HCCA
Physician Practice
Compliance Conference

“Why Physicians Should Care
About Never Events”
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Question of the Day!

These initiatives create challenges for which providers listed below?

A. Acute care hospitals
B. Physicians and ancillary services
C. Rehab centers
D. Nursing homes
E. Phillie Phanatic
Today’s Program

- Why are physicians involved?
- Where are conflicts emerging?
- Review definitions and history
- Patient safety issues generally
- Litigation issues
- Recommendations

Financial Environment

- Rate pressures
- More uninsured
- Staffing costs up
- Cost of capital (if available at all)
- Philanthropy down in hospital-based and academic practices
Financial Pressure From “Never Events”

- Increased compliance costs for billing and quality
- Impact of pre-admission screening
- Change in outlook causing admission of fewer elderly, less healthy patients to hospitals

Conflicts Emerging

- Adverse event reporting requirements v. payment limitations
- Payment rules v. liability cases

Resolving these conflicts will require new thinking on policies and procedures
### Reviewing Some Key Definitions

**HAC** - Hospital or Healthcare Acquired Conditions  
**NCD** - National Coverage Determination  
**HAI** - Hospital or Healthcare Acquired Infections  
**POA** - Present on Admission

### Reviewing Some Key Definitions (cont.)

**IOM** - Institute of Medicine  
**NQF** - National Quality Forum  
**Leapfrog Group** - National Business Group  
**AHRQ** - Agency for Healthcare Research and Quality  
**GAO** - Government Accountability Office  
**OIG** - Office of Inspector General
Historical Perspective

- IOM 1999 Report *To Err is Human; Building a Safer Health System* stated:
  - HAC caused by medical errors are leading cause of morbidity and mortality in U.S.
  - Estimated 98,000 die each year
  - Lost productivity and disability estimated between $17 billion and $29 billion

Historical Perspective (cont.)

- NQF 2002 Report *Serious Reportable Events in Healthcare* identified 27 adverse events (later 28) that are serious, but highly preventable.
Historical Perspective (cont.)

• Leapfrog Group built upon NQF findings and publicized to consumers and providers the need to avoid the list of 28 adverse events

Leapfrog’s most current study (2008) reveals continued difficulty of compliance* with evidence-based standards known to save lives:

- Heart Bypass Surgery  only 43% compliant
- Heart Angioplasty  only 35% compliant
- High-Risk Deliveries  only 32% compliant
- Bariatric Surgery  only 16% compliant
- Aortic Valve Replacement  only 7% compliant

* In Leapfrog hospitals only
Historical Perspective (cont.)

Leapfrog Group Hospital Survey 2008:

“Seventy-five percent do not fully meet the standards for 13 evidence-based safety practices, ranging from hand washing to competency of nursing staff.”

Historical Perspective (cont.)

• Today’s estimate of cost to Medicare program during the period 2005 to 2007:
  – $6.9 billion
  – 92,882 deaths could have been avoided

(Source: Healthgrades April 2009)
Historical Perspective (cont.)

Healthgrades Report for 2009:
- 913,215 total patient safety events among 864,765 Medicare beneficiaries
- Unchanged from 2008
- Represents 2.3% of Medicare inpatients
- Seven indicators worsened
- Eight indicators showed improvement

Historical Perspective (cont.)

- **Medicare Initiatives**
  - Congress took action in 2005 on patient safety (Deficit Reduction Act)
  - HSS to select at least two conditions:
    - High cost/volume
    - Result in a higher payment when present as a secondary diagnosis
    - Could reasonably have been prevented through evidence-based guidelines
Historical Perspective (cont.)

- CMS Final Rule (8/22/07) effective for discharges beginning on October 1, 2008 identified 8 HACs
  - Object left from surgery
  - Air embolism
  - Blood incompatibility
  - UT infection due to catheter
  - Pressure ulcer
  - Vascular catheter infection
  - Surgical site infection
  - Certain falls and trauma

Historical Perspective (cont.)

- CMS 8/19/08 Final Rule added three additional events:
  - Surgical site infections from bariatric and orthopedic surgery
  - Evidence of poor glycemic control
  - Deep-vein thrombosis/pulmonary embolism
- CMS would not pay the higher costs associated with any of the HACs
- May 2009 CMS decided not to add additional HACs
Historical Perspective (cont.)

• National Coverage Determinations –
  – Wrong surgical or other invasive procedure performed on a patient
  – Surgical or other invasive procedure performed on wrong body part
  – Surgical or other invasive procedure performed on the wrong patient

• NCD impacts all providers and suppliers, not only those payments as a result of an inpatient hospital stay

(Final Rules issued January 15, 2009 and final instructions issued July 24, 2009.)
Financial Impact of Medicare Decisions

- Stage III and IV pressure ulcers
  - Cases: 257,412
  - Average charge/stay: $43,180
  - Total: $11.1 Billion
- Fall or trauma resulting in serious injury
  - Cases: 193,566
  - Average charge/stay: $33,894
  - Total: $6.6 Billion
- Vascular catheter-associated infection
  - Cases: 29,536
  - Average charge/stay: $103,027
  - Total: $3.0 Billion
Financial Impact of Medicare Decisions (cont.)

- Catheter-associated urinary tract infection
  - Cases: 12,185
  - Average charge/stay: $44,043
  - Total: $536.7 Million

- Foreign object retained after surgery
  - Cases: 750
  - Average charge/stay: $63,631
  - Total: $47.7 Million

- Surgical site infection – mediastinitis after coronary artery bypass graft
  - Cases: 69
  - Average charge/stay: $299,237
  - Total: $20.6 Million

- Air embolism
  - Cases: 57
  - Average charge/stay: $71,636
  - Total: $4.0 Million

- Blood incompatibility
  - Cases: 24
  - Average charge/stay: $50,455
  - Total: $1.2 Million

(Source: CMS)
Cost Benefit Analysis
(An example)

- NQF recommends prevention programs for pressure ulcers include mechanisms to:
  - Institute a risk-assessment protocol and permit nurse interventions
  - Periodically assess and document patients’ risks in records
  - Use fire-code compliant or plastic polymer pressure-relieving pads
  - Regularly change the position of immobile patients every two hours

Cost Benefit Analysis
(An example) (cont.)

- Assess patients’ nutrition and incorporate nutritional consults with a dietician
- Prevent and manage incontinence
- Educate patients and families on minimizing bed sores
Medicaid Secondary Payor Initiative

- CMS advised all Medicaid Directors to determine if they wanted to block additional payments for HACs (CMS letter 7/31/08) for dual eligibles, including the proposed NCDs.
- CMS encouraged them to coordinate policies through State Health Plan amendments for both dual eligibles and entire Medicaid population.

State Initiatives

- Some states are developing legislation to block payments from ALL payors (NJ).
- Pennsylvania has adopted NQF list of adverse events and will update per new legislative action – all providers, including physicians blocked from billing.
State Initiatives (cont.)

- Florida refers wrong-site errors to Medical Board for review
- Maryland single payer system aligned with CMS but rewards “good” performance and penalizes “bad” performance

Adverse Event Reporting

- Most reporting goes to state regulators
  - 26 states now require reporting
  - Underreporting is an issue - Indiana Medical Error Reporting System issued 2008 Report on 8/20/09 showing level reporting between year 1 and 2.
  - Little validation of reporting
Adverse Event Reporting (cont.)

- Most state reports are kept confidential and non-specific
- Minnesota a notable exception – names hospitals and describes events
- Is this progress?

Adverse Event Reporting (cont.)

Pennsylvania Health Care Cost Containment Council
HAI Data for 2007

- Compared 2007 vs. 2006
- 30,237 vs. 27,949 patients contracted an infection
- Represents decline of 7.8%
- Established peer group categories of hospitals

(Source HAI Report January 2009)
Consumers Union

Critical of Progress on Safety for Patients
- Few hospitals have adopted available systems to prevent medication errors and FDA rarely intervenes
- National system of accountability still does not exist
- No national entity empowered to coordinate and track safety improvements
- Physicians and other clinicians not required to demonstrate competency in patient safety

Consumers Aware

Top 10 technology hazards:
- Alarm hazards
- Injuries from needle sticks and other sharp objects
- Air embolism from contrast media injectors
- Retained devices and unretrieved fragments left in patients
- Surgical fires
- Anesthesia hazards due to inadequate pre-use inspection
- Misleading displays
- CT radiation dose
- MR imaging burns
- Fiberoptic light-source burns

Impact of Professional Liability

- AON Report (September 29, 2008) – benchmarks claims –
  - Hospital acquired infections
  - Hospital acquired falls and injuries
  - Objects left in surgery
  - Pressure ulcers
- Account for 1/6 of total medical professional liability costs

Impact of Professional Liability (cont.)

“The increased awareness surrounding these non-reimbursable conditions may cause a rise in the frequency . . . of claims, [and] . . . other hospital-acquired conditions not currently addressed by CMS regulations” – AON official
Other Litigation Issues

- Impact of HACs:
  - Is it Negligence *per se*?
  - Are CMS Rules admissible evidence?
  - How about new state law initiatives?
  - Is there a new standard of care that is not community-based?

Other Litigation Issues (cont.)

- Is the failure to receive payment confirmation of negligence?
- Adds to potential liability exposure for non-employee physician errors for hospitals
Consider Proactive Solutions

- Board of Directors, Risk Management, Senior Management, Medical Staff, Public Relations, Legal Counsel, Financial Staff all must consider implications beyond simply the loss of payment from Medicare and all payors

Consider Proactive Solutions (cont.)

- Be aware that payors will be pushing to adopt Leapfrog-type standards into contracts (be sure to review and negotiate) – Recent Aetna action
Consider Proactive Solutions (cont.)

- Who decides when a preventable error has occurred? How quickly? Impact on claims deadlines? What happens when hospital and physician disagree?

Consider Proactive Solutions (cont.)

- Use of terminology may be important ("serious adverse event")
- Use HAC when referring to CMS rules
- Be sure POA conditions are properly documented
- Not billing patients may be an excellent defense strategy
Consider Proactive Solutions (cont.)

- Consider new forms of electronic surveillance for HAI such as Cardinal’s MedMined which was recently given HFMA Peer Review status

JCAHO Leadership Initiative

- Says root cause of safety issues lies with leadership
- Leadership includes governing body, CEO, senior managers, leaders of clinical staff
- Patients and staff may perceive difference between public statements and actual events

(Sentinel Event Alert 8/27/09)
JCAHO Leadership Initiative (cont.)

- Provides a list of suggested actions including
  - Tie CEO review to safety performance
  - Hold open discussion with stakeholders
  - Establish partnerships with physicians

Examples of Change

- Allegheny General Hospital – reduced almost all central line blood stream infections
- UPMC Passavant – reduced rate of falls by patients significantly
- VA Pittsburgh System – reduced MRSA infections by 85%
- UPMC St. Margaret – reduced MRSA, C.diff and CLAB infection rates significantly

(Source: Branches (Jewish Healthcare Federation))
One Approach

Focus on the Service

• Combine Teams – Financial and Quality Managers on one team
• Create Process Reliability teams
• Eliminate “Perverse” incentives – focus on work rather than outcome
• Join with patient as an active participant in care
• Collaboration with physicians, payors and other systems

Questions

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