



HCCA Quality of Care Compliance Conference

October 13, 2009

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 to receive the full annual update to their OPFS 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 OPFS 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.

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

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

Era of increasing governance accountability

- 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!



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