



# ***Serious Adverse Events MHA Quality and Accountability Agenda September 23, 2008***



**Sam R. Watson**

**Michigan Health & Hospital Association**

## Hospital Acquired Conditions

- Medicare nonpayment of related costs of conditions not present on admission is effective October 1, 2008.
- The Centers for Medicare & Medicaid Services (CMS) estimated \$20 million savings (.02%) for FY 2009. Medicare hospital inpatient payments were \$120 billion in 2006.
- Other Payers have followed suit

## Key Messages

- There are events that should not happen. Michigan hospitals agree to not seek payment for these events.
- Reimbursement policies for SAEs are not about "prevention and improving patient care." BCBSM and all payers should commit to prevention and best practices.
- Michigan should pursue a strategy committing to prevention and best practices. There should be national and state advocacy to support these efforts.
- The National Quality Forum (NQF) never intended its list of 28 events to be used for payment policies.

## Defining Terms

- Definitions are critical when using the words ***never events, serious preventable events, hospitals acquired conditions (HACs), and serious adverse events (SAEs)***
- There are unintended consequences that can result from untested nonpayment policies
- The events are difficult to define and it may create a disincentive to report data needed for prevention efforts

## In keeping with the season...Michigan Hospitals approach to SAEs



**The best defense is a strong offense - prevention improves patient outcomes and has higher ROI.**

## Two-Pronged Strategy

1. Use MHA Patient Safety Organization (PSO) to engage hospitals in data collection activities designed to *prevent* SAEs
2. MHA-member task force to reviewed SAE billing practices and finalized an action plan

## MHA / AHA Policy Principles:

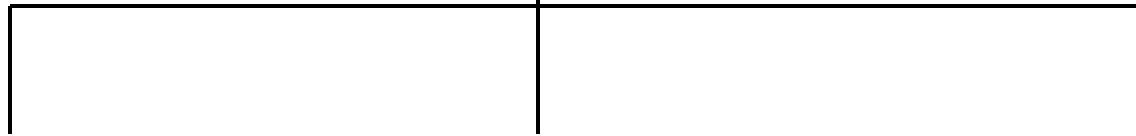
1. The error or event must be preventable.
2. The error or event must be within the control of the hospital.
3. The error or event must be the result of a mistake made in the hospital.
4. The error or event must result in significant harm.
5. The error or event must be clearly and precisely defined in advance.

- **Uniform Approach / Policy**
  - Payer SAE policy should be no more than a subset of CMS
  - SAE billing policy appropriate to physicians
- **Operationalizing and enforcing an SAE Policy**
  - List of events defined
  - Impact of these billing policies should be studied before additional conditions are added to the list
  - MS DRG Grouper and other payment methodology issues
- **Definition challenges**
  - Present On Admission (POA) coding
    - Physicians and clinicians documenting properly
    - Alignment of financial incentives
    - Avoid disrupting patient care priorities
- **Prevention strategies**
  - Prevention and best practices should be the top priority.
  - Billing policies won't prevent HACs, we need to work on collaborative programs.
  - Be proactive with BCBSM/payers to provide funding to prevent HACs. The value to patients is highest with prevention, as well as the ROI to payers.
  - Use the MHA PSO to determine where hard evidence supports a collaborative.

MHA

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# MHA Quality and Accountability Agenda



MHA Keystone Center  
for Patient Safety  
& Quality



## Current Collaboratives

- ***Intensive Care Unit (ICU)***
  - 76 hospitals / 110 ICUs
  - Patient Lives Saved: more than 1,700
  - Hospital Days Saved: nearly 128,000
  - Dollars Saved: over \$246 million



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## Current Collaboratives

- ***Keystone: Hospital-Associated Infection***
- ***Keystone: Gift of Life (organ donation)***
- ***Keystone: Surgery***

## Planned Collaboratives

### *Emergency Care*

- Using LEAN and Six Sigma for improved patient flow
- Pilot in three sites

### • *Obstetrics and Perinatal Safety*

- Interventions to include: culture, induction, and labor bundle
- Piloting in 13 sites across the state

## Patient Safety & Quality Improvement Act of 2005

- Create a voluntary system for reporting of medical errors
  - Airline Industry: Aviation Safety Reporting System
- Collection and analysis of patient safety work product
  - Data/information collected from a provider to improve patient safety

## Responsibilities of a Patient Safety Organization

- Collect data and work with providers to analyze the information
  - Best practices
  - Evidence-based care
- Preserve confidentiality & security of the patient safety work product
  - Data be used to improve patient safety only
- Encourage a culture of patient safety
  - If you want to change behavior you need to change the culture
- Have qualified patient safety personnel and licensed clinicians on staff
- Improve patient safety and the quality of health care delivery
  - Reporting errors alone will not improve patient safety

- Website launched January 2008
- All 146 nonprofit community hospitals
- Top 50 Medicare IP and OP procedures
- Average charges, average payments
- Number of patients, length of stay
- Quality measures
  - Heart attack
  - Congestive heart failure
  - Pneumonia

# *Thank you*



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