NYC Hospital Group to Advertise Error Rates

The strategy: If mortality and infection data are made public, then areas for improvement can be identified.

BY MICHELE G. SULLIVAN
Mid-Atlantic Bureau

You might not expect a hospital to advertise its errors, but that's what the public wants. And that's what the New York City Health and Hospitals Corporation is doing, according to Alan Aviles, the group's president.

In July, Mr. Aviles announced that the group's 11 hospitals would publicize their overall mortality rates, heart attack mortality rates, and rates of nosocomial infections, including central line, ventilator-associated, and surgical site infections.

Nineteen states, including New York, have legislation requiring the public reporting of nosocomial rates. And legislation adopted in 2005 requires New York hospitals to report their incidence of central line bloodstream infections, and coronary artery bypass graft and colon surgery site infections, to the state health department.

It's unclear when that information might be made public and whether it will appear as aggregate or facility-specific information. But Mr. Aviles has taken the bull by the horns because hospitals can't do a better job until they can see the job they're already doing, he said in an interview.

"One of the biggest problems in this industry is the extent to which we keep this kind of quality-related data close to the vest. The practical result of that attitude is that we expect our physicians to make improvements while they're groping around in the dark. They never have the benefit of knowing what we—or others—are achieving and where we stand on that spectrum."

Publicly disclosing what has always been considered a hospital's deepest secrets is the only way to fix them, he said.

Mr. Aviles has had his share of naysayers, including those within his own system who worried that public scrutiny could nick their competitive edge among the city's 60 hospitals. "There was concern that we could be impacted competitively if the public either misinterpreted the data or if the numbers aren't as good as those of the competition," he said. "But people know that medical errors and hospital-acquired infections cause thousands of needless deaths each year. They know there needs to be significant focus and improvement on these, and this transparency can only help."

To that end, Mr. Aviles and his team have set a lofty goal: By 2010, they want to have the safest hospitals in the country.

There's no mistaking the single-mindedness behind that goal, said Jim Conway, senior vice president of the Institute for Healthcare Improvement (IHI). "It's extraordinarily courageous and extraordinarily hard," he said in an interview. "They're willing to be held accountable not only to their own staff, but to consumers, patients, and families."

The nonprofit IHI supports transformational change in health care quality and safety, both in the United States and internationally. Its "Five Million Lives Campaign," launched in 2006, aims to protect patients from 5 million incidents of medical harm by the end of 2008. To achieve that, at least 4,000 hospitals will have to commit to improving patient safety. At present, 3,500 are involved.

The lofty goals set by the IHI and Mr. Aviles' group are a hallmark of successful change in health care systems, Mr. Conway said. Another example is Ascension Health System, which comprises 65 hospitals across the United States and aims to eliminate all preventable harm in all of their hospitals by 2008. "We're seeing the fruits of that goal. In almost every tracked indicator, their performance is much better than almost any other system in the country. For pressure ulcers, for example, the rate in their lowest-performing hospital is one-sixth that of the national average," Mr. Conway added.

Cincinnati Children's Hospital is trying to eliminate 80% of preventable serious harm, including hospital-acquired infections, by July 2008, according to Mr. Conway. Beth Israel Deaconess Medical Center in Boston has become the first hospital to post its 2007 Joint Commission Accreditation Survey findings on its Web site. The center also publicly posts its commitments to quality improvement, including the complete elimination of ventilator-associated pneumonia and central line infections.

"What drives organizations to accomplish goals like these?" Mr. Conway asked. "They have a great vision, and they have a solid sense of their current reality. They understand the gap between where they are and where they need to be, and they use that tension to drive change."

Goals in these organizations are specific and measurable—eliminating 100% of central line infections by a certain date, for instance, as opposed to a broader aim of delivering the best health care.

"We've come to understand that 'some' is not a number and 'soon' is not a time," Mr. Conway said. Just as importantly, everyone from the chief surgeon to housekeeping is considered responsible, he added.

Such efforts may be unusual now, but they are the wave of the future, Mr. Conway said. The public wants the information, states are requiring its disclosure, and the federal government is now refusing to pay for illnesses that could have been prevented—including hospital-acquired infections.

"We're going to see more and more hospitals taking responsibility like this," he predicted. "This is the end of the beginning, and the beginning of something new." ■

LAW & MEDICINE

ERISA's Tangled Web

Can a managed care enrollee sue his plan if he is injured because of what he claims was the result of poor care and treatment by a plan physician? If he dies, can his estate sue the plan for damages?

Before 2004, the answers to these questions were uncertain. The legal cases that had been decided were definitely a mixed bag, depending upon whether the assertions against the managed care plan were found to involve strictly patient care, just administrative decisions, or a combination of both.

BY MILES J. ZAREMSKI, J.D.

The former two were easy enough, because strict patient care would fall under state law governing medical negligence cases. If the allegations were solely administrative, then the case would come under a federal statute known as the Employee Retirement Income Security Act, or ERISA.

ERISA was originally intended by Congress to govern the rights of pension plan beneficiaries. But legal cases morphed this legislation into protection for ERISA health plans against state-filed lawsuits based on medical malpractice.

When allegations involved both patient care and administrative decisions, some cases were not preempted by ERISA while others were—it depended on how the court interpreted what the injured party asserted in a lawsuit. If the court decided that the lawsuit fell under ERISA, that party would be entitled to only a limited remedy: the cost of the denied benefit (generally just the cost of the treatment or procedure in question). If ERISA did not preempt the lawsuit (or if the health plan was not governed by ERISA), the enrollee would be entitled to all remedies allowed under state law.

The landscape for these types of decisions changed in 2004, when the U.S. Supreme Court decided two cases: *Aetna Health Inc. v. Davila (Davila)* and *Cigna Corp. v. Calad (Calad)*. In both cases, the patient sued for wrongful denial of coverage.

In the *Calad* case, Ruby Calad's physician recommended an extended hospital stay after Ms. Calad had a surgical procedure. The managed care plan, through its discharge nurse, thought the extension was unnecessary, and Ms. Calad was discharged from the hospital. Once home, she experienced postsurgical complications that required follow-up care.

In the *Davila* case, Juan Davila had various ailments, including diabetes, gastric ulcer disease, and arthritis. He was insured through Aetna's managed care plan, which he obtained through his employer. His physician, who was not in Aetna's network, recommended Vioxx (rofecoxib) for the treatment of his arthritis.

However, before allowing the use of Vioxx, Aetna required that Mr. Davila try two other medications, both less expensive than Vioxx. While on those "preferred" drugs, he experienced bleeding ulcers, internal bleeding, and a near heart attack. Because of the additional gastric impairment, he was no longer able to take medication absorbed through his stomach.

Both lawsuits were filed in Texas state court and then transferred to federal court. They made their way through the court system and eventually to the Supreme Court. The Supreme Court decided that the lawsuits fell under ERISA and that both lawsuits concerned benefits (coverage) promised to each plaintiff. The suits were not interpreted as asserting inappropriate medical care and treatment. Therefore, the plaintiffs could seek only the benefits promised but not delivered and no other damages.

In a separate but concurring opinion, Justice Ruth Bader Ginsburg, citing the words of an appeals court judge in another case, said, "I also join 'the rising judicial chorus urging that Congress and [this] Court revisit what is an unjust and increasingly tangled ERISA regime.' " That is to say, ERISA has been interpreted to provide protections to managed care plans that were never intended when this legislation was first signed into law.

In a way, this Supreme Court decision is good news for physicians, because it means that if they are named in a lawsuit together with a managed care plan, and the suit is found to fall under the ERISA statute, the odds are great that the only exposure to both parties will be ERISA's remedy: the cost of the benefit denied. They will escape the prospect of having to pay damages allowed for under state law, which are usually much higher.

That doesn't mean that the physician might not be sued separately, especially if there is a claim not related to treatment provided through the managed care plan. And of course if the health plan is found not to be an ERISA plan, then state laws apply. But unless and until Congress revisits the ERISA statute, physicians might find that being part of an ERISA plan isn't such a bad position to be in. ■

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