Hospital Reporting and "Never Events"

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In *To Err is Human,* its landmark 1999 report, the Institute of Medicine (IOM) estimated that as many as 98,000 deaths a year in United States hospitals were attributable to medical errors.[1] In a 2007 report, the Agency for Healthcare Research and Quality (AHRQ) found only a 1% improvement per year in this rate following publication of the IOM report.[2] Another study found that "never events" added significantly to Medicare hospital payments.[3] The added costs for these events, which are defined by the National Quality Forum as "errors in medical care that are clearly identifiable, preventable, and serious in their consequences for patients,"[4] are estimated by the IOM to range from an additional $700 per case for treatment of decubitus ulcers to $9,000 per case to treat postoperative sepsis.[3]

Accordingly, the National Quality Forum (NQF), a voluntary organization that sets consensus standards for health care quality, has adopted a list of 28 never events.[4] Examples include surgery on the wrong body part, hospital-acquired pressure ulcers, mismatched blood transfusions, and preventable postoperative deaths.

In 2003, Minnesota, with strong support from the Minnesota Hospital Association, became the first state to require hospital reporting of NQF-defined never events.[5] The law requires hospitals to report 28 NQF never events to the hospital association's Patient Safety Registry. The Minnesota Department of Health publishes an annual report and encourages the state's hospitals to share information and learn from one another.

At least 13 states now use the NQF list as a basis for public reporting. Reimbursement is also increasingly being tied to never events and other hospital-acquired conditions.[6] Over the last year, four state Medicaid programs have stopped reimbursing providers for NQF-defined never events.[7] A number of commercial insurers, including Wellpoint, Aetna, Cigna, and seven Blue Cross Blue Shield associations have ceased never event reimbursement.[7] The Leapfrog Group, a coalition of major employers, has asked hospitals to waive all billing related to never events; to apologize to the patient and/or family; and to report the never event to a state agency, a patient safety organization, or The Joint Commission. More than 650 hospitals across the US have signed on to the Leapfrog initiative.[6]

New Medicare Policies

Against this backdrop, new Medicare policies on hospital billing and reporting of hospital-acquired conditions (HACs) have taken effect.[8] The Centers for Medicare & Medicaid Services (CMS), an agency of the US Department of Health and Human Services, has been charged with instituting these new policies, as mandated by federal law.

Under provisions of Section 5001 (c) of the Deficit Reduction Act of 2005, for hospital discharges taking place after October 1, 2008, hospitals do not receive payment for cases in which certain conditions occur during hospitalization that were not present on the patient's admission. The Secretary of Health and Human Services is required under the Act to identify conditions that: are high cost, high volume, or both; result in the case being assigned to a diagnosis-related group (DRG) associated with a higher payment as a secondary diagnosis; and could have been reasonably prevented by following evidence-based clinical guidelines. These conditions, consistent with the NQF-designated "never events," are considered hospital-acquired and are not reimbursable at the higher-weighted Medicare Severity (MS) DRG level (Table 1).

As a result, CMS has established a new program known as *Hospital-Acquired Conditions (HACs) and Present on Admission (POA) Reporting*.[8] The HAC payment provision applies to all Inpatient Prospective Payment System (IPPS) hospitals. A special section of the CMS Web site is devoted to this program: http://www.cms.gov/HospitalAcqCond/.

IPPS hospitals are required to

submit POA information on diagnoses for inpatient discharges. This means that, on admission, a provider must document whether a patient has conditions covered by this program, such as pressure ulcers, when he or she is admitted to the hospital. If pressure ulcers are present, their presence at discharge will not affect reimbursement unless the ulcers progress from Stage I or II to Stage III or IV. Non-IPPS hospitals are currently exempt from the HAC and POA indicator reporting (Table 2).

Quality Improvement Focus on Pressure Ulcers

As part of CMS' 9th Scope of Work (SOW), the nation's 53 Quality Improvement Organizations (QIOs) are assigned to work with select hospitals and nursing homes on comprehensive pressure ulcer prevention projects. To ensure that Medicare beneficiaries receive health care that meets nationally accepted standards of care, CMS contracts with QIOs located in the 50 states, the US Virgin Islands, Puerto Rico, and the District of Columbia. QIOs conduct activities with providers in each of their contracted states/jurisdictions to improve quality of care.

Pressure ulcer prevention, which is part of CMS' national Patient Safety Theme, focuses on bringing together hospitals and nursing homes to achieve pressure ulcer reduction across the continuum of care. The 9th SOW began August 1, 2008, and continues through July 31, 2011.

The nationwide objective established by CMS is to achieve a minimum of 8% relative improvement over baseline pressure ulcer status in each of the participating facilities.

Participating hospitals and nursing homes agree to participate in the project through the end of the 9th SOW, with sustained support from their CEOs or administrators. Their involvement includes working cooperatively at the local level to accelerate quality improvement through sharing tools and discussing strategies, barriers, successes, and lessons learned in the prevention, identification, and treatment of pressure ulcers.

The effectiveness of the quality improvement approach to pressure ulcer control has already been demonstrated by the National Nursing Home Improvement Collaborative. As reported in the *Journal of the American Geriatrics Society,* a sustained focus on pressure ulcer reduction was able to prevent serious pressure ulcers in a collaboration among 52 nursing homes in 39 states.[9] The project was facilitated

Table 1. HACs Not Reimbursable at the MS-DRG Rate

- Foreign object retained after surgery
- Air embolism
- Blood incompatibility
- Stage III and IV pressure ulcers
- Falls and traumas (fractures, dislocations, intracranial injuries, crushing injuries, burns, electric shock)
- Manifestations of poor glycemic control (diabetic ketoacidosis, nonketotic hyperosmolar coma, hypoglycemic coma, secondary diabetes with ketoacidosis, secondary diabetes with hyperosmolarity)
- Catheter-associated urinary tract infection
- Vascular catheter-associated infection
- Surgical site infection:
  - Mediastinitis following coronary artery bypass graft
  - Any surgical site infection following bariatric surgery for obesity (laparoscopic gastric bypass, gastroenterostomy, laparoscopic gastric restrictive surgery)
  - Any surgical site infection following spine, neck, shoulder, or elbow orthopedic procedures
- Deep vein thrombosis/pulmonary embolism following total hip/knee replacement

Source: *Hospital-Acquired Conditions* (http://www.cms.gov/HospitalAcqCond/)

Table 2. HAC and POA-Exempt Facilities

Critical Access Hospitals	Federally Qualified Health Centers
Long-term Care Hospitals	Religious Non-Medical Health Care Institutions
Maryland Waiver Hospitals	Inpatient Psychiatric Hospitals
Cancer Hospitals	Inpatient Rehabilitation Facilities
Children's Inpatient Facilities	Veterans Health Administration/ Department of Defense Hospitals
Rural Health Clinics	

Source: *Affected Hospitals* (http://www.cms.gov/HospitalAcqCond/)

Provider Action

Impact to You

Almost 100,000 deaths a year are attributed to medical errors in hospitals. As a result, CMS is moving to hold hospitals accountable for errors that occur, especially those classified as never events. These events include hospital-acquired pressure ulcers and preventable postoperative deaths.

What You Need to Know

Hospitals will not receive payment for cases in which certain conditions occur during the hospitalization that were not present on the patient's admission (POA). As a result resources will likely be assigned in the hospital to manage this process.

What You Need to Do

On admission, providers must document whether a patient has conditions covered by this program, such as pressure ulcers, when they are admitted to the hospital. As part of CMS' 9th Scope of Work, the nation's 53 Quality Improvement Organizations (QIOs) are assigned to work with hospitals and nursing homes on such things as comprehensive pressure ulcer prevention. QIOs work to facilitate opportunities for knowledge transfer and sharing of best practices among participating providers. The bottom line is careful initial assessment and documentation of the POA conditions as well as working with the QIOs to develop `best' practices to improve outcomes.

by intensive cooperation involving hospitals, home health agencies, emergency services, and participating nursing homes to identify and reduce the causes of pressure ulcers.

The paper's authors reported that more than two-thirds of residents' serious pressure ulcers were eliminated in the 35 nursing homes that reported data from the project. In addition, participating facilities found that they could reduce the onset of new pressure ulcers by 69%.

Drawing on the lessons of this and other pressure ulcer prevention projects, the 9th SOW encourages each participating institution to establish a multidisciplinary team that includes nursing, wound care, quality improvement, and medical staff. Each participant conducts a review of its prevention and treatment policies and identifies and implements strategies to change care processes. Participants institute a quality improvement plan and collect and submit data in accordance with the plan.

The designated QIO works with the hospitals and nursing homes to facilitate the development of cooperative relationships. The QIO helps each facility's team in reviewing its pressure ulcer policies and results and provides quality benchmarks and information on standards of care. The QIO also provides technical assistance and data collection guidance; facilitates information and "best practice" sharing; may conduct on-site and conference calls to assess progress, identify obstacles, and advise on pathways to success; and conducts informational sessions and knowledge-sharing opportunities.

In New Jersey, where HQSI serves as the CMS-designated QIO, we are working with 20 hospitals and 58 nursing homes. The participating nursing homes have a referring relationship with the hospitals. Our goal is to promote the development of collegial relationships. Throughout the length of the project, we are facilitating opportunities for knowledge transfer and sharing of best practices among participating providers, with the understanding that pressure ulcer prevention and treatment is a shared responsibility across provider settings. *MPM*

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