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Medical Errors Cost U.S. \$8.8 Billion, result in 238,337 potentially preventable deaths, according to HealthGrades Study

Top-Performing Hospitals have 43 Percent Lower Incidence Rate Compared with Poorest Performers

GOLDEN, Colo. (April 8, 2008) – Patient safety incidents cost the federal Medicare program \$8.8 billion and resulted in 238,337 potentially preventable deaths during 2004 through 2006, according to HealthGrades' fifth annual Patient Safety in American Hospitals Study. HealthGrades' analysis of 41 million Medicare patient records found that patients treated at top-performing hospitals had, on average, a 43 percent lower chance of experiencing one or more medical errors compared to the poorest-performing hospitals.

The overall incident rate was approximately three percent of all Medicare admissions evaluated, accounting for 1.1 million patient safety incidents during the three years studied. With the Centers for Medicare and Medicaid Services scheduled to stop reimbursing hospitals for the treatment of eight major preventable errors, including objects left in the body after surgery and certain post-surgical infections, starting October 1, the financial implications for hospitals are substantial.

The HealthGrades study, which also identifies those hospitals with patient-safety incidence levels in the lowest five percent in the nation, also found:

- Medicare patients who experienced a patient-safety incident had a one-in-five chance of dying as a result of the incident during 2004 to 2006.
- Overall death rate among Medicare beneficiaries that developed one or more patient safety incidents decreased almost five percent from 2004 through 2006.
- However, four indicators, post-operative respiratory failure, post-operative pulmonary embolism or deep vein thrombosis, post-operative sepsis, and post-operative abdominal wound separation/splitting, increased when compared to 2004.
- Medical errors with the highest incidence rates were bed sores, failure to rescue, and post-operative respiratory failure and accounted for 63.4 percent of incidents. Failure to rescue improved 11.1 percent during the study period, while both bed sores and post-operative respiratory failure worsened during the study period.

- Of the 270,491 deaths that occurred among patients who developed one or more patient safety incidents, 238,337 were potentially preventable.

If all hospitals performed at the level of Distinguished Hospitals for Patient Safety™, approximately 220,106 patient safety incidents and 37,214 Medicare deaths could have been avoided while saving the U.S. approximately \$2.0 billion during 2004 to 2006.

“While many U.S. hospitals have taken extensive action to prevent medical errors, the prevalence of likely preventable patient safety incidents is taking a costly toll on our health care systems – in both lives and dollars,” said Dr. Samantha Collier, HealthGrades' chief medical officer and the primary author of the study. “HealthGrades has documented in numerous studies the significant and largely unchanging gap between top- performing and poor-performing hospitals. It is imperative that hospitals recognize the benchmarks set by the Distinguished Hospitals for Patient Safety are achievable and associated with higher safety and markedly lower cost. ”

The fifth annual HealthGrades Patient Safety in American Hospitals Study applies methodology developed by the U.S. Department of Health and Human Services' Agency for Healthcare Research and Quality to identify the incident rates of 16 patient safety indicators among Medicare patients at virtually all of the nation's nearly 5,000 nonfederal hospitals. Additionally, HealthGrades applied its methodology using 13 patient safety indicators to identify the best-performing hospitals, or Distinguished Hospitals for Patient Safety™, which represent the top five percent of all U.S. hospitals.

Ratings for individual hospitals were posted today to HealthGrades' consumer Web site, www.healthgrades.com.

The following are the 16 patient-safety incidents studied:

- Accidental puncture or laceration
- Complications of anesthesia
- Death in low-mortality DRGs
- Decubitus ulcer (bed sores)
- Failure to rescue
- Foreign body left in during procedure
- Iatrogenic pneumothorax
- Selected infections due to medical care
- Post-operative hemorrhage or hematoma
- Post-operative hip fracture
- Post-operative physiologic metabolic derangement
- Post-operative pulmonary embolism or deep vein thrombosis
- Post-operative respiratory failure
- Post-operative sepsis
- Post-operative abdominal wound dehiscence
- Transfusion reaction

Distinguished Hospital Awards and Findings

Of the nearly 5,000 hospitals studied, the HealthGrades study identified 249 hospitals – those in the top five percent of all hospitals – to serve as a benchmark against which other hospitals can be evaluated, naming them Distinguished Hospitals for Patient Safety.

On average, these hospitals had a 43 percent lower rate of patient-safety incidents when compared with the poorest-performing hospitals. If all hospitals performed at the level of the Distinguished Hospitals for Patient Safety, the study found:

- Approximately 220,106 patient safety incidents and 37,214 Medicare deaths could have been avoided during 2004 to 2006

and

- More than \$2.0 billion of costs could have been avoided during the three years.

To be ranked in overall patient-safety performance, hospitals had to be rated in at least 17 of the 27 procedures and diagnoses rated by HealthGrades and have a current overall HealthGrades star rating of at least 2.5 out of 5.0. The final ranking set included 767 teaching hospitals and 891 non-teaching hospitals. The top 15 percent, or 249 hospitals, were identified as Distinguished Hospitals for Patient Safety, and represent less than five percent of all U.S. hospitals examined in the study.

The study says, “...more hospitals than ever are pledging to report their performance on safe practices and have agreed to not bill for preventable medical errors. Healthcare professionals are witnessing that zero defects is in fact possible.

Progress is being seen. We now have convincing case studies that perfection is possible when will to change and improve is present and the effort is made to implement new practices. While these examples illustrate that we have a much clearer idea of what we need to do, formidable barriers remain. Many in the industry continue to deny that truly safe care is achievable, thus the status quo continues, resulting in variation in patient safety in U.S. hospitals that is large and unpredictable. Numerous studies, including the 2007 AHRQ National Healthcare Quality Report (NHQR) assessing the state of hospital quality and patient safety, conclude and support the findings the progress remains modest and variation in healthcare quality remains high.”

The full study is available at www.healthgrades.com.

About HealthGrades

Health Grades, Inc. (Nasdaq: HGRD) is the leading healthcare ratings organization, providing ratings and profiles of hospitals, nursing homes and physicians. Millions of consumers and many of the nation’s largest employers, health plans and hospitals rely on HealthGrades’ independent ratings and decision support resources to make healthcare decisions based on the quality and cost of care. More information on the company can be found at <http://www.healthgrades.com>.