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HEALTH CARE VALUE HUB

Welcome to

Medical Harm:
The Taxonomy You've Been Waiting For

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Welcome and Introduction

Lynn Quincy

Director, Health Care Value Hub

Housekeeping

- **Thank you for joining us today**
- **All lines are muted until Q&A**
- **Technical problems? Please text/call Tad Lee at 703-408-3204 or our office at 202-462-6262**

Agenda for Today

Welcome & Introduction – Lynn Quincy (Consumers Union, Hub)

Unpacking the Concepts and Strategies to Address Medical Harm – Lisa McGiffert (Consumers Union, Safe Patient Project)

Strategy in Action – Francois de Brantes (Health Care Incentives Improvement Institute)

Releasing New Data for Maximum Impact: Early Insights – Susan Smith (NH Voices for Health)

Q&A

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Medical Taxonomy and Strategies to Address Medical Harm

Lisa McGiffert

Project Director
Safe Patient Project
Consumers Union


440,000 Americans Die
each year following a medical error
or infection in the hospital
That's more than two jumbo jets
full of passengers crashing every day
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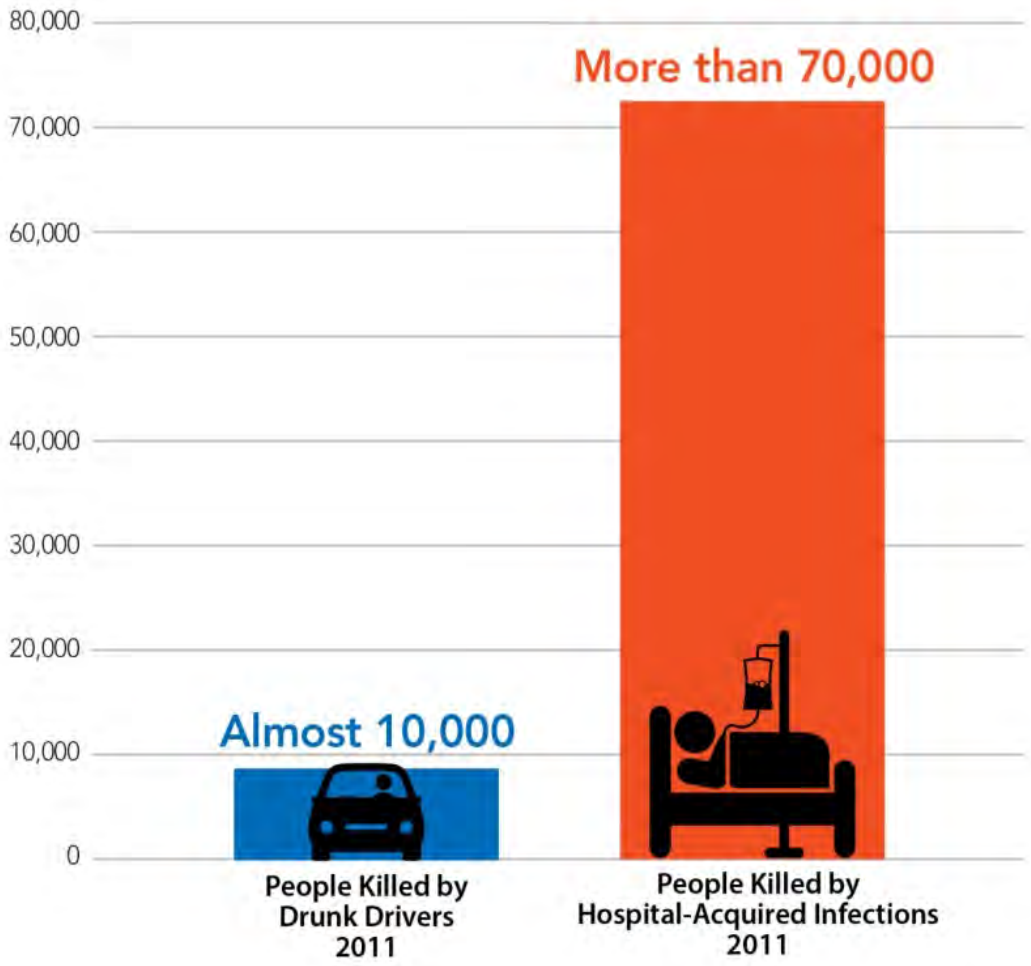
POLICY & ACTION FROM CONSUMER REPORTS
SafePatient Project.org

Medical Harm is a big problem

- Each year 440,000 hospital patients die following an infection, a medical error or a misdiagnosis.
- One in four hospital patients are victims of mostly preventable harm.
- No one tracks all medical harm

Hospitals Can Be Dangerous



Every year in the U.S., drunk drivers kill almost **10,000** people, but hospital-acquired infections kill **over seven times** that many.

The CDC estimates these infections add **$45 billion** every year to hospital costs.

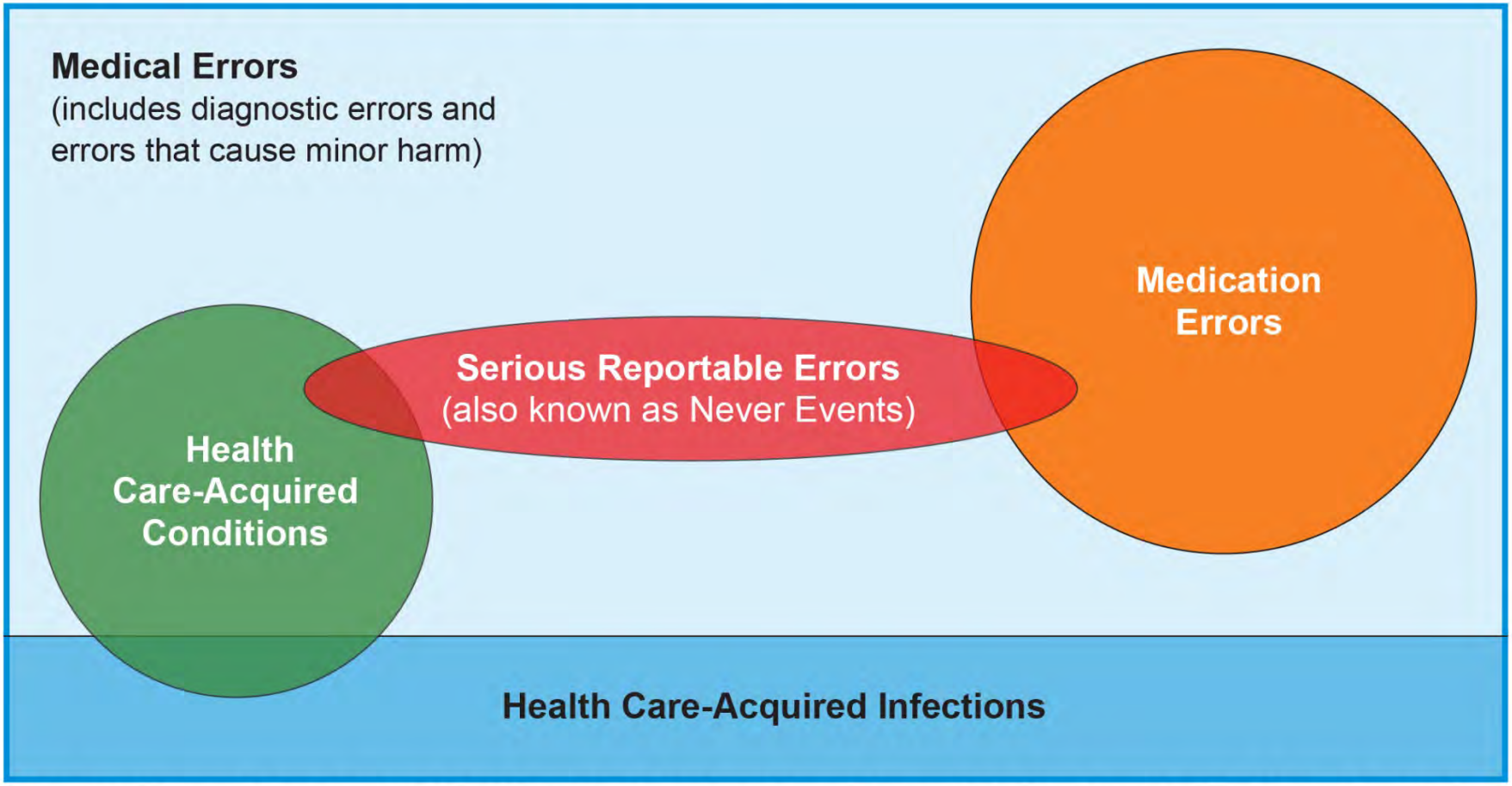
Medical Harm Definitions

World Health Organization (WHO)
"An injury related to medical management, in contrast to complications of disease. Medical management includes all aspects of care, including diagnosis and treatment, failure to diagnose or treat, and the systems and equipment used to deliver care…"
Institute for Healthcare Improvement
The "unintended physical injury resulting from or contributed to by medical care (including the absence of indicated medical treatment), that requires additional monitoring, treatment or hospitalization, or that results in death."

Medical Harm – making sense of a plethora of terms

- Serious reportable events
  - National Quality Forum measures
- Medication errors
- Hospital acquired conditions & health care acquired conditions – “HACs”
  - Created by federal law
  - Connected to payment programs

Types of Medical Harm and How They Overlap



Notes: Graphic excludes benign errors and near misses that don't cause harm. Poor reporting of harm makes it difficult to gauge the relative frequency of each type of harm.

Source: Health Care Value Hub, *Medical Harm: A Taxonomy*, Research Brief No. 9 (November 2015).

Medical Harm - what is it?

- Medical Errors – overarching term
  - 1999 Institute of Medicine (IOM) study, *To Err Is Human*, **Error** can be defined as the "[f]*ailure of a planned action to be completed as intended or the use of a wrong plan to achieve an aim.*"
- Health care acquired infections
  - infections that are not associated with the reason for which a person went to the hospital or sought health care.
- Adverse events connected with medical devices or prescription drugs
- Diagnostic errors

Health care-acquired infections - HAIs

- Nosocomial infections
- Health care associated infections
- Hospital acquired infections
- Described by devices or procedures associated with them:
  - SSI – Surgical Site Infections
  - CAUTI – Catheter Associated Urinary Tract Infections
  - CLABSI – Central Line Associated Bloodstream Infections

HAIs

Described by the type of bacteria causing them

- Antibiotic resistant infections
  - MRSA – Methicillin Resistant Staph Aureus
  - CRE – carbapenem-resistant Enterobacteriaceae; a form of this recently pegged “nightmare bacteria”
- *Clostridium difficile* (C.diff)
  - On CDC urgent threat list
- Linked to the overuse of antibiotics, which are often prescribed unnecessarily or used inappropriately

More on HACs

- Hospital acquired condition nonpayment program
- Hospital acquired condition reduction program
- ACA-required state Medicaid programs
  - Provider Preventable Conditions
  - Other Provider Preventable Conditions

How Prevalent is Medical Harm?

Our country does a poor job of tracking the medical harm experienced by patients. There are no estimates of the prevalence of all types of medical harm in all health care provider settings. This table provides partial information about estimates of hospital related medical harm (unless otherwise noted).

Type of Medical Harm	Incidents	Deaths	Excess Cost (per year)
All Medical Harm in Hospitals	8,800,000	440,000	?
Medical Errors Generally	8,078,000	365,000	?
Hospital Acquired Infections	722,000	75,000	$45 billion
Serious Reportable Events	?	?	?
Hospital Acquired Conditions	494,000 (Medicare only)	?	$21 billion
Medication Errors in Surgery	8,000,000[27]	?	$3.5 billion
Undetected Diagnostic Errors	?	40,000	?

Source: Health Care Value Hub, *Medical Harm: A Taxonomy*, Research Brief No. 9 (November 2015).

Questions for Lisa?

Click the “raise hand” icon at the top of your screen

To unmute, press *6

Please do not put us on hold!

Strategies to address medical harm

Public Reporting

- State mandated reports
  - More than 30 states report hospital infections
  - Only six states report medical errors by hospital
- Hospital Compare – national measures
- Other organizations using government collected data
  - Consumer Reports
  - Leapfrog Group

More Strategies to address medical harm

- Pay for Performance
- Education and training programs for health care providers
  - Partnership for Patients
  - Institute for Healthcare Improvement
- Involving patients in hospital training and policymaking
  - Patient and Family Councils; Board members

What state advocates can do

- Engage people who have been harmed
- Familiarize yourself with resources available in your state reports and Hospital Compare; push for more reporting and consumer-friendly reports
- Monitor and call attention to Medicaid “Provider Preventable Conditions” and “Other Provider Preventable Conditions”
- Use social media to call attention to state and national ratings of local hospitals in their communities
- Seek and direct public to information available at Hospital Licensing Agencies & Medical Boards

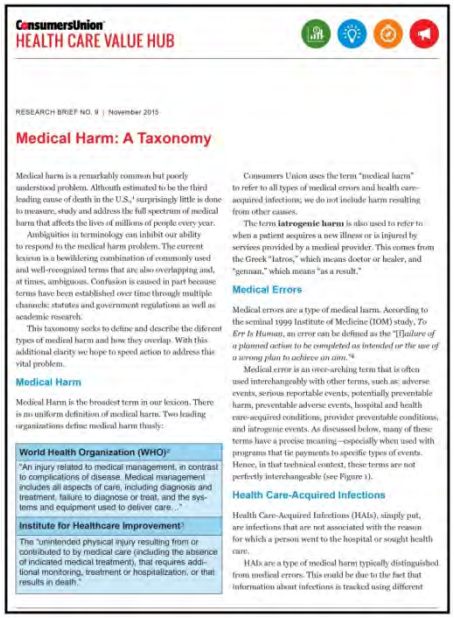
Where harm is happening

- Most of what we know about is harm in hospitals
- But errors and infections happen throughout the system
- Not much information available yet about:
  - Physicians and surgeons
  - Outpatient surgical centers
  - Independent clinics, like cancer treatment centers
  - Nurses, dentists, other health care providers
  - Nursing homes, dialysis centers

Resources to Help

- The Hub's Research Brief No. 9
- Medical Harm Reporting By State (DRAFT)
- More at:

www.safepatientproject.org
www.healthcarevaluehub.org/medical-harm-webinar



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RESEARCH BRIEF NO. 9 | November 2015

Medical Harm: A Taxonomy

Medical harm is a remarkably common but poorly understood problem. Although estimated to be the third leading cause of death in the U.S.,[1] surprisingly little is done to measure, study and address the full spectrum of medical harm that affects the lives of millions of people every year.

Ambiguities in terminology can inhibit our ability to respond to the medical harm problem. The current lexicon is a bewildering combination of commonly used and well-recognized terms that are also overlapping and, at times, ambiguous. Confusion is caused in part because terms have been established over time through multiple channels: statutes and government regulations as well as academic research.

This taxonomy seeks to define and describe the different types of medical harm and how they overlap. With this additional clarity we hope to speed action to address this vital problem.

Medical Harm

Medical Harm is the broadest term in our lexicon. There is no uniform definition of medical harm. Two leading organizations define medical harm thusly:

World Health Organization (WHO)[2]

"An injury related to medical management, in contrast to complications of disease. Medical management includes all aspects of care, including diagnosis and treatment, failure to diagnose or treat, and the systems and equipment used to deliver care…"

Institute for Healthcare Improvement[3]

The "unintended physical injury resulting from or contributed to by medical care (including the absence of indicated medical treatment), that requires additional monitoring, treatment or hospitalization, or that results in death."

Consumers Union uses the term "medical harm" to refer to all types of medical errors and health care-acquired infections; we do not include harm resulting from other causes.

The term **iatrogenic harm** is also used to refer to when a patient acquires a new illness or is injured by services provided by a medical provider. This comes from the Greek "latros," which means doctor or healer, and "genman," which means "as a result."

Medical Errors

Medical errors are a type of medical harm. According to the seminal 1999 Institute of Medicine (IOM) study, *To Err Is Human*, an error can be defined as the "[f]*ailure of a planned action to be completed as intended or the use of a wrong plan to achieve an aim.*"[4]

Medical error is an over-arching term that is often used interchangeably with other terms, such as: adverse events, serious reportable events, potentially preventable harm, preventable adverse events, hospital and health care-acquired conditions, provider preventable conditions, and iatrogenic events. As discussed below, many of these terms have a precise meaning--especially when used with programs that tie payments to specific types of events. Hence, in that technical context, these terms are not perfectly interchangeable (see Figure 1).

Health Care-Acquired Infections

Health Care-Acquired Infections (HAIs), simply put, are infections that are not associated with the reason for which a person went to the hospital or sought health care.

HAIs are a type of medical harm typically distinguished from medical errors. This could be due to the fact that information about infections is tracked using different

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Strategy in Action

Francois de Brantes

Health Care Incentives Improvement Institute, Inc.

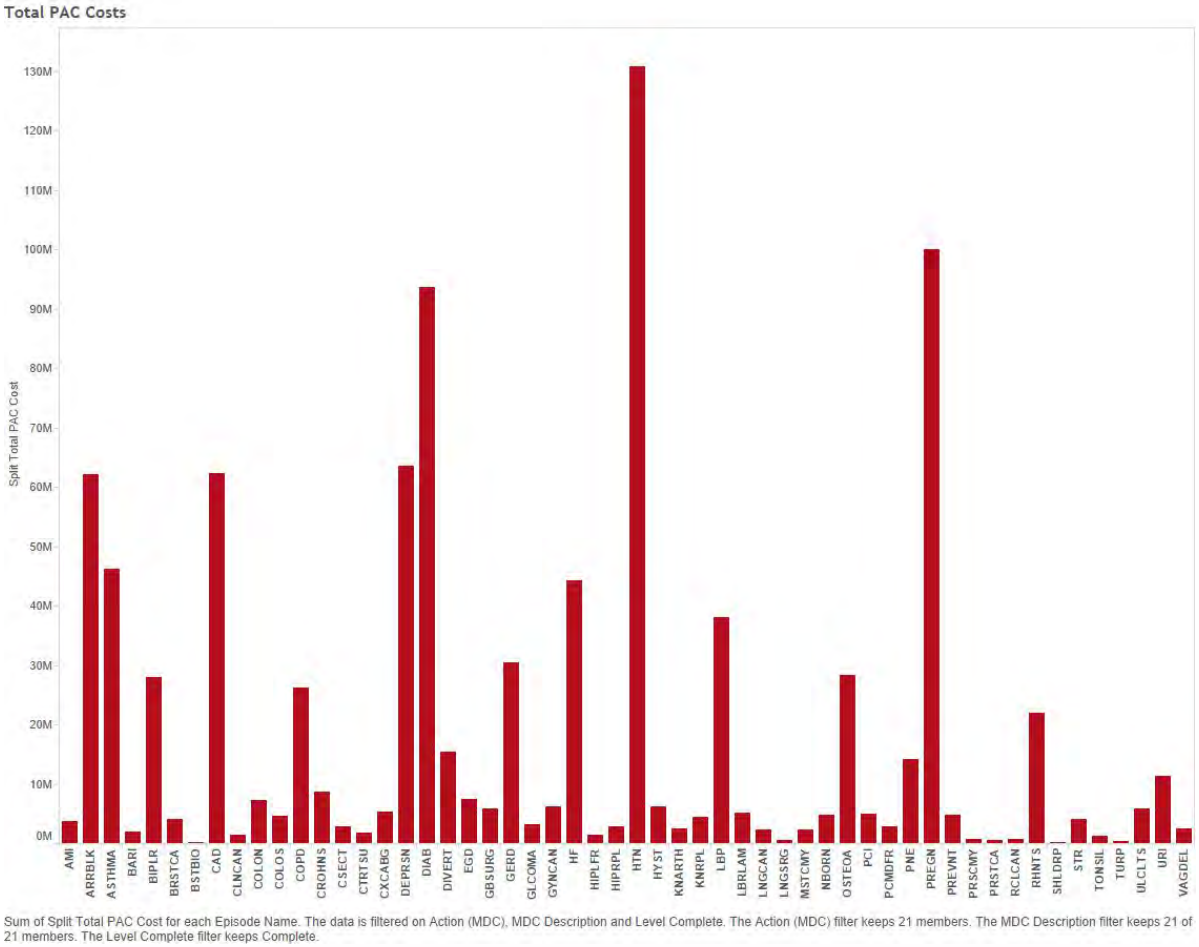
Risk Standardized PAC* Rates (RSPR)

* Potentially Avoidable Complications

What Are PACs?

- Complications that result from poor control or management of a condition, illness or injury
- Complications resulting from treatments or procedures
- Patient safety-related events and other patient harm due to the health care system

How Big Is the PAC Problem?

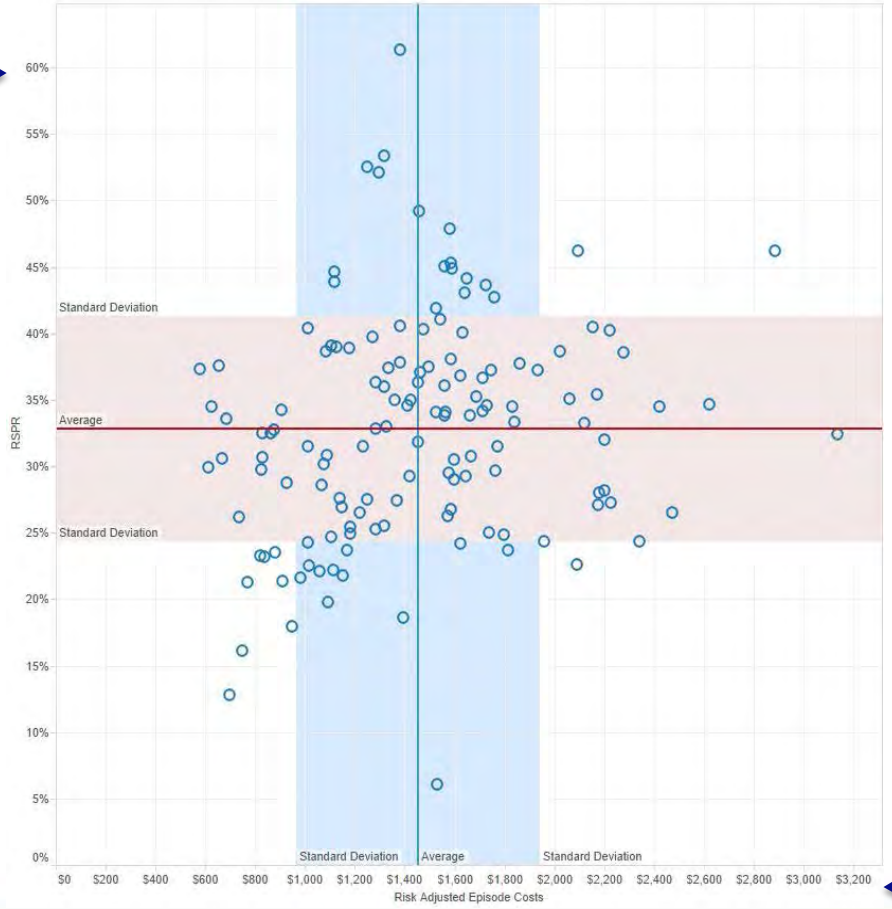


Sum of Split Total PAC Cost for each Episode Name. The data is filtered on Action (MDC), MDC Description and Level Complete. The Action (MDC) filter keeps 21 members. The MDC Description filter keeps 21 of 21 members. The Level Complete filter keeps Complete.

- Billions of dollars every year
- ~20% of total costs of care
- Lots and lots of variation by physician or facility

Example: Variation In Costs and PACs for Asthma

Rates of PACs vary from less than 10% to over 60%, meaning that for some physicians, 6 out of 10 patients experience an asthma complication during the course of the year.



Annual episode costs also vary with, for the most part, higher prices being driven by higher rates of complications.

What's The Plan?

- We can measure rates of complications (RSPR), adjusted for patient sickness and overall health, by physician or facility, for many conditions and procedures*
- We plan to start in New Hampshire because we have the state's all-payer claims database and the right to publish results
- We're working closely with local patient advocates (NH Voices for Health) to manage stakeholders and roll-out
- We can create a model for the rest of the country

* More info on methods at: http://www.hci3.org/piercing-the-darkness-a-generalizable-approach-to-reliably-measuring-quality-of-care

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Releasing New Data for Maximum Impact: Early Thoughts

Susan Smith

Executive Director
NH Voices for Health

Questions for the panelists?

Click the “raise hand” icon at the top of your screen

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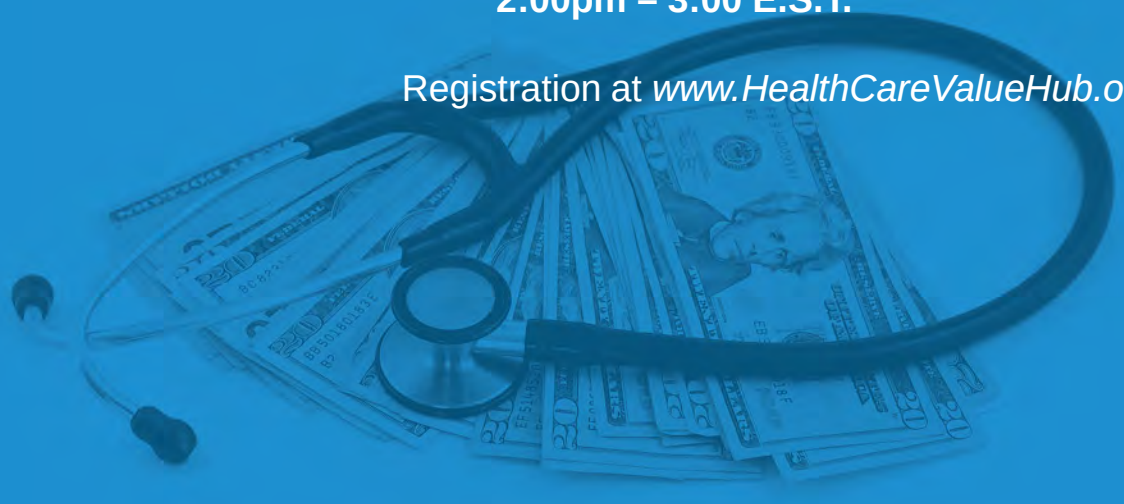
Please do not put us on hold!

Next Webinar:

Better Coordination or Price Gouging? Plan and Provider Consolidation

Jan. 15, 2016
2:00pm – 3:00 E.S.T.

Registration at *www.HealthCareValueHub.org/events*



Thank you!

Robert Wood Johnson Foundation
Lisa McGiffert
Francois de Brantes
Susan Smith

Contact Lynn Quincy at lquincy@consumer.org
or any member of the Hub team with your follow-up questions.

Visit us at *www.HealthCareValueHub.org*