Managing Adverse Events and the Associated Risks

Know.Right.Now

September 4, 2014
Agenda

- “Adverse Event” and Related Phrases Defined
- Hospital Conditions of Participation Requirements
- Findings from OIG Reports
- Adverse Events in Skilled Nursing Facilities
- AHRQ Common Formats
- Demonstration of ComplyTrack Solutions
- Q&A (time permitting)
Adverse Event and Related Phrases Defined

- **Adverse event** - an event, preventable or nonpreventable, that caused harm to a patient as a result of medical care.
- **Temporary harm event** - an event that requires intervention but does not cause lasting harm.
- **Never event** - a serious event that the National Quality Forum included on a specific list of events that “should never occur in a health care setting.”
- **Hospital-acquired conditions** - identified conditions that are: (1) high cost or high volume or both; (2) result in the assignment of a case to a DRG that has a higher payment when present as a secondary diagnosis; and (3) could reasonably have been prevented through the application of evidence-based guidelines.

OIG Spotlight Article on Adverse Events (July 2012); MLN Fact Sheet: Hospital-Acquired Conditions (HAC) in Acute Inpatient Prospective Payment Systems (IPPS) Hospitals (October 2012).
Hospital Conditions of Participation (CoPs)

- Quality Assessment and Performance Improvement CoP
  - 42 CFR 482.21(a)(1) requires measurable improvement
  - 42 CFR 482.21(a)(2) requires hospitals to track adverse patient events
  - 42 CFR 482.21(b) obligates hospitals to use the data to monitor the effectiveness and safety of services
  - 42 CFR 482.21(c)(2) obligates hospitals to analyze the causes of adverse patient events and implement actions and mechanisms to prevent recurrences

- October 2011 Report
  - Recommended that all Immediate Jeopardy complaints evaluate compliance with QAPI CoPs

42 CFR 482.21; Adverse Events in Hospitals: Medicare’s Responses to Alleged Serious Events, OEI-01-08-00590
November 2010 report found that:

- An estimated 13.5 percent of hospitalized Medicare beneficiaries experienced an adverse event during their hospital stay
  - 1.5 percent experienced an event that contributed to their deaths (15,000 patients over a one month span)
- Additional 13.5 percent experienced events during their hospital stays that resulted in temporary harm
- Physician reviewers determined that 44 percent of adverse and temporary harm events were clearly or likely preventable
January 2012 report found that:

- Hospital staff did not report 86 percent of events to incident reporting systems, partly due to staff misperceptions regarding what constitutes patient harm.
- Administrators expect staff to report any instance of patient harm and even circumstances that could lead to harm.
  - Administrators view staff reports as some of the most valuable information.
- Yet, none of the hospitals in the review maintained a list of events required to be reported to their incident reporting systems...not even the NQF or HAC lists.
July 2012 report found that:

- Even though an estimated 60% of adverse and temporary harm events occurred at hospitals in States with reporting systems, only an estimated 12% of events met State reporting requirements.
- Hospitals reported only 1% of events.
- OIG determined that the lack of reporting to State systems was likely due to the hospital’s failure to identify events.
  - Again, hospital staff are not identifying incidents of harm as reportable events.

Memorandum Report: Few Adverse Events in Hospitals Were Reported to State Adverse Event Reporting Systems, OEI-06-09-00092
Adverse Events in Skilled Nursing Facilities

- February 2014 OIG report findings:
  - An estimated 22 percent of Medicare beneficiaries experienced adverse events during their stays.
  - An additional 11 percent experienced temporary harm events during their stays.
  - Physician reviewers determined that 59 percent of the adverse and temporary harm events were clearly or likely preventable.

- Report recommends that:
  - CMS instruct State agency surveyors to review NH practices for identifying and reducing adverse events.
  - CMS/AHRQ create/promote list of NH events for staff.

Adverse Events in Skilled Nursing Facilities: National Incidence Among Medicare Beneficiaries, OEI-06-11-00370
AHRQ Common Formats

- AHRQ Common Formats define a systematic process for reporting adverse events incidents, near misses, and unsafe conditions, and allow a hospital to report harm from all causes
- Provides common definitions and reporting formats
  - Generic Common Formats - apply to all events
  - Event-Specific Common Formats - relate to certain high frequency event types
- Use of the AHRQ Common Formats is not required but both CMS and the OIG suggest using in order to meet QAPI COPs

CMS Survey & Certification Memorandum: 13-19-Hospitals (March 2013); AHRQ Common Formats Overview (www.pso.ahrq.gov/common)
Contact Information

Darci Friedman, JD, CHPC, CSPO
Director of Regulatory Products
darci.friedman@wolterskluwer.com

Lynne Rinehimer, JD
Sr. Healthcare Solutions Consultant
lynne.rinehimer@wolterskluwer.com