FOR IMMEDIATE RELEASE

Contact:
David P. Lind, President
Heartland Health Research Institute
Phone: (515) 868-0920
Email: david@dplindbenchmark.com
Web: hhri.net/silently-harmed-wisconsin-white-paper/

WISCONSIN REPORT ESTIMATES THOUSANDS OF PATIENTS ARE HARMED ANNUALLY IN HOSPITALS DUE TO PREVENTABLE MEDICAL ERRORS
Estimated Social Cost of Those Harmed in Billions

DES MOINES, IA (February 15, 2016) – A new white paper released in Wisconsin estimates that thousands of hospitalized patients are seriously or fatally harmed annually due to largely unreported preventable medical errors. In addition, the report suggests that the social cost of patients harmed can range from $1.5 billion to $40.5 billion annually. The white paper, "Silently Harmed - Hospital Medical Errors in Wisconsin©," was produced by Heartland Health Research Institute (HHRI) of Clive, Iowa, a knowledge-based organization that conducts research on a broad spectrum of healthcare issues.

According to the report, if the Centers for Disease Control (CDC) were to include preventable medical errors in U.S. hospitals as a category, it would be the third leading cause of death in the United States, behind heart disease and cancer. Using credible national estimates on medical errors, the HHRI report provides state-specific estimates for patients harmed in hospitals in Wisconsin and six midwestern states: Illinois, Iowa, Minnesota, Missouri, Nebraska and South Dakota. No assumptions were made about quality of care in Wisconsin or any other state, as the national estimates of hospital harm/fatalities upon which this paper is based, made no such assumptions.

Nationally, between 6.6 million to 11.5 million patients are estimated to be seriously harmed in hospitals due to preventable medical errors each year. According to HHRI - in Wisconsin, between 110,100 to 191,400 patients may be seriously harmed, with the mid-range being about 145,000 Wisconsin patients. If we assume this mid-range estimate is true, consider the following averages:

- Approximately every four minutes, one patient is harmed in a Wisconsin hospital.
- For every four hospital admissions, one patient in Wisconsin is harmed from a preventable adverse event (PAE).
- About two and one-half percent of the Wisconsin population is harmed each year. This is enough to fill TWO Lambeau Fields at 90 percent capacity annually.
- The annual estimated social cost of these injuries is approximately $2 billion.

National estimates show that 98,000 to 440,000 patients are fatally harmed each year due to preventable medical errors. Based on the number of hospital admissions in Wisconsin, HHRI estimates between 1,640 to 7,340 Wisconsin patients may be fatally harmed annually due to medical mistakes, with 4,170 patients being the mid-range estimate. If we assume this mid-range estimate is true, consider the following averages:

- One hospital fatality occurs in Wisconsin every 126 minutes from a PAE.
- One in every 139 admissions results in a death due to a PAE.
- For every vehicle death in Wisconsin, about seven patients die from preventable medical errors.
- For every murder in Wisconsin, 26 patients die from preventable medical errors.

The estimated annual social cost of fatalities due to such errors range from $9 billion to $40.5 billion.

The HHRI Wisconsin report estimates that the number of patients harmed annually - due to the most common preventable medical errors – would calculate to be:

1. Adverse Drug Events - 28,400 patients
2. Venous Thromboembolisms (VTEs) - blood clot that forms within a vein - 19,100
3. Decubitus ulcers (bed sores) - 14,200
4. Catheter-related urinary tract infections - 6,800
5. Falls in the hospital - 6,300
6. Nosocomial pneumonia - 4,900
7. Catheter - related bloodstream infections - 2,500

Why are estimates of preventable medical errors necessary? Because they are seldom reported by hospitals.

HHRI Recommendations:
"Silently Harmed" recommends that hospital leaders and board members develop a 'zero tolerance' mentality for preventable medical errors within each unit of the hospital.

HHRI Conclusion:
HHRI concludes that a new 'culture of safety' is needed and internal systems and policies instituted to prevent these errors. Reporting of medical errors should be mandated so progress on prevention can be measured.

"Preventable medical errors in our hospitals is clearly alarming, both in the number of lives affected and in cost." noted David P. Lind, President of Heartland Health Research Institute. "Is Wisconsin making progress on preventable medical errors? The quick answer is we don't really know because reporting is voluntary and not highly practiced. Without having stringently-coordinated regulations and policies that effectively hold providers accountable through transparent reporting, medical errors will continue and the public will remain in the dark. The Federal Aviation Administration has such regulations - shouldn't our safety be just as important when we enter a hospital as it is when we board an airplane? The public deserves transparency and accountability on this issue."

Located in Clive, Iowa, Heartland Health Research Institute (HHRI) is a knowledge-based organization that conducts research and analysis on a broad spectrum of healthcare issues. Topics specifically focus on employer and patient perspectives and measure expectations, satisfaction and trust in the healthcare system. To learn more about HHRI, visit HHRI.net.

###