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Medicare Set To Implement Major New Strategy To Increase Patient Safety And Save Costs

Beginning October 1, 2008, the Centers for Medicare and Medicaid Services (CMS) will begin its implementation of a policy to withhold Medicare payments to hospitals for "never events," serious, preventable and costly errors which occur during hospital stays and never should happen in the delivery of services.

Background

In the wake of the sensational 1999 report by the national Institute of Medicine, *To Err is Human*, which identified that up to 98,000 preventable deaths occur annually in the process of U.S. health care service delivery, much activity has taken place in the public and private sectors to identify precisely how these events are happening and how they can be avoided.

The National Quality Forum (NQF), with CMS, has identified 27 preventable occurrences in the areas of surgical events, product or device events, patient protection, and events related to care management and the care environment.

To be included in the NQF ''never events'' list, the event had to have been characterized by the NQF team as:

- *Unambiguous*. Clearly identifiable and measurable, and thus feasible to include in a reporting system.
- *Usually preventable.* Recognizing that some events are not always avoidable in the complex health care system.
- *Serious*. Resulting in death or loss of a body part, disability, or more than transient loss of a body function; and
- *Any of the following*:
  - Adverse and/or,
  - Indicative of a problem in a health care facility's safety systems and/or,
  - Important for public credibility or public accountability.

The cost of treating preventable adverse events is estimated at $17 billion annually.[1] Studies indicate that ''never events add significantly to Medicare hospital payments, ranging from an average of an additional $700 per case to treat decubitus ulcers, to $9,000 per case to treat postoperative sepsis. A study that reviewed 18 types of medical events concluded that errors may account for 2.4 million extra hospital days, $9.3 billion in excess charges (for all payers) and 32,600 deaths.

Methicillin-resistant staph infections (MRSAs) alone can add $30,000 per case in additional hospital costs. The importance of awareness of the prevalence of MRSA infections was underlined in the late 2006 survey by the Association for Professionals in Infection Control, which suggested that as many as 5 percent of all hospital and nursing

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[1] Kim Breen, ''Information is new tool in fight against hospital infections,'' *The Dallas Morning News* , 5/3/07.

home patients are infected with MRSA at any given time—with roughly one-third of the cases showing no sign of illness and the other two-thirds exhibiting symptoms.[2]

State and Local Responses to "Never Events"

Several state legislatures have acted to address the problem, including those in Connecticut, Illinois, Minnesota, New Jersey, Pennsylvania, and Texas. Minnesota was the first (2003) to require mandatory reporting of the 27 NQF "never events." The department of health publishes an annual report and provides a forum for sharing information across the state to assist hospitals to learn from one another.

In 2004 New Jersey enacted a statute requiring hospitals to report serious, preventable adverse events to the state and to patients' families. Connecticut adopted a mix of 36 NQF specific, reportable events in hospitals and outpatient surgical facilities. The 2005 Illinois law requires the reporting of 24 "never events" in 2008.

In 2007, the Texas House moved to make hospital infection rates public—"a move to bring a historically secret problem to light."[3]

Questions arise as to whether mandatory reporting improves patient safety and reduces preventable harm, but the jury is still out. Minnesota, in its first two years of mandatory reporting, saw participating hospitals increase from 30 to 47, and deaths decline from 20 to 12. Serious injuries, however, increased from nine to 12. Providers have raised concerns about whether the new Medicare payment concept is clinically and morally acceptable. They question whether the targeted events are in fact measurable and preventable.

Wrong site surgeries happen or almost happen every other day in Pennsylvania health care organizations. The Pennsylvania Safety Authority indicated that over a 30-month time period from 2004-2006, it received 427 reports, including 253 reports of surgical "near misses," of which 174 reported harmed patients; 120 were wrong site surgeries (69%); 24 were wrong body part surgeries (14%); 16 were wrong procedures (9%); and 14 were wrong patient cases (8%).

VA Hospitals and Other Initiatives

Examples of hospital efforts to "search and destroy" infections to nip them in the bud, are initiatives in the nation's 139 VA hospitals which have cut their MRSA rates by 50 to 60 percent (a 70% drop at the Pittsburgh VA hospital). Screening when patients are admitted to determine if they are carrying a community-related version of MRSA is the strategy used for inpatient treatment and control by the VA system, as well as university-related programs at the Chicago area's Evanston Northwestern and the University of Maryland which have cut their MRSA rates by 50 and 30 percent, respectively.

Focus of the New Medicare Nonpayment Initiative

In January 2005, a private Minnesota health insurer said it would stop paying for things that should never happen to a patient in a hospital, such as leaving a sponge in the body after surgery. The Minnesota company chose not to cover the 27 types of NQF's "never events" which were now going to be reported due to the passage in 2003 of the first

[2] "Study: MRSA infecting up to 5 percent of patients," *FierceHealthcare*, 6/24/07
[3] Karol Wareck, *New CMS Reimbursement Rule: Eight "Preventable Conditions*", presentation, November 2007.

mandatory reporting law in the nation by a state legislature. There was a significant uproar around this move: hospitals complained that the practice would discourage hospital staff from reporting errors and patients worried that they would be hit with a large bill if the insurer did *not* pay. Since the onset of the new policy, the insurer has been billed for fewer than 10 never events.[4]

Taking its cue from the Minnesota initiative, the Medicare program, as of October 1, will not be paying any of the nation's hospitals for eight preventable hospital-acquired conditions (the known frequency rates in 2006 are in parentheses[5]):

- pressure ulcers (322,946)
- hospital-acquired injuries, such as falls, fractures, burns (175,000)
- object left in during surgery (764)
- air embolism (45)
- blood incompatibility (33)
- catheter-associated urinary tract infection (11,780)
- post-CABG (coronary artery bypass graft) inflammation/ infection (108)
- vascular catheter-associated infection (frequency not specified)

Under consideration as well by Blue Cross Blue Shield of Michigan is the addition of three preventable errors—surgery on the wrong patient, surgery on the wrong body part and the wrong surgery.[6]

It is projected that an additional nine preventable hospital-acquired conditions will be added to the Medicare list on October 1, 2009.

Consumer liability for any revenue shortfalls experienced by hospitals as a result of this new policy is not expected.

Detroit and Grand Rapids Receive RWJF Grants

The Robert Wood Johnson Foundation—a generous supporter of Michigan health projects—announced in early June that it will give $1 million each to Detroit and Grand Rapids health councils to work on quality in their respective communities. Since 1972, the foundation has awarded $148.2 million to 390 Michigan projects.

Both health councils received Robert Wood Johnson Foundation (RWJF) grants when the foundation unveiled its campaign in 2006 to improve quality and eliminate racial and ethnic disparities in health care.

The grants to the Greater Detroit Area Health Council and the Grand Rapids-based Alliance for Health are part of a $300-million initiative in 14 communities across the nation called *Aligning Forces for Quality* (AF4Q). The first phase of the AF4Q initiative sought to help communities build health care systems where none existed. In its second phase, it is focusing on the fragmented way in which health care markets function, where the different players often work within their own silos.

The project encouraged the local grantees to work with physicians to improve quality of care, to measure and publicly report on the quality of ambulatory care, and to engage consumers in making informed choices about their own health and health care. In 2008, the initiative expanded to include inpatient care as well as a focus on reducing racial and ethnic gaps in care and enhancing the central role that nursing plays in quality health care.

HEALTH CARE BY THE NUMBERS

69.8 Percent of Michigan Medicare beneficiaries (65-69) who had a screening mammogram in 2004-2005; Detroit rate: **66.7%**; national average: **63.6%**

81.8 Percent of Michigan Medicare beneficiaries whose predominant provider was a primary care physician (2004); black Detroiters' rate: **80.8%**; white Detroiters: **78.2%**; national average: **77.6%**

76.9 Number per 1,000 Michigan Medicare beneficiaries discharged from hospitals whose condition could have been treated on an outpatient basis; black Detroiters' rate: **115.5**; white Detroiters: **82.**8; national average: **78.3** (2003-2005)

Source: "Disparities in Health and Health Care among Medicare Beneficiaries: A Brief Report of the Dartmouth Atlas Project" www.rwjf.org/qualityequality.

[4] Chen May Yee, "Medicare tightening the screws on medical mistakes," *Star Tribune*, 8/22/2007.
[5] Caroline Brill, "Physician Partnership in Reducing CMS Hospital-Acquired Preventable Conditions," *RiskR*x, Vol. 6, Spring 2008.
[6] Jay Greene, "Billed for wrong surgery? Hospitals revise policy," *Crain's Detroit Business*, 5/26-6/1, 2008.

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The Detroit health council will use the grant to expand its Web-based system that provides public information on how area hospitals and doctor groups fare on key health measurements. More information is available at www.SaveLivesSaveDollars.org.

The Grand Rapids council's grant will fund regional discussions to improve hospital outcomes for patients undergoing heart surgery or who have congestive heart failure. Details of the current campaign are at www.afh.org.

For more information on the RWJF initiative, go to www.rwjf.org.

We want to hear from you—suggestions for improvements and topics, questions, even encouragement!
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The Health Care Happenings...

In Michigan…

National Institutes of Health (NIH) grants to states, usually to universities, medical schools and other research institutions, result not only in biomedical research that improves health in the United States and around the world, but also provides economic stimulus to the related communities. In 2007, Michigan received about $578 million in research grants and contracts from NIH. These grants provide well-paying jobs in Michigan while advancing progress in health care issues. The estimated number of new jobs related to the grant totals nearly 8,700 with average wages of nearly $54,000.

Source: Families USA's Global Health Initiative and *In Your Own Backyard*, June 2008 available at http://www.familiesusa.org/assets/pdfs/global-health/in-your-own-backyard.pdf.

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