Never Events: Practical Ideas to Consider Now to Improve Quality and Reduce Risk

Presenters:

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The Quality Revolution

3

- Since the 1999 Institute of Medicine report, *To Err is Human*, there has been an increased national focus on quality
- Quality of care is the top priority for health care entities in 2009

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Incentivizing Quality of Care Through Payment Reform

4

- The new paradigm for reimbursement
- CMS is transforming payment policy from passive payor of services to active purchaser of high value health care
- Private payors also are changing payment policies to pay for quality

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Incentivizing Quality of Care Through Payment Reform (cont'd)

5

- ***"I strongly support linking provider payment to quality care as a way to make Medicare a better purchaser of health care services. Today, Medicare rewards poor quality care. That is just plain wrong and we need to address this problem."***

  Sen. Chuck Grassley
  Budget Hearing with Michael Leavitt
  February 7, 2007

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Incentivizing Quality of Care Through Payment Reform (cont'd)

6

Pay for Performance

- Financial incentives for:
  - Adhering to recommended tasks or processes
  - Adopting desired tools or infrastructure
  - Meeting or improving measured outcomes
- Sometimes includes cost savings or efficiency targets (aka "gainsharing")

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Incentivizing Quality of Care Through Payment Reform (cont'd)

7

No Payment for Poor Quality

- Effective October 1, 2007, hospitals must report all secondary diagnoses present on admission (POA)
- Effective October 1, 2008, hospitals will not be paid for 12 "hospital acquired conditions" (HACs) unless present on admission:
  - Foreign object retained after surgery;
  - Air embolism;
  - Blood incompatibility;
  - Pressure ulcers (stage III and IV);
  - Falls and trauma;
  - Catheter associated UTI;
  - Vascular catheter associated infection;
  - Surgical site infection following CABG;

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Incentivizing Quality of Care Through Payment Reform (cont'd)

8

No Payment for Poor Quality

- Effective October 1, 2008, hospitals will not be paid for 12 HACs unless present on admission (cont'd.)
  - Manifestations of poor glycemic control
  - Surgical site infection following certain orthopedic procedures
  - Surgical site infection following bariatric surgery for obesity
  - Deep vein thrombosis and pulmonary embolism following certain orthopedic procedures
    - The last four HACs were added in the Aug. 19, 2008 Final IPPS Rule (73 Fed. Reg. 48434)

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Driving Quality of Care Through Public Reporting

9

Reporting Hospital Quality Data for Annual Payment Update (RHQDAPU) program

- Effective October 1, 2008, hospitals are required to report 30 inpatient measures in the following sets:
  - Heart attack (MI) – 8 measures
  - Heart failure (HF) – 4 measures
  - Pneumonia (PN) – 7 measures
  - Surgical Care Improvement Project (SCIP) – 7 measures
  - Mortality – 3 measures
  - Experience of Care (HCAHPs survey) ***Published March 28, 2008!***
- Hospitals that do not participate will receive a 2% reduction in their Medicare Annual Payment Update for 2009

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National Quality Forum

10

- National Quality Forum lists 29 "serious reportable events" – errors in medical care that are
  - Clearly identifiable
  - Preventable
  - Serious in their consequences for patients

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National Quality Forum (cont'd)

11

- Current NQF Serious Reportable Adverse Events:
  - Surgical Events
    - Surgery on wrong body part
    - Surgery on wrong patient
    - Wrong surgery on a patient
    - Foreign object left in patient after surgery
    - Post-operative death in normal healthy patient
    - Implantation of wrong egg
  - Product or Device Events
    - Death/disability associated with use of contaminated drugs, devices or biologics
    - Death/disability associated with use of device other than as intended
    - Death/disability associated with intravascular air embolism

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National Quality Forum (cont'd)

12

- Current NQF Serious Reportable Adverse Events (cont'd):
  - Patient Protection Events
    - Infant discharged to wrong person
    - Death/disability due to patient elopement
    - Patient suicide or attempted suicide resulting in disability
  - Care Management Events
    - Death/disability associated with medication error
    - Death/disability associated with incompatible blood
    - Maternal death/disability with low risk delivery
    - Death/disability associated with hypoglycemia
    - Death/disability associated with hyperbilirubinemia in neonates
    - Stage 3 or 4 pressure ulcers after admission
    - Death/disability due to spinal manipulative therapy

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National Quality Forum (cont'd)

13

- Current NQF Serious Reportable Adverse Events (cont'd):
  - Environmental Events
    - Death/disability associated with electric shock
    - Incident due to wrong oxygen or other gas
    - Death/disability associated with a burn incurred within facility
    - Death/disability associated with a fall within facility
    - Death/disability associated with use of restraints within facility
  - Criminal Events
    - Impersonating a heath care provider (*i.e.*, physician, nurse)
    - Abduction of a patient
    - Sexual assault of a patient within or on facility grounds
    - Death/disability resulting from physical assault within or on facility grounds

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CMS National Coverage Determinations

14

- On January 15, 2009, CMS issued 3 National Coverage Determinations (NCDs) establishing a uniform policy of Medicare not paying for certain never events:
  - Wrong surgical or other invasive procedures performed on a patient
  - Surgical or other invasive procedures performed on the wrong body part
  - Surgical or other invasive procedures performed on the wrong patient

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CMS National Coverage Determinations (cont'd)

15

- Wrong surgeries performed on a patient are those inconsistent with documented informed consent for the patient
  - Does not include emergent situations in the course of surgery
  - Does not include changes in the plan upon surgical entry
  - Payment denied because the wrong surgeries are not "reasonable and necessary treatment for the Medicare beneficiaries particular medical condition"

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CMS National Coverage Determinations (cont'd)

16

- Wrong surgeries on the wrong body part are those inconsistent with documented informed consent for that patient including surgery on the right body part, but on the wrong location of the body
  - Does not include emergent situation in the course of surgery
  - Does not include changes in the plan upon surgical entry
  - Payment denied because the wrong surgeries are not "reasonable and necessary treatment for the Medicare beneficiaries medical condition"

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CMS National Coverage Determinations (cont'd)

17

- Surgical or other invasive procedures performed on the wrong patient
  - Wrong surgery performed on the wrong patient is that procedure is not consistent with the correctly documented informed consent for that patient
  - Payment denied because the wrong surgeries are not "reasonable and necessary treatment for the Medicare beneficiaries"

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Never Event Awareness

18

- 2002 – List endorsed by NQF
- 2003 – First state, Minnesota, requires public reporting
- 2005 – Deficit Reduction Act, enacts reporting requirements and payment implications
- 2008 & 2009 – Most insurers, commercial and federally funded have adopted reduced or "no payment" policies surrounding "never events"

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19

Possible Implications of Never Events

1. Patient Safety – low quality care
2. Reduced payment or 0 payment for services rendered
3. Litigation – civil or criminal prosecution
4. Damage to reputation
5. False Claims Act Implications

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False Claims Act

- The False Claim Act (31 U.S.C. § 3729) imposes liability for persons who
  - Present or cause to be presented
  - A false or fraudulent claim for payment to the U.S. government
  - With knowledge the claim is false
    - Deliberate ignorance or reckless disregard will satisfy the knowledge element.
- Violations may lead to triple damages

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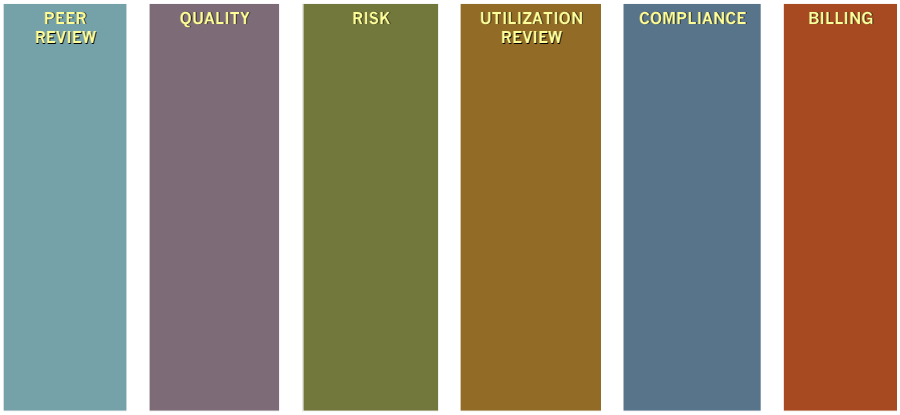
Problems Under Current Structures

21

SILO Approach



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Process Improvements

22

Proactive steps to prevent ‘‘never event’’ exposure:

- Designate “never events” response team; include physician leadership, compliance officer, nursing leadership, operations management, quality and risk management, legal, HIM and Finance (allow for ad hoc involvement)
- Revisit sentinel events policies; assure **all** “never events” are included
- Assure policy addresses record security and confidentiality and places a hold or flag on the patient’s account

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Process Improvements (cont'd)

23

- Post policies and response team contacts on nursing units/OR areas, etc.
- Increase awareness of "never events," POA, HACs among all staff – include as part of new hire orientation – focus on patient safety and prevention
- Assure all associates are aware of reporting "never events," as soon as possible, to enact "never event" response team
- Assure appropriate forms or occurrence reports are updated and available for use pursuant to policies and procedures

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Process Improvements (cont'd)

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If event occurs:

- Establish time frames for investigation and report completion
- Perform a root cause analysis
- Assure event is documented in the medical record
- Have a discussion with the patient
- Develop action plan to avoid recurrence

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Financial Policies

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- Bill holds are critical
- Quality and risk management, compliance officer and legal determine accounts to write-off; use a case-by-case approach
- Write-off transaction codes for HACs and "never events" should be unique in order to track the amounts individually and as a combination
- Demonstrates impact quality has on bottom line

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POA Link to Never Events

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- CMS requires present on admission (POA) indicators to identify Hospital Acquired Conditions (HACs)
- POA indicators appended to diagnosis codes submitted on claims
- Utilizing claims data to identify "never events" occurring to Medicare patients

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POA Link to Never Events (cont'd)

27

- POA indicators signify if a diagnosis or condition was present upon the patients admission to the hospital
- Medicare will not pay for conditions reported with N or U, if it is the only CC or MCC on the claim

Y = Present at time of inpatient admission

N* = Not present at time of inpatient admission

U* = Unable to determine based upon documentation

W = Condition is clinically undetermined

1 = Unreported/Exempt from POA

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POA Reporting and Monitoring

28

- Develop a report that tracks all indicators from claims – include all payors
- Audit and monitor those with "N" and those with "U"
- Develop documentation improvement strategies for "U"
- Compare cases with "N" status indicators an "Y" indicators to identify best practices in prevention

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POA Reporting (cont'd)

- Tracking payment implications
- Separate report for the ICD-9-CM codes on CMS HAC list
- CMS only reduces payment if event is the only CC or MCC reported and POA is "N" or "U"
- Utilize POA data from 2007 as benchmark for improvement

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OIG Reports on Adverse Events

- OIG recently conducted studies on "adverse events in hospitals" and issued 3 reports to Congress
  - An overview of key issues related to measuring, preventing, and responding to adverse events
  - The variety of state sponsored programs that require reporting of adverse events
  - A study of the incidence of adverse events among Medicare beneficiaries in 2 undisclosed counties
- Reports required by the Tax Relief and Health Care Act of 2006
  - Studies and reports will continue through 2009

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OIG Reports on Adverse Events (cont'd)

- The Key Issues Report
  - Identifies 7 issues regarding adverse events deemed "most critical"
  - Concludes with 6 strategies for reducing the incidence of adverse events:
    - Create national body to lead patient safety efforts
    - Focus on structures to encourage hospital use of evidenced based practices
    - Establish consistent method to measure incidence of adverse events
    - Expand use of electronic health records
    - Monitor effect of policies to deny payment for adverse events
    - Improve and streamline adverse event reporting

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OIG Reports on Adverse Events (cont'd)

- The State Report
  - 26 states have an adverse event reporting system and are actively receiving reports as of January 1, 2008
  - Reporting systems are disparate in list of reportable events, criteria to determine adverse events; information that must be reported and strategies to obtain reports and maintain confidentiality
    - Hospital underreporting is common problem
  - OIG Conclusion: state adverse event reporting systems are unsuitable for use in national initiatives

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OIG Reports on Adverse Events (cont'd)

33

- The County Incidence Report
  - Measuring the incidence of adverse events is common problem
  - Review included events on NQF list; CMS HAC list; and those resulting in serious harm to patient (prolonged hospital stay, permanent harm, life-sustaining intervention, or death)
  - 15% experienced adverse event; another 15% experienced adverse event classified as "temporary harm". THIS MEANS OVERALL INCIDENCE WAS 30%
  - Most "adverse events" found were not on NQF or CMS list and only 2 resulted in higher reimbursement
  - Some hospitals omitted the HAC diagnosis codes (of concern to OIG)

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Useful Resource Links

34

- CMS: http://www.cms.hhs.gov/
- CMS Hospital Compare: http://www.hospitalcompare.hhs.gov/Hospital/Home2.asp?version=alternate&browser=IE%7C6%7CWinXP&language=English&defaultstatus=0&pagelist=Home
- OIG: http://www.oig.hhs.gov/
- NQF: http://www.qualityforum.org/

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Questions & Answers

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