medicare and Medicaid Services for its accredited hospitals to be deemed to have met the conditions of participation in Medicare. Previously, the Joint Commission's deeming authority had been automatic and was not subject to oversight by CMS.

Officials at the Joint Commission supported the intention of the change, and plan to apply to CMS for hospital deeming authority. The Joint Commission and other accrediting bodies already apply to CMS for deeming authority in other areas, such as home care, laboratory, and ambulatory surgery accreditation programs.

Under the new law, the Joint Commission will have 24 months to apply to CMS for deeming authority and to be recognized. During the transition period, accredited hospitals will not be affected by this change, according to the Joint Commission.

"The Joint Commission anticipates a seamless transition," said Ken Powers, a spokesman for the organization.

In recent years, some members of Congress have tried unsuccessfully to eliminate the Joint Commission's unique deeming authority. In 2004, the U.S. Government Accountability Office (GAO) issued a report that called on Congress to consider giving CMS greater authority over the Joint Commission's hospital accreditation program. GAO investigators examined state agency validation surveys for 500 hospitals accredited by the Joint Commission and found that the commission had missed most of the serious deficiencies picked up during the state reviews.

—Mary Ellen Schneider

Management Can't Overrule Medical Staff Bylaws, Fla. Supreme Court Says

BY MARY ELLEN SCHNEIDER
New York Bureau

The Florida Supreme Court recently overturned a law that had given two Florida hospitals unique authority to disregard their medical staff bylaws.

In late August, the court threw out the St. Lucie County Hospital Governance Law, a 2003 law that applied to the two private hospitals in St. Lucie County, both owned by HCA Inc. of Nashville, Tenn.

Under the special law, the hospital board of directors' bylaws would prevail over the medical staff bylaws on any area of conflict related to medical staff privileges, quality assurance, peer review, and contracts for hospital-based services.

In *Lawnwood Medical Center v. Randall Seeger, M.D.* (president of the Lawnwood Medical Center medical staff), the Florida Supreme Court upheld a lower court ruling that found that the law was unconstitutional because it granted a "privilege to a private corporation" and violated the constitution's "equal protection" clause by creating two different classes of hospitals in the state.

The Florida Supreme Court concluded that the law granted the management of the hospital "almost absolute power in running the affairs of the hospital, essentially without meaningful regard for the recommendations or actions of the medical staff."

Since the approval of the medical staff bylaws at the Lawnwood Regional Medical Center in 1993, there had been several disputes between the hospital management and the medical staff regarding issues such as peer review, resulting in multiple lawsuits. After years of conflict, the hospital management sought and received a legislative remedy in 2003.

In an unusual legal move, the hospital management filed a court action shortly after the law went into effect to have it declared "constitutional." The law was rejected by a trial court and an appellate court before making its way to the Florida Supreme Court this year.

Officials at HCA Inc. are disappointed in the ruling and are reviewing the decision to determine possible next steps, said Nicole Baxter, a spokesperson for HCA.

The American Medical Association praised the decision. "Those bylaws represent a binding contract," said Dr. Cecil B. Wilson, a board member of the AMA, which filed "friend of the court" briefs in opposition to the 2003 statute through its litigation center.

The AMA litigation center and the Florida Medical Association also provided financial support to defray the legal costs of the medical staff.

By superseding jointly approved bylaws, the hospital was doing a disservice to both its physician staff and patients, Dr. Wilson said. Ignoring medical staff input on issues such as credentialing can have serious implications for safety and quality of care, he said.

Dr. Wilson said the AMA is hopeful that the case will serve as an example around the country, where conflicts between hospital management and medical staffs are becoming more common as both groups try to discharge their responsibilities related to quality and patient safety. ■