



Differences in Patient Safety Events by Race and Ethnicity: Leapfrog's Enhanced Lives and Dollars Lost Calculator Webinar

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Differences in Patient Safety Events by Race and Ethnicity

Leapfrog's Enhanced Lives and Dollars Lost Calculator

November 2023



Agenda

- **Lives and Dollars Lost Calculator Overview**
 - Leah Binder, president and CEO, The Leapfrog Group
- **Findings from “Racial, Ethnic and Payer Disparities in Adverse Safety Events: Are there Differences across Leapfrog Hospital Safety Grades?”**
 - Matt Austin, Principal Faculty Member, Armstrong Institute for Patient Safety and Quality
- **Employers and the Hospital Safety Grade**
 - Michelle Martin, Senior Vice President, Total Rewards Experience, Paramount
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 - Alex Campione, Program Analyst, The Leapfrog Group
- **One Employer’s Experience**
 - Michelle Martin, Senior Vice President, Total Rewards Experience, Paramount
- **Discussion**
 - Leah Binder, president and CEO, The Leapfrog Group

Overview

- When mistakes happen in the hospital, employers pay the price in lives and dollars.
- For some employers, the dollars lost to medical errors can represent up to 30% of their overall health care spend. By shifting employees to “A” hospitals through improved benefits plan design, employers can decrease these hidden surcharges and protect their employees and dependents from harm.
- A study conducted by the Johns Hopkins Armstrong Institute for Patient Safety and Quality in 2015 found that Leapfrog-graded D and F hospitals carry nearly twice the risk of mortality than A hospitals. Over 50,000 lives could be saved if all hospitals performed at the level of A graded hospitals.

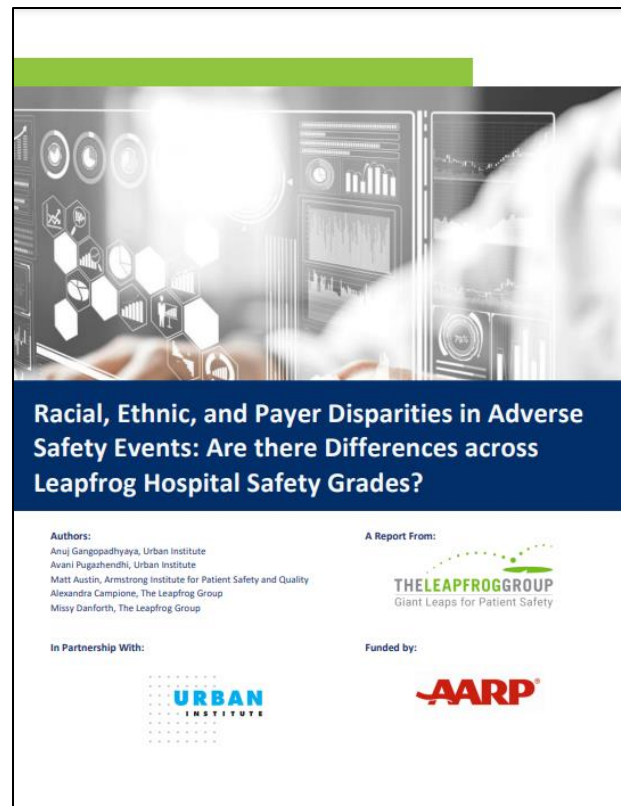


The Lives & Dollars Lost Calculator was awarded a Certificate of Validation Seal, demonstrating our commitment to the highest standards of validity.

The Validation Institute's Certificate of Validation is a seal of approval designed specifically for the health care industry. The Calculator also won a [2019 Health Value Award](#) for Value Transparency Services.

Racial, Ethnic and Payer Disparities in Adverse Safety Events: Are there Differences across Leapfrog Hospital Safety Grades

- In partnership with the Urban Institute and Johns Hopkins Armstrong Institute for Patient Safety and Quality, Leapfrog released a new report that examines the relationship between Leapfrog Hospital Safety Grades and racial, ethnic and payer disparities in rates of harm.
- The report compares the rate of 11 dangerous, preventable patient safety events, including blood clots or sepsis after surgery, among white, Black, and Hispanic patients at hospitals that earned Hospital Safety Grades of “A,” “B,” and “C/D/F.”
- Data used in this report was derived from 2019 hospital discharge data from 15 states, including over 10 million patient records.



Report Key Findings

- Analyzing differences across all graded hospitals, Black patients experience a higher incidence of surgery-related complications than white patients, including:
 - 34% higher rates of sepsis after surgery
 - 51% higher rates of dangerous blood clots after surgery
 - 17% higher rates of respiratory failure after surgery
- Relative to white patients and across all Hospital Safety Grades, Black patients have a significantly higher risk of Stage 3 and 4 pressure ulcers
 - Pressure ulcers are bed sores that have progressed to a stage that is debilitating or deadly
- Relative to white patients, Hispanic patients have a higher risk of experiencing sepsis and respiratory failure after surgery, and these differences remain significant at higher-graded hospitals.
 - 34% higher rates of sepsis after surgery
 - 21% higher rates of respiratory failure after surgery

Enhancing the Lives and Dollars Lost Calculator

- The report established that the differences in rates of many patient safety events among Non-Hispanic Black, Non-Hispanic white, and Hispanic patients significantly differed between "A", "B" and "C/D/F" hospitals.
- Leapfrog built a new calculator feature that allows employers to estimate differences in harm experienced by race and ethnicity.
- Gaps in care are influenced by the percent of "B" and "C/D/F" hospitals that are utilized by employees

We estimate among your covered lives

8% **higher** rate of harm for **Non-Hispanic Black patients***

4% **higher** rate of harm for **Hispanic patients***

**when compared to Non-Hispanic white patients*

Employers and the Hospital Safety Grade- Paramount



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Safety first! Does your hospital get an A? Leapfrog Hospital Safety Grade

When planning a surgery or procedure, you have a tool you can use to see how a hospital scores on patient safety: an A, B, C, D or F for how well hospitals protect their patients from errors, injuries, accidents and infections. If your local hospital rates below an "A," talk with your doctor at that hospital or start a conversation with hospital leadership and local policymakers about improving hospital safety. You should never refuse care in an emergency because of a hospital's safety grade, but use this website as a guide for planned events and as a research tool.

LEAPFROG HOSPITAL SAFETY GRADE hospitalsafetygrade.com

Dedicated appointment scheduling in the New York City (NYC) metro area

New York University (NYU) Langone Health provides network access to primary, behavioral and specialty care for Paramount UnitedHealthcare medical plan participants. Same-day appointments are available for urgent matters. To make an appointment Monday through Friday, call 1-877-698-3295, 7 a.m. to 8 p.m. ET.

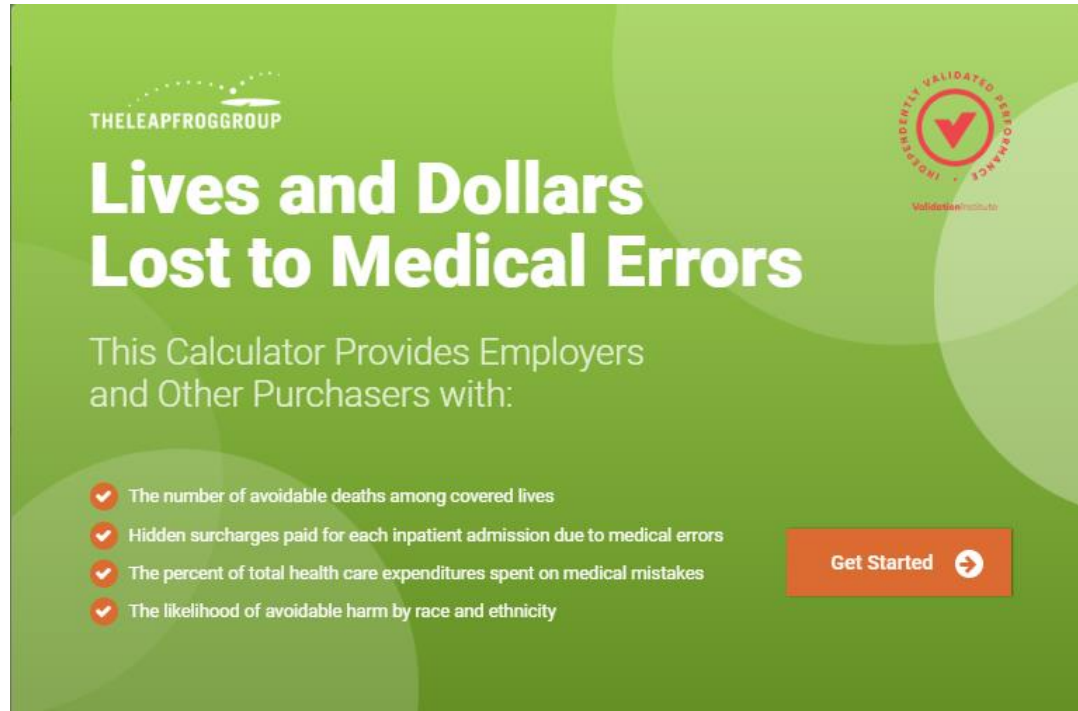
HR Team Gem
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"Many NYU mental health providers are paid as in-network providers under a contract with Paramount. Since they are not part of the UnitedHealthcare network, NYU providers will not show up when you search the UnitedHealthcare network. Paramount has worked directly with NYU to offer high-quality care and timely appointments! You just call the dedicated Paramount number and you'll be connected to an appropriate provider quickly!"

If a doctor does not have a Premium designation, it does not mean they provide a lower standard of care. It could mean that the data available to us was not sufficient to include the doctor in the program. All doctors who are part of the UnitedHealthcare network must meet our credentialing requirements (source from the Physician program).

The UnitedHealth Premium designation program is a resource for informational purposes only. Designations are displayed in UnitedHealthcare online physician directories at myuhc.com. You should always visit myuhc.com for the most current information. Premium designations are a guide to choosing a physician and may be used as one of many factors you consider when choosing a physician. If you already have a physician, you may also want to confer with them for advice on selecting other physicians. Physician evaluations have a risk of error and should not be the sole basis for selecting a physician. Please visit myuhc.com for detailed program information and methodologies.

Live Calculator Demonstration



The screenshot shows a green-themed landing page for a calculator. At the top left is the Leapfrog Group logo. The main title is 'Lives and Dollars Lost to Medical Errors'. Below it, a subtitle reads 'This Calculator Provides Employers and Other Purchasers with:'. A list of four bullet points, each preceded by a red checkmark, describes the calculator's outputs. In the top right corner is a red circular seal with a checkmark and the text 'INDEPENDENTLY VALIDATED PERFORMANCE' and 'ValidationInstitute'. At the bottom right is an orange 'Get Started' button with a right-pointing arrow.

THE LEAPFROG GROUP

Lives and Dollars Lost to Medical Errors

This Calculator Provides Employers and Other Purchasers with:

- ✓ The number of avoidable deaths among covered lives
- ✓ Hidden surcharges paid for each inpatient admission due to medical errors
- ✓ The percent of total health care expenditures spent on medical mistakes
- ✓ The likelihood of avoidable harm by race and ethnicity

Get Started →

Paramount's Experience

When mistakes happen in the hospital, employers pay the price in lives and dollars.



With Leapfrog's groundbreaking Lives and Dollars Lost risk calculator, employers and purchasers can:

- Estimate the number of avoidable deaths among their covered lives
- Identify the hidden surcharge paid for each inpatient admission
- Calculate how much of their total health care spend goes to medical mistakes

Information Needed for Calculator:

- Your total number of inpatient admissions for a calendar year within the U.S.
- Current Leapfrog Hospital Safety Grades for the facilities your employees utilize
- Estimated percent of admissions that require surgery or an ICU stay
- Your estimated annual total expenses for health care coverage

Paramount's Experience

Lives and Dollars Lost to Medical Errors

Upwards of 250,000 people die annually from preventable hospital errors. And when mistakes happen in the hospital, employers pay the price in lives and dollars. To run our calculator, you may need to work with your health insurer or third-party administrator (TPA) to determine your company's information in COLUMN G. If you would like assistance with the calculator, please contact info@leapfroggroup.org

NOTE: the following calculation includes a field for average inflation rate (Step 4) and a ratio of your costs to Medicare payments (Step 5). These variables are only included in this version of the Calculator.

Step		Average U.S. Employer*	Enter Your Company's Information Here
1	Enter your total number of inpatient admissions for a calendar year within the U.S.	1000	1,204
2	Enter the total percent of admissions to hospitals with the following Leapfrog Hospital Safety Grades		
	"A" Hospitals	29%	40%
	"B" Hospitals	26%	25%
	"C" Hospitals	39%	36%
	"D" & "F" Hospitals	6%	0%
3	Enter the estimated percent of admissions that require surgery or an ICU stay:		Leapfrog Members: log in to Leapfrog's website for assistance with these calculations
	Surgery	29.0%	20.0%
	Intensive Care Unit (ICU) stay	20.0%	20.0%
4	Average inflation rate of medical costs	4.0%	4.0%
5	Ratio of your costs to Medicare payments	2.5	2.5

LIVES AND DOLLAR LOST CALCULATOR STEP-BY-STEP INSTRUCTIONS

November 2023



Calculator Overview

When mistakes happen in the hospital, employers pay the price in lives and dollars. Using Leapfrog's groundbreaking and award-winning Lives and Dollars Lost risk calculator, employers and purchasers can:

- Estimate the number of avoidable deaths among their covered lives
- Identify the hidden surcharge paid for each inpatient admission
- Calculate how much of their total health care spend goes to medical mistakes

Information Needed for Calculator:

- Your total number of inpatient admissions for a calendar year within the U.S.
- Current Leapfrog Hospital Safety Grades for the facilities your employees utilize
- Estimated percent of admissions that require surgery or an ICU stay
- Your estimated annual total expenses for health care coverage

Finding the Calculator

Navigate to the Lives & Dollars Lost Calculator Webpage: [Click here](#)

Click “Open the Lives and Dollars Lost Calculator”

When mistakes happen in the hospital, employers pay the price in lives and dollars.

Using Leapfrog's groundbreaking and [award-winning Lives and Dollars Lost](#) risk calculator, employers and purchasers can:

1. Estimate the number of avoidable deaths among their covered lives
2. Identify the hidden surcharge paid for each inpatient admission
3. Calculate how much of their total health care spend goes to medical mistakes

What price do you pay?

Find out how many lives and dollars are at risk for your company

Open the Lives and Dollars Lost Calculator

Welcome

This calculator provides employers and other purchasers with:

- The number of avoidable deaths among covered lives
- Hidden surcharges paid for each inpatient admission due to medical errors
- The percent of total health care expenditures spent on medical mistakes

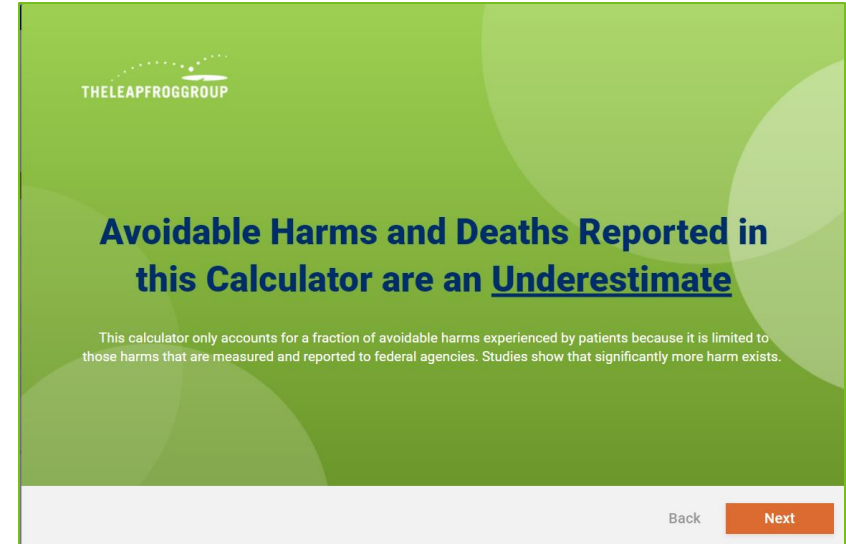
The likelihood of avoidable harm by race and ethnicity

The screenshot shows a green-themed landing page for a calculator. At the top left is the Leapfrog Group logo. The main title is 'Lives and Dollars Lost to Medical Errors' in large white text. Below it, a subtitle reads 'This Calculator Provides Employers and Other Purchasers with:'. A list of four bullet points, each with a red checkmark icon, details the calculator's outputs: 'The number of avoidable deaths among covered lives', 'Hidden surcharges paid for each inpatient admission due to medical errors', 'The percent of total health care expenditures spent on medical mistakes', and 'The likelihood of avoidable harm by race and ethnicity'. In the top right corner, there is a circular seal that says 'INDEPENDENTLY VALIDATED PERFORMANCE' around a red checkmark. A red 'Get Started' button with a right-pointing arrow is located in the bottom right corner.

Remember

This calculator only amounts for a **fraction of avoidable harms** experienced by patients because it is limited to those harms that are measured and reported to federal agencies.

Studies have shown that significantly more harm exists.



THELEAPFROGGROUP

Avoidable Harms and Deaths Reported in this Calculator are an Underestimate


This calculator only accounts for a fraction of avoidable harms experienced by patients because it is limited to those harms that are measured and reported to federal agencies. Studies show that significantly more harm exists.

Back Next

Getting Started


Collect employee hospital inpatient admission information, Hospital Safety Grades for hospitals used by employees, percentage of admissions that require surgery or an ICU stay, and total annual expenses for health coverage.

You may need to work with your health insurer or TPA to get this information.



Leap Tip

This calculator is provided at no cost as a public service from The Leapfrog Group, a nonprofit founded by purchasers who had a vision of transforming patient safety and quality in American hospitals.



Get Started

Upwards of 250,000 people die annually from preventable hospital errors. And when mistakes happen in the hospital, employers pay the price in lives and dollars.

To run our calculator, you'll need a few key pieces of information. You may already have this information on hand, but you may need to work with your health insurer or third-party administrator (TPA) to get it. If you don't have everything right now, you can estimate or use the national averages we provide.

What You'll Need:

- ✓ Your total number of inpatient admissions for a calendar year within the U.S
- ✓ Current Leapfrog [Hospital Safety Grades](#) for the facilities your employees utilize
- ✓ Estimated percent of admissions that require surgery or an ICU stay
- ✓ Your estimated annual total expenses for health care coverage

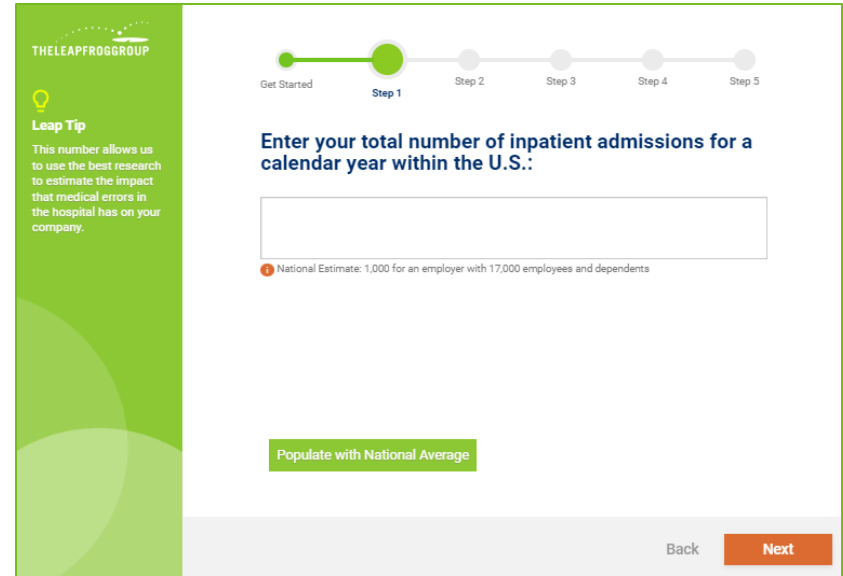
[Back](#) [Next](#)

Step 1: Inpatient Admissions

Enter your total inpatient admissions for a calendar year.

This number allows us to use the best research to estimate the impact that medical errors in the hospital has on your company.

If you do not know this number, you can populate with the national average, which is 1,000 for an employer with 17,000 employees and dependents




The screenshot shows a web form for 'Step 1: Inpatient Admissions' by The Leapfrog Group. On the left, a green sidebar contains the logo and a 'Leap Tip' stating that the number is used to estimate medical errors. The main content area features a progress bar at the top with five steps: 'Get Started', 'Step 1' (active), 'Step 2', 'Step 3', 'Step 4', and 'Step 5'. Below the progress bar, the instruction 'Enter your total number of inpatient admissions for a calendar year within the U.S.:' is followed by a large text input field. A note below the field indicates the 'National Estimate: 1,000 for an employer with 17,000 employees and dependents'. A green button labeled 'Populate with National Average' is positioned below the input field. At the bottom right, there are 'Back' and 'Next' navigation buttons.

Step 2: Hospital Safety Grade


Look up the Leapfrog Hospital Safety Grades of the hospitals in your community and calculate the percentage of your admissions per hospital.

To complete this section, look up the [Leapfrog Hospital Safety Grades](#) of the hospitals in your community, and then calculate what percentage of your admissions utilized these facilities. If a hospital [doesn't have a grade](#), we suggest assigning them to the “B” category, which is close to average.









Leap Tip

To complete this section, look up the Leapfrog Hospital Safety Grades of the hospitals in your community, and then calculate what percentage of your admissions utilized these facilities. If a hospital doesn't have a grade, we suggest assigning them to the “B” category, which is close to average.



Get Started Step 1 **Step 2** Step 3 Step 4 Step 5


Adjust the percent of admissions using your network's [Leapfrog Hospital Safety Grade](#) or use the national estimates:

 A HOSPITALS	 B HOSPITALS	 C HOSPITALS	 D HOSPITALS	 F HOSPITALS
<input type="text" value=""/>	<input type="text" value=""/>	<input type="text" value=""/>	<input type="text" value=""/>	<input type="text" value=""/>
 Estimated National Average: 29%	28%	36%	7%	
<input type="button" value="Populate with National Averages"/>				
<div>Back <input type="button" value="Next"/></div>				

STEP 3: Percent Of Admissions That Require Surgery Or An ICU Stay

Look up the Leapfrog Hospital Safety Grades of the hospitals in your community and calculate the percentage of your admissions that require surgery, or an ICU stay.

Some patients are admitted to an ICU following a surgical procedure, so they may be counted in both estimates.



Leap Tip

Some patients are admitted to an ICU following a surgical procedure, so they may be counted in both estimates.

Get Started

Step 1

Step 2

Step 3

Step 4

Step 5

Adjust the percent of admissions that require surgery or an ICU stay or use the national estimates:

Surgery

%

Intensive Care Unit (ICU)

%


Estimated National Average: 29%

20%

Populate with National Averages

Back

Next


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Giant Leaps for Patient Safety

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Step 4: Employee Productivity

Estimate how much you lose on employee productivity for every dollar spent on inpatient care.


Higher hospital bills aren't the only way medical errors take a toll on your business. Researchers and planners often include productivity loss as a factor of overall spending. If you don't want to factor this in, just enter "0".

The national estimate is \$1.00




Leap Tip

Higher hospital bills aren't the only way medical errors take a toll on your business. Researchers and planners often include productivity loss as a factor of overall spending. If you don't want to factor this in, just enter "0".



Estimate how much you lose on employee productivity for every dollar spent on inpatient care:



1 National Estimate: \$1.00

Populate with National Average

Back Next


Step 5: Annual Total Expenses

Estimate your company's annual total expenses for healthcare coverage.

This should include: inpatient care, outpatient care, primary care, or any other expenses you consider part of your healthcare spend.

For some employers, the dollars lost to medical errors can represent up to 30% of their overall health care spend. Your estimate of total expenses should include inpatient care, outpatient care, primary care, or any other expense you consider part of your overall health care spend. This calculation is optional.

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**Leap Tip**
For some employers, the dollars lost to medical errors can represent up to 30% of their overall health care spend. Your estimate of total expenses should include inpatient care, outpatient care, primary care, or any other expense you consider part of your overall health care spend. This calculation is optional.

Get Started

Step 1

Step 2

Step 3

Step 4

Step 5

Optional
Estimate your company's annual total expenses for health care coverage:

\$

Populate with National Average

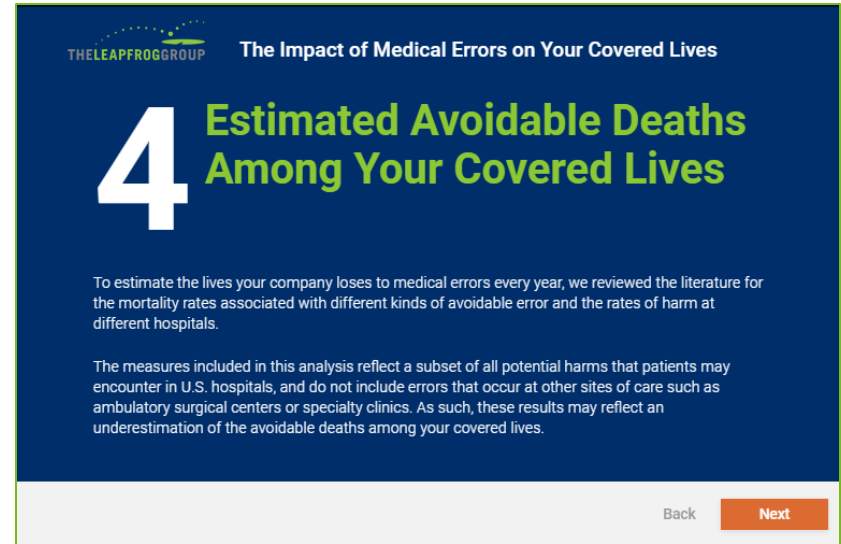
Back

Finish

Estimated Avoidable Deaths Among Your Covered Lives

To estimate the lives your company loses to medical errors every year, we reviewed the literature for the mortality rates associated with different kinds of avoidable error and the rates of harm at different hospitals.

The measures included in this analysis reflect a subset of all potential harms that patients may encounter in U.S. hospitals, and do not include errors that occur at other sites of care such as ambulatory surgical centers or specialty clinics. As such, these results may reflect an underestimation of the avoidable deaths among your covered lives.



THE LEAPFROG GROUP The Impact of Medical Errors on Your Covered Lives

4 Estimated Avoidable Deaths Among Your Covered Lives

To estimate the lives your company loses to medical errors every year, we reviewed the literature for the mortality rates associated with different kinds of avoidable error and the rates of harm at different hospitals.

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[Back](#) [Next](#)

The Impact of Medical Errors on Your Covered Lives

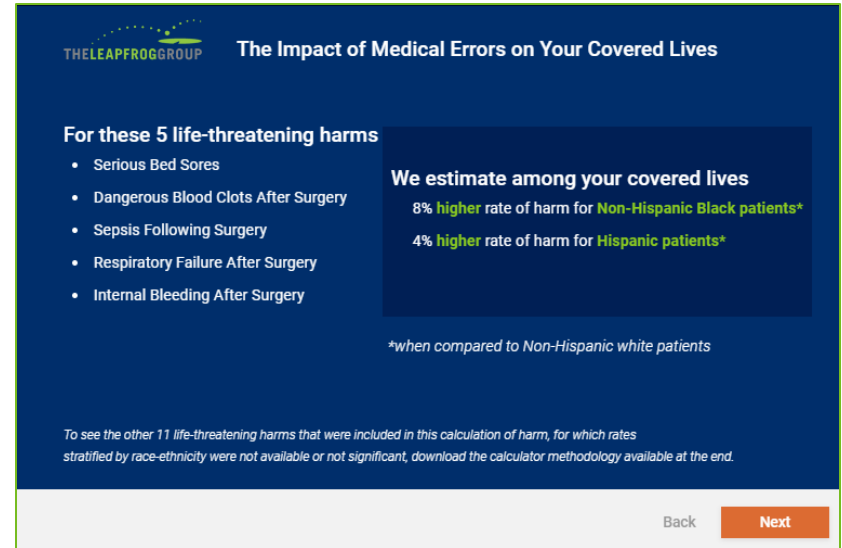
To estimate the dollars your company loses to medical errors every year, we reviewed the literature for the dollar value associated with different kinds of avoidable error and the rates of harm at different hospitals. The resulting number is a hidden surcharge associated with every inpatient admission that is due to preventable medical errors.



The Impact of Medical Errors on Your Covered Lives

A recent study conducted by Leapfrog uncovered higher rates of several life-threatening harms among Black and Hispanic patients at "C", "D" or "F" hospitals.

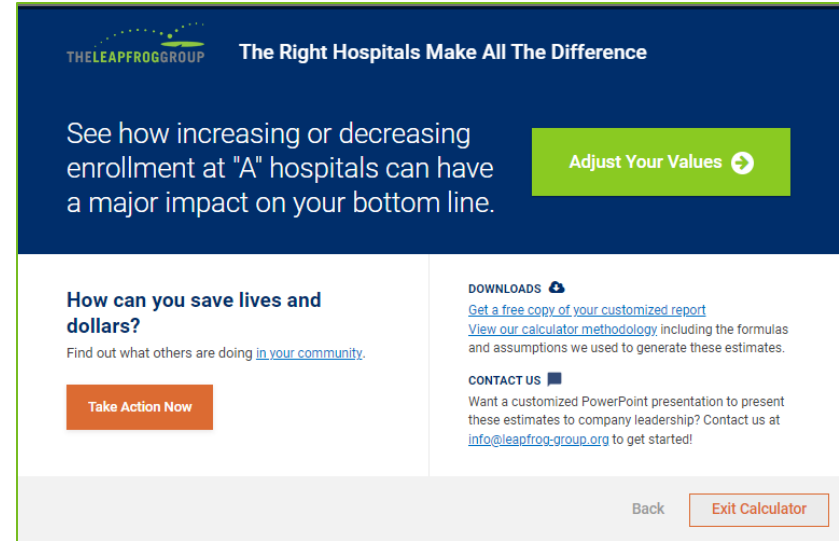
Rates of harm for your employees and their dependents were calculated by race and ethnicity. Depending on the percent of your hospitals that are "C", "D" or "F" hospitals, the gap in harm between Non-Hispanic white patients and Non-Hispanic Black or Hispanic patients might be greater among your covered lives.



The Right Hospitals Make All the Difference

The final page allows you to adjust your values and determine the impact of more "A" hospitals in your network. You can also download a PDF of your report or an excel with calculator formulas to further explore the measures used in this calculator.

Want a customized PowerPoint presentation to present these estimates to company leadership? Contact us at info@leapfrog-group.org to get started!



The screenshot shows the final page of the Leapfrog Group calculator. The header features the Leapfrog Group logo and the title "The Right Hospitals Make All The Difference". The main content area has a dark blue background with white text stating: "See how increasing or decreasing enrollment at 'A' hospitals can have a major impact on your bottom line." A green button labeled "Adjust Your Values" with a right arrow icon is positioned to the right. Below this, the page is divided into two columns. The left column is titled "How can you save lives and dollars?" and includes a link to "in your community" and an orange "Take Action Now" button. The right column is titled "DOWNLOADS" and includes links to "Get a free copy of your customized report" and "View our calculator methodology". Below this is a "CONTACT US" section with a text box and a link to "info@leapfrog-group.org". At the bottom, there is a light gray bar with a "Back" link and an orange "Exit Calculator" button.

THELEAPFROGGROUP The Right Hospitals Make All The Difference

See how increasing or decreasing enrollment at "A" hospitals can have a major impact on your bottom line.

Adjust Your Values ➔

How can you save lives and dollars?
Find out what others are doing [in your community](#).

Take Action Now

DOWNLOADS 📄
[Get a free copy of your customized report](#)
[View our calculator methodology](#) including the formulas and assumptions we used to generate these estimates.

CONTACT US 📧
Want a customized PowerPoint presentation to present these estimates to company leadership? Contact us at info@leapfrog-group.org to get started!

[Back](#) **Exit Calculator**



Racial, Ethnic, and Payer Disparities in Adverse Safety Events: Are there Differences across Leapfrog Hospital Safety Grades?

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Avani Pugazhendhi is a research assistant in the Health Policy Center at the Urban Institute. Her research focuses on disparities in patient safety and Medicare. Pugazhendhi holds a bachelor's degree in economics and a minor in environmental studies from Hamilton College.



Matt Austin is an associate professor at the Johns Hopkins University School of Medicine and a principal faculty member at the Armstrong Institute for Patient Safety and Quality. His research focuses on performance measurement in health care and his current research interests include understanding the role of transparency of quality and safety data in driving improvements in care delivery, measuring disparities in the quality of care, and measuring the diagnostic performance of hospitals. He provides strategic guidance to The Leapfrog Group on their performance measurement and public reporting activities.



Alexandra Campione is a Program Analyst at The Leapfrog Group. She works closely with internal and external team members to ensure Leapfrog's Hospital Safety Grade Program reflects the highest standards for measurement and public reporting. Her work includes managing and analyzing data used in Leapfrog's current ratings programs and providing technical expertise to hospitals. Campione holds a master's degree in public health from the George Washington University.



Missy Danforth is the Vice President of Health Care Ratings, where she serves as member of Leapfrog's senior leadership team informing Leapfrog's strategic direction, engaging experts, and stakeholders, and analyzing program results to engage purchasers and consumers and drive safety and quality improvements. Ms. Danforth oversees Leapfrog's various measurement and public reporting activities including the Leapfrog Hospital Survey, the Leapfrog ASC Survey, the Leapfrog Hospital Safety Grade, and emerging ratings programs.

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RACIAL, ETHNIC, AND PAYER DISPARITIES IN ADVERSE SAFETY EVENTS

Understanding whether hospitals achieve low rates of adverse safety events by delivering inpatient care uniformly to patient populations is critical to designing and evaluating policies and programs that aim to improve overall hospital quality. The Leapfrog Group calculates Hospital Safety Grades, A, B, C, D, and F, for general acute care hospitals twice per year to reflect how well they keep patients safe from preventable harm (i.e., rates of in-hospital accidents, errors, injuries, and infections). To date, little is known about the association between Hospital Safety Grades and the delivery of safe care specific to a patient's racial-ethnic background or insurance. Further, no evidence indicates whether safer overall care is associated with narrowing disparities in patient safety among patients with different racial-ethnic backgrounds or among patients with different types of insurance coverage.

Leapfrog Hospital Safety Grades are determined, in part, using the patient safety indicators (PSIs) developed by the Agency for Healthcare Research and Quality (AHRQ). Safety Grades are based on aggregated PSI measures across all Medicare fee-for-service discharges, calculated and published by the Centers for Medicare and Medicaid Services (CMS). In this study, we use complete patient-level hospital discharge records from 15 states in 2019 to assess rates of adverse safety events by patient racial and ethnic background (non-Hispanic white, non-Hispanic Black, or Hispanic patients).¹ Rates of adverse safety events were calculated for four “general” PSIs (adverse safety events that most hospital patients are at risk for) and seven surgery-related PSIs (adverse safety events occurring during or after a surgical procedure) by three hospital Safety Grade cohorts (i.e., A hospitals, B hospitals, and C/D/F hospitals).² The Black-white and Hispanic-white differences were compared between the three Safety Grade cohorts. We also assessed differences in rates of adverse safety events between privately insured patients and patients with Medicare and, separately, Medicaid coverage by the same three hospital cohorts.

This study provides two insights. First, the Leapfrog Group Hospital Safety Grades are a useful resource for patients irrespective of their racial and ethnic backgrounds. For most measures, Black patients can expect safer care in A-graded hospitals than in C/D/F-graded hospitals—this is also true for white and Hispanic patients. Thus, a hospital's Safety Grade provides a signal of the quality of care for distinct racial-ethnic backgrounds. Second, the hospital's Safety Grade does not ensure that any disparity in the quality of care delivered to different patient populations will be minimized. In other words, these findings suggest that the hospitals most adept at achieving safe care overall are no better at identifying and narrowing inequities in the delivery of that care. For certain measures, we observed that A-graded hospitals had the lowest Black-white or Hispanic-white

¹ Throughout the remainder of the report, “Black” patients refers to patients identified as non-Hispanic Black and “white” patients refers to patients identified as non-Hispanic white.

² We combine all hospitals that receive a Leapfrog Hospital Safety Grade of C, D, and F. This results in similar sized Hospital Safety Grade cohorts.

differences in patient safety (e.g., pressure ulcers and postoperative pulmonary embolisms); for others, A-graded hospitals had the largest Black-white or Hispanic-white differences in patient safety (e.g., postoperative sepsis infections, perioperative hemorrhage). Similarly, we observed no pattern between the hospital Safety Grade cohorts and differences in the delivery of safe care delivered to patients with public coverage (i.e., Medicare or Medicaid) relative to patients with private coverage.

Key Findings

- For most PSIs, white patients, Black patients, and Hispanic patients all receive safer care in the A and B hospital cohorts. For each racial-ethnic patient group, rates of adverse safety events are typically highest in hospitals with lower Safety Grades (the C/D/F hospital cohort).
- Across the 11 PSIs, relative to white patients, Black patients had significantly higher rates of adverse safety events on 5 PSIs, statistically similar rates of adverse safety events on 4 PSIs, and significantly lower (or better) rates of adverse safety event on 2 PSIs. Black-white differences were most notable among surgery-related PSIs, with Black patients experiencing rates of postoperative sepsis infections, perioperative pulmonary embolisms, and postoperative respiratory failure that are 34 percent, 51 percent, and 17 percent higher than the rates for white patients.
- Across the 5 PSIs for which Black patients had significantly higher rates of adverse safety events relative to white patients, no overall pattern emerged between the Hospital Safety Grade cohorts and the size in the Black-white safety disparity.
- Relative to white patients, Hispanic patients had significantly higher rates of adverse safety events on 2 of 11 PSIs, statistically similar rates of adverse safety events on 5 PSIs, and significantly lower rates of adverse safety events on 4 PSIs. We again observe little to no pattern between hospital's overall letter grade and the magnitude of the Hispanic-white difference in adverse safety events.
- Relative to privately insured patients, Medicare patients averaged significantly higher rates of adverse safety events on 10 of 11 PSIs and statistically similar rates on 1 PSI. Relative to privately insured patients, Medicaid patients had significantly higher rates of adverse safety events on 8 of 11 PSIs and statistically similar rates on the remaining 3 PSIs. Again, we observed little pattern between a hospital's overall letter grade and the size of the difference in adverse safety events between patients with Medicare or Medicaid coverage and those with private insurance.

BACKGROUND

Patient safety is the cornerstone of quality care and therefore unequal access to safe hospital care reflects unequal access to quality hospital care in the US (Institute of Medicine 2000; Mitchell 2008). Past research has documented higher rates of hospital-acquired illness and injuries among Black patients than among white patients (e.g., AHRQ 2021; Hasnain-Wynia et al. 2007; Metersky et al. 2011; Shen et al. 2016). For select measures, Hispanic patients also experience higher rates of adverse inpatient safety events relative to non-Hispanic patients (e.g., AHRQ 2021). Recent studies have shown that, relative to white patients, Black patients in the US are more likely to receive care at institutions that have higher rates of adverse safety events and are more likely to experience adverse safety events, even when admitted to the same hospital as white patients (Gangopadhyaya 2021a, 2021b).

Evidence also indicates that patients with different types of insurance coverage systematically receive differential care quality, with privately insured patients having lower rates of inpatient mortality rates relative to patients with Medicare or Medicaid coverage (Spencer, Gaskin, and Roberts 2013). Insurers reimburse hospital services at different rates, with private insurers paying higher rates than Medicare, which, in turn, reimburses hospitals at higher rates than Medicaid (Selden 2020). It has long been recognized that variation in payment rates could create financial incentives for hospitals to deliver differential care to patients on the basis of payer type, particularly if maintaining high-quality and safe care is costly (Institute of Medicine 2003).

Because eligibility pathways for public insurance programs are based primarily on income, disability, or age, investigating differences in adverse safety events among patients with distinct payer types could highlight another area of inequitable delivery of care. Specifically, comparing differences in rates of adverse safety events between Medicaid and privately insured patients helps highlight disparities in the incidence of adverse safety events by socioeconomic or disability status. In contrast, comparing differences in these rates between Medicare and privately insured patients serves to assess the differences in the quality of hospital care delivered to elderly versus nonelderly patients (although we note that many Medicare patients receiving hospital care may be nonelderly and disabled as well). Insurance type is also related to patient racial-ethnic background, with Black or Hispanic patients significantly more likely to have Medicaid coverage than white patients.³ Thus, examining differences in safe hospital care delivery by payer type highlights a potential mechanism through which racial and ethnic disparities may widen.

Leapfrog Hospital Safety Grades were developed in 2012 to summarize hospitals' overall performance in patient safety (Austin et al. 2014). The grade is calculated on the basis of process and structural measures, such as the efficacy of a hospital's computerized physician ordering system in alerting prescribers to fatal

³ See figure 2 in Samantha Artiga, Latoya Hill, and Anthony Damico, "Health Coverage by Race and Ethnicity, 2010–2021," KFF, December 20, 2022, <https://www.kff.org/racial-equity-and-health-policy/issue-brief/health-coverage-by-race-and-ethnicity/>.

medication order errors, as well as outcome measures, such as health care associated infections and PSIs.⁴ These outcome measures are key elements of CMS quality data reporting programs, including the Hospital-Acquired Condition (HAC) Reduction Program. The Hospital Safety Grade methodology uses this publicly available data, as well as data collected via the annual voluntary Leapfrog Hospital Survey, to calculate letter grades for hospitals across the country. This letter grade allows patients to quickly compare hospitals' safety records. The provision of equitable care is not currently measured in the Hospital Safety Grade, but patients might expect higher-graded hospitals to provide safer care than lower-graded hospitals.

In this study, we sought to assess whether hospitals achieving better Leapfrog Safety Grades deliver, on average, safer care to all patients, including patients with different racial-ethnic backgrounds and coverage types. We further investigated differences in the delivery of safe care among patients of distinct racial-ethnic backgrounds and coverage types. We hypothesized that hospitals with higher grades would be in the best position to narrow inequities in care by applying standardized, effective hospital safety protocols across all patients. Evaluating this hypothesis is fundamental to understanding whether policies aimed at improving overall hospital quality are also effective at narrowing well-documented racial and ethnic differences.

METHODS

To investigate whether Leapfrog Safety Grades correspond with more equitable safety outcomes, we acquired complete hospital discharge data from 15 states through the State Inpatient Databases processed by the AHRQ Healthcare Cost and Utilization Project. We selected all states that had available data for 2019 and included identifiers that enabled hospitals to be matched to their Leapfrog Hospital Safety Grades. The state databases included in this analysis are Arkansas, Arizona, California, Florida, Kentucky, Massachusetts, Maryland, Mississippi, North Carolina, New Jersey, Nevada, Oregon, Utah, Washington, and Wisconsin.⁵ The included states are geographically diverse and represent both small and large populations.

These data represent the universe of patient-level discharge records for each state and include information on patient age, sex, racial and ethnic background, insurer type, diagnostic condition, procedure codes, and more. Using AHRQ-developed software (version 2022) for PSIs, we identified discharge records reporting adverse safety events among 11 measures.⁶ The AHRQ software also identifies all discharges at risk for experiencing each adverse safety event, and we use these hospitalizations as denominators to construct rates of adverse safety events. We classified these 11 measures into 4 general patient safety measures (adverse events most

⁴ For more information on the methodology used to construct the grades, see "About the Grade," Leapfrog Hospital Safety Grade," <https://www.hospitalsafetygrade.org/your-hospitals-safety-grade/about-the-grade>.

⁵ Analysis for all states except California was led by the Urban Institute. Analysis of California discharge databases was conducted by the Armstrong Institute for Patient Safety and Quality at Johns Hopkins University.

⁶ The 11 measures selected are the ones used by CMS in evaluating the Hospital-Acquired Conditions Reduction Program. For more information on calculating PSIs, see "Patient Safety Indicator Measures," AHRQ, https://qualityindicators.ahrq.gov/measures/psi_resources.

patients are at risk for in hospital settings) and 7 surgery-related patient safety measures (measures related to adverse events occurring during or shortly after surgical procedures). These are clinically validated measures of injuries or illnesses patients acquire that are unrelated to the primary diagnoses that initiated the hospital admission (Romano et al. 2009). Therefore, the adverse safety events measured by AHRQ's PSIs represent events that all hospitals should seek to minimize.

All short-term acute care hospitals with enough publicly available data are eligible to receive a Hospital Safety Grade twice per year. In our analysis, we restricted discharges to hospitals that received a spring 2022 Hospital Safety Grade. Further, PSIs are measured for adult patients only, so we excluded all patients under age 18. In our assessment of racial and ethnic disparities, we defined white patients as the historically advantaged patient group and compared differences in overall rates of adverse safety events between Black and white patients, as well as between Hispanic and white patients. In our assessment of payer-type disparities, we defined patients who had private insurance as their primary payer as the advantaged group and compared differences in overall rates of adverse safety events between Medicare-insured and privately insured patients, as well as between Medicaid-insured and privately insured patients.

We investigated unadjusted overall differences in adverse patient safety events, but in recognizing that patient populations differ in ways that affect susceptibility to adverse safety events, we further assessed differences after adjusting for patient age, sex, indicators for state of residence, quartile of income based on zip code of residence, and indicators for racial-ethnic background (in payer disparities analysis only) and payer type (in racial-ethnic disparities analysis only). Several of these controls could drive underlying disparities in access to quality hospitals, and controlling for them could underreport total disparities. However, in our comparisons of unadjusted versus adjusted estimates, estimated differences are generally *wider* in adjusted models, indicating that unadjusted models underestimate underlying patient safety disparities in ways not accounted for when excluding these controls (Clemans-Cope, Garrett, and McMorow 2023).

RESULTS

Table 1 presents rates of adverse safety events by Hospital Safety Grade for each PSI. We further tested whether rates of adverse safety events in B- and C/D/F-graded hospitals are statistically different from those in A-graded hospitals. This table validates accurate matching of patient-level discharge records to Hospital Safety Grades. As we should generally expect, given that the Hospital Safety Grades are in part based on PSIs among Medicare beneficiaries, A-graded hospitals had the lowest rates (with two small exceptions in rates of pressure ulcers and perioperative hemorrhage that are slightly higher than B-graded hospitals). Adverse safety events in B-graded hospitals were slightly higher than rates in A-graded hospitals, but for most measures these rates were not statistically different between these two groups of hospitals. C/D/F-graded hospitals had the highest rates of adverse safety events across most measures, and several differences between rates of adverse safety events in C/D/F-graded hospitals and A-graded hospitals were statistically significant.

Table 1 also highlights that the four general patient safety events occur less frequently than the seven surgery-related PSIs. The rate of in-hospital falls with hip fractures was less than 0.1 per 1,000 at-risk discharges and the rate of pressure ulcers was 0.6 per 1,000 at-risk discharges, compared with 6.6 incidences of postoperative respiratory failure, 4.0 incidents of postoperative sepsis infections, and 3.2 incidents of perioperative pulmonary embolism per 1,000 at-risk discharges.

Table 1. Rates of General Patient Safety Events and Surgery-Related Patient Safety Events by Leapfrog Hospital Safety Grade, 2019

	All Hospitals	A Hospitals	B Hospitals	C/D/F Hospitals
General Patient Safety Indicators				
Pressure Ulcer	0.620	0.521	0.520	0.802*
Iatrogenic Pneumothorax	0.173	0.168	0.172	0.180
Central venous catheter-related bloodstream infection	0.100	0.081	0.099	0.125*
In-hospital fall with hip fracture	0.065	0.064	0.063	0.067
Surgery-Related Patient Safety Indicators				
Perioperative Hemorrhage	2.261	2.181	2.123	2.458
Postoperative acute kidney injury requiring dialysis	1.006	0.942	0.976	1.130
Postoperative respiratory failure	6.550	5.660	7.134*	7.607*
Perioperative pulmonary embolism or deep vein thrombosis	3.224	2.985	3.257	3.535*
Postoperative sepsis	3.952	3.483	4.085	4.633*
Postoperative wound dehiscence	1.634	1.470	1.710	1.805*
Abdominopelvic accidental puncture or laceration	1.006	0.985	0.989	1.046

Source: Agency for Healthcare Research and Quality, State Inpatient Databases for Arkansas, Arizona, California, Florida, Kentucky, Massachusetts, Maryland, Mississippi, North Carolina, New Jersey, Nevada, Oregon, Utah, Washington, and Wisconsin, 2019, <https://hcup-us.ahrq.gov/db/state/siddbdocumentation.jsp>.

Note: Estimates indicate rates per 1,000 at-risk discharges.

*indicates estimate is significantly different from the rate at A hospitals. Standard errors are robust clustered at the hospital-level.

Adjusted Rates of Adverse Safety Events by Patient Race and Ethnicity

Tables 2 and 3 present adjusted *averages* for the four general PSIs and the seven surgery-related PSIs by patient racial and ethnic background—we present and discuss estimates of the *differences* in adverse safety events by patient racial and ethnic background in tables 4 and 5. Tables 2 and 3 show that, for each patient group, A-graded and B-graded hospital cohorts had lower rates of adverse safety events. This is particularly true when comparing A-graded hospitals with C/D/F-graded hospitals, with a small number of exceptions. White patients, Black patients, and Hispanic patients experience, on average, lower rates of pressure ulcers, in-hospital falls with hip fracture, postoperative respiratory failure, and postoperative sepsis infections if they can access A-graded hospitals rather than C/D/F-graded hospitals.

Table 2. Adjusted Rates of General Patient Safety Events by Patient Race and Ethnicity and by Leapfrog Hospital Safety Grade

	All Hospitals	A Hospitals	B Hospitals	C/D/F Hospitals
Pressure ulcer				
White	0.602	0.528	0.476	0.793*
Non-Hispanic Black	0.775	0.669	0.653	1.003*
Hispanic	0.623	0.486	0.646*	0.690*
Iatrogenic pneumothorax				
White	0.192	0.186	0.198	0.197
Non-Hispanic Black	0.164	0.152	0.172	0.170
Hispanic	0.151	0.140	0.148*	0.167*
Central venous catheter–related bloodstream infection				
White	0.100	0.080	0.100	0.131
Non-Hispanic Black	0.118	0.088	0.132	0.152
Hispanic	0.075	0.056	0.052*	0.112*
In-hospital fall with hip fracture				
White	0.080	0.079	0.078	0.085*
Non-Hispanic Black	0.043	0.033	0.034	0.063*
Hispanic	0.054	0.043	0.055*	0.063*

Source: Agency for Healthcare Research and Quality, State Inpatient Databases for Arkansas, Arizona, California, Florida, Kentucky, Massachusetts, Maryland, Mississippi, North Carolina, New Jersey, Nevada, Oregon, Utah, Washington, and Wisconsin, 2019, <https://hcup-us.ahrq.gov/db/state/siddbdocumentation.jsp>.

Notes: Estimates indicate rates per 1,000 at-risk discharges. Rates are adjusted for a quadratic function of age and indicators for sex, state of residence, quartile of household income based on the zip code of residence, and indicators for payer type (private coverage, Medicare, Medicaid, other insurance, or uninsured).

* indicates estimate is significantly different from the rate at A hospitals.

Table 3. Adjusted Rates of Surgery-Related Patient Safety Events by Patient Race and Ethnicity and by Leapfrog Hospital Safety Grade

	All Hospitals	A Hospitals	B Hospitals	C/D/F Hospitals
Perioperative hemorrhage				
White	2.169	2.012	2.029	2.512*
Non-Hispanic Black	2.763	2.799	2.643	2.823
Hispanic	2.254	2.409	2.165	2.226
Postoperative acute kidney injury requiring dialysis				
White	1.011	0.934	1.027	1.137
Non-Hispanic Black	1.215	1.092	1.068	1.493
Hispanic	1.172	1.125	1.017	1.317
Postoperative respiratory failure				
White	6.434	5.511	7.063*	7.640*
Non-Hispanic Black	7.549	6.751	7.490	8.743*
Hispanic	7.810	5.959	9.453	9.169*
Perioperative pulmonary embolism or deep vein thrombosis				
White	3.131	2.873	3.216	3.480*
Non-Hispanic Black	4.730	4.216	4.735	5.387*
Hispanic	2.979	2.911	2.800	3.159
Postoperative sepsis				
White	3.628	3.126	3.795	4.417*
Non-Hispanic Black	4.851	4.461	4.333	5.686*
Hispanic	4.869	4.397	5.958	4.875
Postoperative wound dehiscence				
White	1.873	1.679	1.961	2.115
Non-Hispanic Black	1.854	1.780	1.960	1.922
Hispanic	1.266	0.995	1.303	1.611
Abdominopelvic accidental puncture or laceration				
White	1.029	1.005	1.050	1.055
Non-Hispanic Black	1.081	0.931	1.110	1.263
Hispanic	0.927	0.816	0.812	1.115

Source: Agency for Healthcare Research and Quality, State Inpatient Databases for Arkansas, Arizona, California, Florida, Kentucky, Massachusetts, Maryland, Mississippi, North Carolina, New Jersey, Nevada, Oregon, Utah, Washington, and Wisconsin, 2019, <https://hcup-us.ahrq.gov/db/state/siddbdocumentation.jsp>.

Notes: Estimates indicate rates per 1,000 at-risk discharges. Rates are adjusted for a quadratic function of age and indicators for sex, state of residence, quartile of household income based on the zip code of residence, and indicators for payer type (private coverage, Medicare, Medicaid, other insurance, or uninsured).

* indicates estimate is significantly different from the rate at A hospitals.

Adjusted Differences in Rates of Adverse Safety Events by Patient Race and Ethnicity

Tables 4 and 5 present adjusted Black-white and Hispanic-white differences in rates of adverse safety events by Hospital Safety Grade cohorts. Differences are based on the same models used in tables 2 and 3, however, we now estimate Black-white and Hispanic-white differences in adverse safety events and assess whether these differences are significant within each Hospital Safety Grade cohort. Estimates report the adjusted difference in adverse safety events between patients historically disadvantaged in the health care system (i.e., non-Hispanic Black or Hispanic patients) relative to white patients. Positive differences indicate a higher (worse) adverse patient safety event rate for Black or Hispanic patients relative to white patients.

For general PSIs, Black-white and Hispanic-white differences in adverse safety event rates are typically small and not systematic in direction (table 4). Black patients have statistically significant higher rates of adverse safety events on one of the four measures (pressure ulcers), statistically similar rates on one of the four measures, and significantly *lower* rates on two of the four measures (iatrogenic pneumothorax and in-hospital falls with hip fracture) relative to white patients. Hispanic patients have statistically similar rates of adverse safety events on one of the four measures (pressure ulcers) and significantly lower rates on the remaining three of four measures relative to white patients. Our findings suggest that, in 2019, across the 15 states studied here, there is not strong evidence for persistent, large Black-white and Hispanic-white disparities in quality of care among these four measures of patient safety.

However, for pressure ulcers, the only measure that Black patients experience at significantly higher rates relative to white patients, the Black-white difference is large. Across all hospitals, the rate of pressure ulcers is higher by 0.173 per 1,000 at-risk discharges for Black patients relative to white patients (i.e., 28 percent higher than the overall average reported in table 1). When assessing differences by Hospital Safety Grade, we observe that the difference remains large and significant in A-graded hospitals, B-graded hospitals, and C/D/F-graded hospitals. That is, we observe no pattern between a hospital's overall Safety Grade and the magnitude of the Black-white disparity in this measure.

Table 4. Adjusted Differences in General Patient Safety Events by Patient Race and Ethnicity and by Leapfrog Hospital Safety Grade

Reference group: Non-Hispanic White Patients	All Hospitals	A Hospitals	B Hospitals	C/D/F Hospitals
Pressure ulcer				
Non-Hispanic Black	+0.173*	+0.141*	+0.177*	+0.210*
Hispanic	+0.021	-0.042	+0.170*	-0.103
Iatrogenic pneumothorax				
Non-Hispanic Black	-0.028*	-0.034	-0.026	-0.027
Hispanic	-0.041*	-0.046*	-0.050	-0.030
Central venous catheter–related bloodstream infection				
Non-Hispanic Black	+0.018	+0.008	+0.032	+0.021
Hispanic	-0.025*	-0.024	-0.048*	-0.019
In-hospital fall with hip fracture				
Non-Hispanic Black	-0.037*	-0.046*	-0.044*	-0.022
Hispanic	-0.026*	-0.036*	-0.023	-0.022

Source: Agency for Healthcare Research and Quality, State Inpatient Databases for Arkansas, Arizona, California, Florida, Kentucky, Massachusetts, Maryland, Mississippi, North Carolina, New Jersey, Nevada, Oregon, Utah, Washington, and Wisconsin, 2019, <https://hcup-us.ahrq.gov/db/state/siddbdocumentation.jsp>.

Notes: Estimates indicate rates per 1,000 at-risk discharges. A positive estimate (+) indicates a higher rate when compared with Non-Hispanic white patients. Standard errors are robust clustered at the hospital level. Differences are adjusted for a quadratic function of age and indicators for sex, state of residence, quartile of household income based on the zip code of residence, and payer type (private coverage, Medicare, Medicaid, other insurance, or uninsured).

* indicates estimate is significantly different from the rate among white patients in the same Hospital Safety Grade cohort.

Among the seven surgery-related PSIs, Black patients had significantly higher rates of adverse safety events on four measures and statistically similar rates on three measures relative to non-Hispanic white patients (table 5). For measures that had higher incident rates for Black patients relative to white patients, the size of these differences is clinically large. For example, Black patients experience rates of postoperative respiratory failure that are 1.1 per 1,000 at-risk discharges higher (i.e., 17 percent higher relative to overall averages). Perioperative pulmonary embolism and postoperative sepsis infections occur 1.6 and 1.2 per 1,000 at-risk discharges more frequently for Black patients relative to white patients (i.e., 51 percent and 34 percent higher, respectively).

For each of the four measures for which Black patients have significantly higher rates of adverse safety events relative to white patients, these disparities persist and remain significant in A-graded hospitals. That is, in gaining access to a hospital with a higher Safety Grade, a Black patient has no assurance that the quality of care received relative to a white patient will be any better than lower-rated hospitals. In fact, Black-white differences in postoperative respiratory failure and postoperative sepsis infections are narrowest among B-graded hospitals. Rates of perioperative hemorrhage are higher for Black patients relative to white patients in A- and B-graded hospitals but not C/D/F-graded hospitals. Black-white disparities in perioperative pulmonary embolism are large and significant across all Hospital Safety Grade cohorts.

Overall, Hispanic patients had significantly higher rates of adverse safety events on two of the seven surgery-related measures, statistically similar rates of adverse safety events on four of the seven measures, and significantly lower rates of adverse safety events on one of the seven measures. Hispanic patients experience postoperative respiratory failure at a rate that is 1.4 per 1,000 at-risk discharges higher than white patients.

However, among A-graded hospitals, this difference is much smaller and statistically indistinguishable from 0. The Hispanic-white differences for this measure are larger and statistically significant in B-graded and C/D/F-graded hospitals. This provides some limited evidence that perhaps the quality of care delivered to Hispanic patients may be similar to that for white patients in hospitals with better overall Hospital Safety Grades. However, Hispanic patients are also observed to experience significantly higher rates of postoperative sepsis infections relative to non-Hispanic white patients. These large and significant differences are concentrated among A-graded and B-graded hospitals and are statistically insignificant and small in C/D/F-graded hospitals. Altogether, the evidence in table 5 suggests no clear pattern between hospital overall Hospital Safety Grades and the underlying size of Black-white and Hispanic-white disparities in patient safety.

Table 5. Adjusted Differences in Surgery-Related Patient Safety Events by Patient Race and Ethnicity and by Leapfrog Hospital Safety Grade

Reference group: Non-Hispanic White Patients	All Hospitals	A Hospitals	B Hospitals	C/D/F Hospitals
Perioperative hemorrhage				
Non-Hispanic Black	+0.594*	+0.787*	+0.614*	+0.311
Hispanic	+0.085	+0.397*	+0.136	-0.286
Postoperative acute kidney injury requiring dialysis				
Non-Hispanic Black	+0.204	+0.158	+0.041	+0.356
Hispanic	+0.161	+0.191	-0.010	+0.18
Postoperative respiratory failure				
Non-Hispanic Black	+1.115*	+1.240*	+0.427	+1.103*
Hispanic	+1.376*	+0.448	+2.390*	+1.529*
Perioperative pulmonary embolism or deep vein thrombosis				
Non-Hispanic Black	+1.599*	+1.343*	+1.519*	+1.907*
Hispanic	-0.152	+0.038	-0.416	-0.321
Postoperative sepsis				
Non-Hispanic Black	+1.223*	+1.335*	+0.538	+1.269*
Hispanic	+1.241*	+1.271*	+2.163*	+0.458
Postoperative wound dehiscence				
Non-Hispanic Black	-0.019	+0.101	-0.001	-0.193
Hispanic	-0.607*	-0.684*	-0.658*	-0.504*
Abdominopelvic accidental puncture or laceration				
Non-Hispanic Black	+0.052	-0.074	+0.060	+0.208
Hispanic	-0.102	-0.189	-0.238*	+0.060

Source: Agency for Healthcare Research and Quality, State Inpatient Databases for Arkansas, Arizona, California, Florida, Kentucky, Massachusetts, Maryland, Mississippi, North Carolina, New Jersey, Nevada, Oregon, Utah, Washington, and Wisconsin, 2019, <https://hcup-us.ahrq.gov/db/state/siddbdocumentation.jsp>.

Notes: Estimates indicate rates per 1,000 at-risk discharges. A positive estimate (+) indicates a higher rate when compared with Non-Hispanic white patients. Standard errors are robust clustered at the hospital level. Differences are adjusted for a quadratic function of age and indicators for sex, state of residence, quartile of household income based on the zip code of residence, and payer type (private coverage, Medicare, Medicaid, other insurance, or uninsured).

* indicates estimate is significantly different from the rate among white patients in the same hospital Safety Grade cohort.

Adjusted Differences in Rates of Adverse Safety Events by Payer Type

Tables 6 and 7 present regression-adjusted estimates of differences in rates of adverse safety events between Medicare- and privately insured patients and Medicaid- and privately insured patients (adjusted averages for each outcome by payer type and by Leapfrog Hospital Safety Grade are reported in tables A.1 and A.2). We chose privately insured patients as the advantaged reference group. Positive estimates indicate higher (worse) estimates for either Medicare- or Medicaid-insured patients relative to privately insured patients.

Table 6. Adjusted Differences in General Patient Safety Events by Payer Type and by Leapfrog Hospital Safety Grade

Reference group: Privately insured patients	All Hospitals	A Hospitals	B Hospitals	C/D/F Hospitals
Pressure ulcer				
Medicare	+0.102*	+0.069	+0.074	+0.101
Medicaid	+0.164*	+0.131*	+0.098	+0.190*
Iatrogenic pneumothorax				
Medicare	+0.007	+0.038*	+0.020	-0.051
Medicaid	-0.014	-0.007	+0.001	-0.048
Central venous catheter–related bloodstream infection				
Medicare	+0.048*	+0.053*	+0.061*	+0.033
Medicaid	+0.053*	+0.035*	+0.046	+0.070*
In-hospital fall with hip fracture				
Medicare	+0.020*	+0.025*	+0.023	+0.010
Medicaid	+0.026*	+0.015	+0.033*	+0.030*

Source: Agency for Healthcare Research and Quality, State Inpatient Databases for Arkansas, Arizona, California, Florida, Kentucky, Massachusetts, Maryland, Mississippi, North Carolina, New Jersey, Nevada, Oregon, Utah, Washington, and Wisconsin, 2019, <https://hcup-us.ahrq.gov/db/state/siddbdocumentation.jsp>.

Notes: Estimates indicate rates per 1,000 at-risk discharges. A positive estimate (+) indicates a higher rate when compared to privately insured patients. Differences are adjusted for a quadratic function of age and indicators for sex, state of residence, quartile of household income based on the zip code of residence, and patient racial-ethnic background (white, Black, Hispanic, non-Hispanic and of other racial background or multiracial).

* indicates estimate is significantly different from the rate among privately insured patients.

Across all hospitals, both Medicare- and Medicaid-insured patients have higher rates of surgery-related adverse safety events relative to privately insured patients (table 7). Most of these differences are large and significant. Public-private pay differences in adverse safety event rates are highest for postoperative sepsis and postoperative respiratory failure. For instance, for all hospitals, the postoperative respiratory failure rate is 1.9 and 2.2 per 1,000 at-risk discharges higher for Medicare- and Medicaid-insured patients, respectively, relative to privately insured patients.

Table 7 indicates that disparities in adverse safety events between public and privately insured patients are prevalent in all Hospital Safety Grade cohorts. We discern little systematic pattern throughout this analysis. Differences in postoperative respiratory failure rates between Medicare-insured patients and privately insured patients clearly increase as Hospital Safety Grade falls (but remain large and significant across all grades), but we fail to see a similar pattern with all other measures. Similarly, we see little to no pattern in differences between rates of adverse safety events in the Medicaid-insured and privately insured patient cohorts by Hospital Safety Grade cohort. Broadly, we find that disparities between privately and publicly insured patient cohorts are large, significant, and fairly common across all hospitals irrespective of their Hospital Safety Grade.

Table 7. Adjusted Differences in Adverse Safety Rates of Surgery-Related Patient Safety Events by Payer Type and by Leapfrog Hospital Safety Grade

Reference group: Privately insured patients	All Hospitals	A Hospitals	B Hospitals	C/D/F Hospitals
Perioperative hemorrhage				
Medicare	+0.401*	+0.264*	+0.677*	+0.419*
Medicaid	+0.109	+0.083	-0.159	+0.271
Postoperative acute kidney injury requiring dialysis				
Medicare	+0.348*	+0.327*	+0.215	+0.465*
Medicaid	+0.266*	+0.353	+0.348	+0.161
Postoperative respiratory failure				
Medicare	+1.861*	+1.119*	+1.422*	+3.223*
Medicaid	+2.183*	+2.029*	+2.438*	+2.068*
Perioperative pulmonary embolism or deep vein thrombosis				
Medicare	+0.313*	+0.396*	-0.048	+0.418*
Medicaid	+1.192*	+1.221*	+0.973*	+1.275*
Postoperative sepsis				
Medicare	+1.468*	+1.085*	+2.014*	+1.708*
Medicaid	+1.616*	+1.422*	+1.148*	+2.112*
Postoperative wound dehiscence				
Medicare	+1.110*	+1.125*	+0.827*	+1.247*
Medicaid	+0.793*	+0.519*	+1.062*	+0.856*
Abdominopelvic accidental puncture or laceration				
Medicare	+0.149*	+0.137	+0.192	+0.156
Medicaid	+0.007	+0.058	-0.164	+0.073

Source: Agency for Healthcare Research and Quality, State Inpatient Databases for Arkansas, Arizona, California, Florida, Kentucky, Massachusetts, Maryland, Mississippi, North Carolina, New Jersey, Nevada, Oregon, Utah, Washington, and Wisconsin, 2019, <https://hcup-us.ahrq.gov/db/state/siddbdocumentation.jsp>.

Notes: Estimates indicate rates per 1,000 at-risk discharges. A positive estimate (+) indicates a higher rate when compared with privately insured patients. Standard errors are robust clustered at the hospital-level. Differences are adjusted for a quadratic function of age and indicators for sex, state of residence, quartile of household income based on the zip code of residence, and patient racial-ethnic background (white, Black, Hispanic, non-Hispanic and of other racial background or multiracial).

* indicates estimate is significantly different from the rate among privately insured patients.

DISCUSSION

In this study, we examined average rates of 11 adverse safety events by patient racial and ethnic background and by payer type across 15 states in 2019. We estimated these rates across all hospitals and separately by their Spring 2022 Leapfrog Hospital Safety Grade. We found that for most PSIs, Black patients, Hispanic patients, and white patients accessing hospitals with higher Hospital Safety Grades experience, on average, lower rates of adverse safety events—emphasizing Hospital Safety Grades’ usefulness in directing patients to safer care.

Across all hospitals, we found little evidence of systematic racial-ethnic disparities in rates of adverse safety events among the four general PSIs. However, among the sole measure that indicated substantially higher rates of adverse safety events for Black patients relative to white patients (pressure ulcers), we found that

Black-white differences were large and significant in all three Safety Grade hospital cohorts (A-graded hospitals, B-graded hospitals, and C/D/F-graded hospitals).

When examining the seven surgery-related PSIs, we found evidence that Black patients experience systematically higher rates of adverse safety events relative to white patients, consistent with previous research (AHRQ 2021; Gangopadhyaya 2021a, 2021b). Somewhat surprisingly, we observed little pattern between a hospital's Safety Grade and the size of the estimated Black-white disparity across these measures. Hispanic patients had higher rates of adverse safety events on two measures of the seven surgery-related PSIs, and we discerned no relationship between a hospital's Safety Grade and difference in these rates between Hispanic and white patients.

In our analysis assessing differences in rates of adverse safety events by patient insurance coverage type, we found consistently higher incident rates of adverse safety events among patients with public insurance (Medicare or Medicaid) relative to privately insured patients. Among surgery-related PSIs, most of these differences remained large and significant within each Safety Grade cohort (A-graded hospitals, B-graded hospitals, and C/D/F-graded hospitals), which suggests that Hospital Safety Grades are unrelated to payer-based disparities in patient safety.

Our analysis suggests that hospitals deliver safer care to white patients and patients with private insurance coverage. As we note in table 1, A-graded hospitals have the lowest average rates of adverse safety events. However, Black or Hispanic patients, or patients without private insurance, are still more likely to be harmed during their hospital stay compared with white patients or privately insured patients, irrespective of the hospital's Safety Grade. Leapfrog Hospital Safety Grades, therefore, cannot be used to convey information on the underlying disparity in safe inpatient care.

From a policy perspective, our findings indicate that Black and Hispanic patients and, separately, patients with public insurance would benefit from better tools to help them assess the additional risk that may accompany a hospital stay.⁷ While publicly available hospital quality information is a good indication of the average quality of care a hospital delivers, this study illustrates that some patients systematically receive less safe care. Providing Hospital Safety Grades by patient racial and ethnic subgroups provides a clear solution, but we note that this may not be feasible for small patient subgroups with too few discharge observations from which to construct a reliable measure score. Nonetheless, a public-facing Hospital Safety Grade by patient racial and ethnic group may incentivize hospitals to narrow existing disparities.

⁷ One of the potential mechanisms through which Black-white and Hispanic-white differences in patient safety occur could be related to differences in insurance coverage types among white patients relative to Black and Hispanic patients. Similarly, one of the mechanisms through which payer-based differences in patient safety may occur is through discriminatory care delivered to Black and Hispanic patients relative to white patients. However, in our adjusted regressions examining racial-ethnic differences, we control for patient insurance type. And in our regressions examining payer-type differences, we control for a patient's racial-ethnic background. Thus, our evidence suggests that policies moving patients toward private insurance coverage are unlikely to close racial-ethnic differences in patient safety or differences by payer type.


Attempts to use federal policy to improve patient safety have had mixed results. In an attempt to improve overall patient safety in hospitals, CMS implemented the HAC Reduction Program, which penalizes hospitals with the worst total HAC scores.⁸ The penalties require CMS to withhold Medicare reimbursements by 1 percent. Although the HAC Reduction Program aims to improve overall hospital patient safety, this study finds that clear racial-ethnic and payer-based disparities in major hospital-acquired illnesses and injuries persist well after the program went into effect in 2015—even in hospitals that may not have been penalized by the program (i.e., because they had low overall rates of adverse safety events). Findings from this study suggest that if the goal of policymakers is to narrow racial-ethnic and payer-based inequities in the quality of hospital care, policies cannot solely target the overall average score of hospitals; policy must also incorporate the differences in the quality of care hospitals deliver across their patient populations.

This study has several limitations that represent important areas for future research. First, our analysis is limited to states that (1) shared inpatient databases for release through the AHRQ distributor at the time of data collection and (2) permit linkage to the AHAD hospital identifiers that enabled us to merge on Leapfrog’s Hospital Safety Grades. While this study encompasses millions of discharges from 15 states and includes several exceptionally populous states such as California and Florida, it does not represent hospitalizations for most states in the US. For that reason, our estimates may not generalize to the full population, although we note that most of our overall estimated disparities benchmark compared well with the 2021 AHRQ disparities report, which uses data from across all states.

Finally, in this report we classify patient racial and ethnic background based on information directly reported in the hospital discharge records, however the source and quality of this information can be inconsistent and inaccurate (Hasnain-Wynia and Baker 2006). Comparisons between discharge reported patient racial and ethnic background and self-reported Census data indicate high match rates between 86-90 percent (Zingmond et al. 2015). Nonetheless, we acknowledge the potential for misclassification of patient racial and ethnic background in our analysis – a study that more strongly relies self-reported racial and ethnic background would present a major advance in this evidence base.

Moreover, although PSIs are measures that are clinically validated and intended to represent objective measures of patient safety, it still may be possible that certain patient groups may be more likely to experience an adverse safety event than others in ways that are uncontrolled for in our adjusted regressions. For example, patients insured by Medicare are often older than privately insured patients, and this may put them at higher risk for acquiring an in-hospital infection relative to other patients—while we directly adjust for age in this

⁸ HAC scores are determined in part by a composite measure of patient safety that, in turn, is based on the 11 PSIs used in this analysis. For more information on the HAC Reduction Program and the measures used in calculating the total HAC score, see “Hospital-Acquired Condition Reduction Program,” CMS, <https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Value-Based-Programs/HAC/Hospital-Acquired-Conditions>.



analysis, related, unobserved, factors could also affect infection rates. Similarly, hospitalized patients insured by Medicaid may be more likely to have complex needs that could increase the number of procedures received and possibly the length of stay, both of which could place them at higher risk of exposure to adverse safety events. However, we note that equitable care is not the same as equal care, and that hospitals systems could be expected to recognize which patient groups are at highest risk for adverse safety events and allocate resources accordingly. Our analysis indicates that this has not been most hospitals' approach.

APPENDIX A. ADJUSTED AVERAGE RATES FOR PATIENT SAFETY OUTCOMES

Table A.1. Adjusted Rates of General Patient Safety Events by Payer Type and by Leapfrog Hospital Safety Grade

	All Hospitals	A Hospitals	B Hospitals	C/D/F Hospitals
Pressure Ulcer				
Private Insurance	0.525	0.443	0.470	0.692*
Medicare	0.652	0.521	0.551	0.882*
Medicaid	0.645	0.589	0.530	0.745
Iatrogenic pneumothorax				
Private Insurance	0.143	0.125	0.119	0.189*
Medicare	0.214	0.218	0.220	0.205
Medicaid	0.107	0.091	0.100	0.123
Central venous catheter-related bloodstream infection				
Private Insurance	0.079	0.068	0.075	0.100
Medicare	0.101	0.080	0.106	0.124*
Medicaid	0.130	0.104	0.114	0.158*
In-hospital fall with hip fracture				
Private Insurance	0.032	0.031	0.030	0.035
Medicare	0.090	0.087	0.085	0.096
Medicaid	0.037	0.028	0.041	0.041

Source: Agency for Healthcare Research and Quality, State Inpatient Databases for Arkansas, Arizona, California, Florida, Kentucky, Massachusetts, Maryland, Mississippi, North Carolina, New Jersey, Nevada, Oregon, Utah, Washington, and Wisconsin, 2019, <https://hcup-us.ahrq.gov/db/state/siddbdocumentation.jsp>.

Notes: Estimates indicate rates per 1,000 at-risk discharges. Rates are adjusted for a quadratic function of age and indicators for sex, state of residence, quartile of household income based on the zip code of residence, and indicators for patient racial and ethnic background.

* indicates estimate is significantly different from the rate at A hospitals.

Table A.2. Adjusted Rates of Surgery-Related Patient Safety Events by Payer Type and by Leapfrog Hospital Safety Grade

	All Hospitals	A Hospitals	B Hospitals	C/D/F Hospitals
Perioperative hemorrhage				
Private insurance	2.218	2.199	1.991	2.401
Medicare	2.313	2.167	2.281	2.544
Medicaid	2.378	2.369	1.985	2.564
Postoperative acute kidney injury requiring dialysis				
Private insurance	0.606	0.549	0.606	0.713
Medicare	1.381	1.309	1.298	1.562
Medicaid	0.804	0.867	0.869	0.723
Postoperative respiratory failure				
Private insurance	4.348	3.879	5.089*	4.702*
Medicare	8.355	7.121	8.796*	10.114*
Medicaid	6.403	5.656	7.151	6.701*
Perioperative pulmonary embolism or deep vein thrombosis				
Private insurance	2.638	2.46	2.813	2.812*
Medicare	3.513	3.233	3.5	3.925*
Medicaid	3.676	3.578	3.654	3.764
Postoperative sepsis				
Private insurance	2.627	2.441	2.669	2.945*
Medicare	4.923	4.289	5.115	5.863*
Medicaid	4.552	4.239	4.113	5.002
Postoperative wound dehiscence				
Private insurance	1.021	0.857	1.29*	1.107*
Medicare	2.241	2.117	2.081	2.527
Medicaid	1.632	1.243	2.107	1.713
Abdominopelvic accidental puncture or laceration				
Private insurance	0.952	0.946	0.988	0.938
Medicare	1.093	1.017	1.118	1.187
Medicaid	0.912	0.965	0.769	0.939

Source: Agency for Healthcare Research and Quality, State Inpatient Databases for Arkansas, Arizona, California, Florida, Kentucky, Massachusetts, Maryland, Mississippi, North Carolina, New Jersey, Nevada, Oregon, Utah, Washington, and Wisconsin, 2019, <https://hcup-us.ahrq.gov/db/state/siddbdocumentation.jsp>.

Notes: Estimates indicate rates per 1,000 at-risk discharges. Rates are adjusted for a quadratic function of age and indicators for sex, state of residence, quartile of household income based on the zip code of residence, and indicators for patient racial and ethnic background.

* indicates estimate is significantly different from the rate at A hospitals.

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