Government Initiatives

Initiatives Intended to Reduce Adverse Events in the American Health System
**Patient Safety Act**

- To address the need to capture data, Congress passed The Patient Safety and Quality Improvement Act of 2005 (Patient Safety Act).

- The Patient Safety Act authorizes the creation of Patient Safety Organizations (PSOs) to:
  1. reduce the incidence of events that adversely affect patients and
  2. to improve safety and quality through the collection and analysis of data on patient events.

**Patient Safety Organizations**

- The Agency for Healthcare Research and Quality (AHRQ) administers the provisions of the Patient Safety Act dealing with PSO operations.

- Final rule effective January 19, 2009;

- PSOs create a secure environment where clinicians and health care organizations can collect, aggregate, and analyze data.
HHS Contract with National Quality Forum (NQF)

- The Medicare Improvements for Patients and Providers Act (MIPPA) of 2008 directs the Secretary of HHS to contract with a private, nonprofit, consensus-based entity – NQF.

- NQF is charged with synthesizing evidence and convening stakeholders to make recommendations on an integrated national strategy and priorities for health care performance measurement.

Linking Payments to Quality

- Value Based Purchasing
  - In addition to Pay for Performance…

- Pay-for-Reporting
  - Inpatient/Outpatient

- Paying for Value
  - Serious Reportable Events (SREs)
  - Present on Admission (POA)
  - Hospital Acquired Conditions (HAC)
Pay-for-Reporting – Inpatient

- July 2003: CMS began the National Voluntary Hospital Reporting Initiative n/k/a the Hospital Quality Alliance: Improving Care through Information
  - a public/private collaboration to improve the quality of care provided by hospitals by measuring and publicly reporting on that care
  - Hospital Compare debuted April 1, 2005

Pay-for-Reporting – Inpatient

- 2% reduction in payment update for hospitals that do not submit quality data
- FY 2007 – CMS required hospitals to submit data on 21 quality measures
- FY 2010 – Currently 42 quality measures
Pay-for-Reporting – Outpatient

• Hospital Outpatient Quality Data Reporting Program (HOP-QDRP)
  • Final rule outlining implementation -11/01/07
    • Hospitals required to report data
    • On the quality of hospital outpatient care
    • Using standardized measures of care
    • Effective for payments beginning in calendar year (CY) 2009
    • Must report in order too receive the full annual update to their OPPS payment rate

Pay-for-Reporting – Outpatient

• Hospital outpatient departments that fail to report these quality measures incur a reduction in their annual payment update by 2 percent.

• Initially, hospitals were required to submit data for 7 quality measures (3 medical conditions)

• 2009 OPPS Final Rule expanded outpatient reporting requirements from the initial 7 to 11 measures
  • Added 4 imaging efficiency measures
### P4P/Reporting: Present on Admission (POA)

- Acute care hospitals are required to identify secondary diagnoses that are present upon an inpatient admission. Documentation is key!
- Concept mandated due to concerns about quality healthcare and the government overpaying because of hospital errors
- Goal: Identify conditions caused by inadequate attention to patient care needs and safety.

### Hospital Acquired Condition (HAC)

- Per CDC, HACs result in 2.4 million extra hospital days and approximately $9.3 billion in excess charges in a single year.
- Definition: A reasonably preventable condition, which was not present or identifiable at the time of hospital admission, but was present during discharge.
- CMS requires Medicare-participating hospitals to disclose all hospital-acquired conditions.
Hospital Acquired Condition (HAC)

- CMS will no longer pay hospitals an increased rate or any cost attributed to care made necessary by HACs as part of MS-DRGs.
- For HACs and the included "never events", CMS pays hospitals as though the secondary diagnosis, or never event, was not present.
- Medicare will, however, pay for the items and services necessary to treat or correct the HAC or never event.

Hospital Acquired Condition (HAC)

- Medicare also prohibits the billing of these additional incurred costs to the patient.

- Prior to implementing the no payment policy for HACs, CMS issued an expanded list of HACs
  - Currently 11 (Overlap with Never Events)
  - No payment policy effective October 1, 2008
  - No new HACs proposed by CMS for 2010
Serious Reportable Events ("Never Events")

• In 2002, the National Quality Foundation (NQF) published a list of Serious Reportable Events (SREs) a/k/a/"Never Events"

• Updated in 2006 – Currently 28

• Program is due for review and maintenance
  • Review may result in updates/additions to the list, which will be published in early 2011

Never Events – CMS will deny payment for 3

• 05/18/06: CMS announced it was investigating ways that Medicare could help to reduce or eliminate the occurrence of "never events"

• 01/15/09: (Fast-forward 32 months) CMS issued 3 National Coverage Determinations (NCDs)
  • Establish a uniform policy for denials. – Medicare will not pay for three never events related to surgery.
  • Wrong: (1) patient; (2) surgery; (3) body part
Differences related to non-payment

- Medicare reimburses for services related to HAC
  - Facility receives portion of reimbursement
- Medicare will not reimburse for any aspect of a service related to the three wrong-site surgery never events.
  - As distinguished from an HAC, a never event prevents the hospital and physicians involved in the procedure from receiving any reimbursement.

Data Mining

- **Benefit**: Data mining can facilitate overall improvements in the practice of medicine resulting in enhanced quality of care.
- **Risk**: Data is available to federal and state governmental enforcement agencies.
  - “We are reviewing assorted sources of quality information on your facility to see what it says and if it is consistent. You should be doing the same.”
  - James G. Sheehan, NY Medicaid IG, February 6, 2007
2010 OIG Work Plan

- We will review hospitals’ controls for ensuring the accuracy of data related to quality of care that they submit to CMS for Medicare reimbursement.

- We will determine whether hospitals have implemented sufficient controls to ensure that their quality measurement data are valid.

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2010 OIG Work Plan

- Will review Medicare claims to determine:
  - The number of inpatient hospital admissions for which certain diagnoses were coded as being POA;
  - which of the diagnoses were most frequently coded as POA;
  - which types of facilities are most frequently transferring patients with a POA diagnosis specified by CMS to hospitals; and
  - whether specific providers transferred a high number of patients to hospitals with POA diagnoses.
2010 OIG Work Plan

- **Adverse Events: Various Reviews**
  - Hospitals: National Incidence Among Medicare Beneficiaries
  - Hospitals: Methods To Identify Events
  - Hospitals: Early Implementation of Medicare’s Policy for Hospital-Acquired Conditions
  - Hospitals: Responses by Medicare Oversight Entities
  - Public Disclosure of Adverse Event Info

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**Strategies for Providers**

Facilitating the effective integration of Quality with Compliance to prepare your organization for responding to these new and expanding initiatives
Era of increasing governance accountability

• Board members are expected to understand and be involved in the assessment of quality and patient safety initiatives within their organizations
  • Understanding of clinical quality measurements
  • Ability to read quality scorecards and spot red flags
  • Appreciation of quality of care as a corporate governance issue
  • Understanding of national trends in health care quality

Corporate Responsibility & Health Care Quality: A Resource For Health Care Boards of Directors
• 11-page booklet published in September 2007
• Co-sponsored by the OIG and AHLA
• “With a new era of focus on quality and patient safety rapidly emerging, oversight of quality also is becoming more clearly recognized as a core fiduciary responsibility of health care organization directors.”
Era of increasing governance accountability

- In order to develop an understanding of the relevant quality and patient safety issues:
  - Resource suggests ten questions Board members should ask when examining the scope and operation of the organization’s quality and safety initiatives
  - Identify the Board committee that is responsible for overseeing quality of care within the organization
  - Focus on performance goals that drive the organization to provide the highest quality and most efficient patient care

Performance Goals

- Use clinical benchmarks in conjunction with industry-wide reported data to create quality of care goals.
- Use issues and risks identified within your organization in conjunction with OIG guidance to develop compliance goals.
- Link each goal to management accountability.
  - Incorporate into performance evaluations.
Responsibility for integration resides with leadership

- Collaboration among leaders responsible for:
  - Quality
  - Compliance
  - Internal Audit
  - Patient Safety
  - Risk Management
  - Medical Peer Review
  - Clinical Operations
  - Utilization / Case Management
  - Coding and Billing

Responsibility for integration resides with leadership

- Considerations:
  - Qualifications of individuals
  - Collaborative approach / team players
  - Department leaders meet on a regular basis
  - Share information / Break down silos
  - Committees – integrated
  - Joint assessment of current processes
    - (e.g., peer review / patient safety / quality data reporting)
  - Reporting structure
Clinical Quality/Operational Policies

- Integrate quality improvement processes into policies pertaining to operations;
- Draft operational policies and procedures in such a way as to support clinical quality standards;
- Assess implementation and enforcement of these policies;
- Develop internal controls to monitor and report on quality metrics.

Medical Credentialing / Peer Review

- Align credentialing standards for professional staff with quality data
- Advance quality-driven model for professionals
- Allow the organization to take appropriate action when significant quality deficiencies (adverse patient events) are identified
  - Is medical peer review successful or should quality data be used to effect change?
  - Track data jointly → Identify patterns
Promoting Transparency

• Is reporting quality concerns and medical errors encouraged in the same way as reporting compliance issues?

• Do the measures that have been implemented to protect those who report compliance issues apply to those who report issues related to quality of care?
  • Has your organization’s non-retaliation policy been communicated; Is the policy strictly enforced; Are colleagues routinely assured of non-retaliation?

Quality:
An element of the compliance program

• Are quality of care and patient safety issues addressed in the organization’s annual compliance risk assessment and related corrective action plans?

• Are all relevant departments involved in the risk assessment and development of the related corrective action plans?
How to begin...

• Perform a comprehensive assessment
  • Baseline assessment should be conducted to identify compliance risks related to quality of care and patient safety
  • All key stakeholders should be involved in the assessment including the medical staff and Board of Directors
  • A joint quality and compliance “work plan” should be created based on the gaps unveiled by the risk assessment.

Implementing the work plan

• Policies and Procedures
  • Develop and/or revise to provide guidance for applying best practices in areas where risks are identified

• Education and Training
  • Develop mandatory training modules to address quality, patient safety and compliance obligations

• Auditing and Monitoring
  • Prioritize risk areas based on organization’s needs
Quality/Compliance/Patient Safety/Internal Audit/Peer Review/Utilization/Coding/Billing
An integrated approach to developing a culture of compliance enhances outcomes!

HEALTH CARE GROUP

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