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Hospitals are still killing patients with needless mistakes
And it's inexcusable because we know how to prevent them, complains health care advocate KAREN WOLK FEINSTEIN

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A new report from the Pennsylvania Health Care Cost Containment Council drives home the fact that, for all of the miracles of modern medicine, health care continues to be unnecessarily dangerous for patients.

The PHC4 is a small state agency that reports to Pennsylvanians about quality and safety of our hospitals. According to its latest report, if you were one of the unfortunate 23,000 Pennsylvanians who contracted an infection while hospitalized in 2009, your hospital stay, on average, was five times as long, five times as costly, and you were five times more likely to die in the hospital.

Infections also lead to repeated hospital readmissions. Infections from surgery are particularly problematic; more than 60 percent of patients who contracted surgical site infections had to be re-admitted within 30 days of initial discharge.

Patient safety concerns aren't new. More than a decade ago, the Institute of Medicine issued a ground-breaking report that estimated up to 98,000 Americans were dying each year of preventable infections, medication errors and other health care mistakes.

Since then, we've discovered more and better ways of preventing errors. And most patient safety steps are simple and cheap: such as using a one-dollar pen to mark the limb to be operated on, using safety checklists (as commercial airplane crews do) and diligent hand-washing by hospital staff to prevent the spread of germs.

Nevertheless, there has been no progress since the original national report in 1999. Last year, the New England Journal of Medicine published the results of a five-year study at 10 hospitals that showed nearly one of five patients was harmed by medical care. A 2010 Medicare study found that more than one-fourth of hospitalized Medicare patients suffered preventable harm at least once during their hospital stays -- from infections, medication errors, accidental falls, wrong-site surgeries and other problems.

Harm done by medical errors is particularly threatening for the sickest patients.

Central lines are special I.V. tubes used in intensive care units to deliver medication and other fluids through the body's critical blood vessels. An estimated 80,000 patients get central line-associated bloodstream infections annually, at an average cost of $83,000 per infection. Nearly

40 percent of these patients die. In 2005, a team at Allegheny General Hospital was among the first to prove that virtually all central line infections can be prevented.

Another type of infection threatens critically ill patients who need mechanical ventilator support. Less-than-optimum ventilator maintenance leads to tens of thousands of cases of ventilator-associated pneumonia.

Working together over the past two and a half years, 112 intensive care units in Michigan cut ventilator infections by more than 70 percent. Closer to home, Jefferson Medical Center reduced the incidence of these infections to zero. At UPMC Shadyside, a parallel initiative reduced mechanical ventilator use by nearly one-half, thereby reducing the risk of infection and leading to a 25 percent drop in average ICU length-of-stay.

Perhaps the fragmented nature of health care delivery makes it harder to implement and sustain safety. Maybe, unlike pilots, nuclear power workers and coal miners (all industries with better safety records than health care), health care workers don't put themselves at risk when a mistake is made. Whatever the reasons for the failure of voluntary safety improvement, it's time to take stronger actions.

Pennsylvania was the first state to withhold hospital payments for infections contracted by state-covered patients. Under the new federal health reform law, Medicare will take even stronger steps. Beginning in 2013, 6 percent of Medicare payments to hospitals (rising to 9 percent in 2015) will be tied to public reporting of errors and the provision of safer care, focused on health care-associated infections and preventable hospital readmissions.

Hospitals are recognizing that clever signs and reminders aren't sufficient to get all health care professionals to wash their hands and observe other basic precautions. UPMC Presbyterian recently sent an unequivocal signal to its staff that patient safety is a priority. Physicians at UPMC Presbyterian who don't wash their hands are subject to fines, and other hospital staff members who don't follow infection-prevention guidelines may be sent home without pay.

The new PHC4 report details the terrible consequences -- in cost, extended illness and death -- of making patient safety optional. Better results depend on leaders who commit their organizations to breakthrough improvement, who hold their employees accountable and who provide them with the support and training they need to achieve ambitious goals.

Health care organizations and staff must protect every single patient in every single instance, which includes investigating the root cause of errors and making sure they never happen again.

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