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Never Events & POAs: Changing Reimbursement Changes IT's Value

EXECUTIVE SUMMARY

When October arrives in all its fall glory, CMS will crown that event with a list of its own for which it will deny payment to your hospital. These "Never Events" are occurrences that should never happen to patients in the first place, like wrong-site surgery or an object left in a patient after surgery, ones that can kill or injure a patient. These conditions overlap with another list of serious, reportable hospital-acquired conditions (HACs)—announced last October—for which CMS also denies reimbursement if not documented as "present on admission" (POA):

1. Foreign Object Retained After Surgery*
2. Air Embolism*
3. Blood Incompatibility*
4. Stage III and IV Pressure Ulcers*
5. Falls and Trauma, resulting in:
   a. Fractures
   b. Dislocations
   c. Intracranial Injuries
   d. Crushing Injuries
   e. Burns*
6. Catheter-Associated Urinary Tract Infection (UTI)
7. Vascular Catheter-Associate Infection
8. Surgical Site Infection-Mediastinitis after Coronary Artery Bypass Graft (CABG)

*Also considered Never Events.

An April 14, 2008 CMS Fact Sheet that correlates the 28 NQF-defined Never Events and the eight HACs above is available at www.cms.hhs.gov/apps/media/fact_sheets.asp.

As important as it is for hospitals to prevent Never Events and HACs, the real story is the bigger one of changing reimbursement. Spurred by CMS, as an industry we're taking the first steps in knocking down the perverse incentive system that has long blocked so much technology-enabled reform in healthcare process and treatment. The IT value equation is becoming much more explicit as a result of this refusal by healthcare's largest payer to pay for concrete examples of poor quality. Quality is not only the right thing to do but the financially smart thing to do. There's money on the table. Healthcare organizations that use IT sharply and wisely will be better positioned to get their share.

Fixing the machine

Jerry Osheroff, MD, chief clinical informatics officer at Thomson Reuters and author of several books on improving outcomes using clinical decision support, says we need to view Never Events and the issue of changing reimbursement in a larger context. [More information about guidebooks on improving outcomes with CDS can be found at www.himss.org/cdsguide.] "For many years, health-

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care been driven by the model that smart, dedicated, well-trained people work hard to try to help patients. It is a machine that produces a product, and previously it was assumed that the good people were producing good products. When the horrifying extent of medical errors invaded the public consciousness, through efforts of IOM and others, great attention turned to what's wrong with the machine, and why it produces so many defects. There are many powerful forces now trying to reconfigure the machine so it can reliably produce good products—safe, high quality, efficient patient care."

THOMSON REUTERS

Jerry Osheroff, MD, Chief Clinical Informatics Officer, Thomson Reuters, Cherry Hill, NJ

As the industry grapples with the details of repairing this machine, Never Events represent those "products" we never want to see come out of it. "This re-engineering is complex, hard and expensive, involving HIT, culture changes, new process and workflows and the like," he says, adding that an important component of many performance-improvement solutions is CDS, ideally delivered according to the "CDS Five Rights":

1. the ***right information***: evidence-based, suitable to guide action, pertinent to the circumstance...
2. to the ***right person***: clinicians and patients...
3. in the ***right CDS intervention format***: alert, order set, answer...
4. through the ***right channel***: CIS/EHR/PHR, internet, mobile...
5. at the ***right point in workflow***, for example, at time of decision/action/need...

These help ensure that information delivery improves decisions and reduces errors. However, CDS and other IT-enabled tools are not a panacea for preventing events that shouldn't occur nor are they sufficient in and of themselves to ensure payment in this new era of reimbursement.

"CMIOs probably wouldn't use IT for preventing operating on the wrong side of a patient. Nonetheless, the CDS Five Rights model could include using a magic marker to identify the right leg to operate on," says Osheroff. Many would consider calling this CDS a stretch, but there's a fuzzy line, he says, between CDS, HIT and other performance-improvement approaches.

"The point is that it's going to take lots of different kinds of reengineering to fix our healthcare machine. CDS is an important tool in the toolkit. With clearer improvement goals emerging from national consensus and drivers, the focus for IT and CDS efforts is becoming very concrete and specific," says Osheroff.

Texas Health Resources

"Although there is overlap, there's an important distinction between CMS Never Events and preventable medical errors for which health providers will not receive reimbursement," says Ferdinand Velasco, MD, CMIO, Arlington, Texas-based Texas Health Resources (THR).

A few on the official list of 28 Never Events promulgated by the National Quality Forum (NQF) also fall into the Joint

Texas Health Resources

Ferdinand Velasco, MD, CMIO, Texas Health Resources, Arlington, Texas

Commission's list of Sentinel Events. Never Events are egregious things such as leaving a surgical instrument in a patient's belly, a patient dying in a hospital for an uncomplicated ankle injury or a new mother going home with the wrong baby. "These are clearly serious issues. For the most part, however, there's not a significant IT component because they're process-based. There's confusion in the healthcare trade press between Never Events and preventable errors that involve Present on Admission (POA) documentation," he says.

Effective October 1 of this year, CMS will not pay for incremental reimbursement due solely to the complication. These are not necessarily "Never Events." Some of these, such as infections related to urinary catheter use, are not totally preventable.

Some Never Events also fall into the category of non-refundable errors. Air embolisms—air introduced into the blood stream—although rare, are an example of a Never Event that overlaps with POA conditions. There are eight POA conditions in 2008; three more will be added in 2009. "In the past we got to bill for a patient's return to the OR to remove an object left during surgery, a mistake that should never happen," says Velasco.

The first task is to document pre-existing conditions because failure to do so could result in reduced reimbursement from CMS. IT can help by prompting the physician to document any comorbidities present at the time of admission. CMS requires that this documentation be performed by physicians but currently does not place a time limit on when this must happen. This means that, on the second or third day of a patient's hospitalization, the doctor can still indicate on the patient's record that a urinary infection was, in fact, present on admission. "We're working on a mechanism to query physicians when a non-reimbursed condition is documented to clarify if it was present on admission," says Velasco.

A second way IT can help is to identify patients at risk for a preventable error that can be acquired during hospitalization. "How can we prompt the care team that the patient is at risk for falling? Prior to 2008, we actually got reimbursed for hospital-acquired trauma like a patient falling out of bed. Now we're not going to be paid for that," he says. As a result, THR has built the Hendricks Falls Risk Assessment tool into its nursing documentation system. "Using Hendricks, we can identify patients at risk that may need additional assistance. If you're at a high enough category of risk, for example, perhaps you need a companion to help you get to the restroom," says Velasco.

For pressure ulcers, THR has embedded the Braden Risk Assessment into nursing documentation to identify patients with decreased mobility and other risk factors for skin breakdown. That may trigger provision of a special mattress or ensure that the patient is turned regularly.

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September 22
Ultrasound Technology: Benefits and Impact at the Seton Family of Hospitals
- Robert Petty, Dell Healthcare Practice Executive, Seton Family of Hospitals, Austin, Texas
- Jeff Falwell, Dell Project Manager, Seton Family of Hospitals, Austin, Texas

September 23
Cincinnati Children's Clinical Research Data Warehouse (I2B2)
- Keith Marsolo, director, Research Data Warehouse and Instructor, Pediatrics, Cincinnati Children's Hospital Medical Center

October 1
Clinical Browser Delivers Value at Daughters of Charity Health System
- Dick Hutsell, VP and CIO, Daughters of Charity Health System, Los Altos, Calif.

October 2
Clinical System Benefit Requirements: A Practical Tool for Benefits-Driven System Implementation
- Doug Thompson, director, Navigant Consulting, Chicago

October 7
Business Intelligence Strategy and Approach
- Bruce Johnson, managing director, Data Architecture Strategy and Governance, Recombinant Data Corporation, Minneapolis

more events on next page

THR is exploring how to use clinical business intelligence to monitor its whole population of patients and to intervene to prevent potential complications. "Using analytics, we can identify which subset of our patients has had an indwelling urinary catheter for over three days and prompt the care team to consider whether the catheter is still needed given the increased risk of acquiring a urinary tract infection," says Velasco.

Velasco says that IT can help tailor clinical interventions in a patient-specific manner. By stratifying patients according to their risk of developing a complication, clinical decision support can be used to recommend appropriate preventative measures. "Since some of these are costly and have their own potential side effects, there is also a danger with over-treating patients," he says. "Unfortunately, overtreatment is a possible unintended consequence of the new reimbursement strategy. Errors of commission are as problematic as errors of omission."

Geisinger Health System's contract strategy with health plans—the organization guarantees complications-free cardiac surgery or Geisinger will pay the difference—is an example how delivery systems can turn the new era of reimbursement to their advantage, Velasco says. "They're taking a more proactive approach. They're using it strategically to negotiate better deals with plans to get referrals and they back it up with IT-enabled quality care."

New York Presbyterian

"The primary focus is federal," says Brian Regan, PhD, Director of Clinical Affairs at New York Presbyterian Healthcare System, referring to the changing reimbursement landscape. He also cited efforts of individual states and managed care organizations to limit reimbursement for hospital-acquired conditions.

NewYork-Presbyterian
The University Hospital of Columbia and Cornell

Brian Regan, PhD, Director of Clinical Affairs, New York Presbyterian

One key strategy for hospitals is to ensure that every condition that is present on admission is documented as such by a physician. The second step is to ensure the medical records coders are properly identifying conditions that are POA. The State of New York has required POA indicators for the past eight years. "In a sense, we're fortunate, because our coders have experience in determining whether each secondary diagnosis was 'present on admission' or developed in the hospital. However, physicians are not always so attentive." Regan says, for example, that in most hospitals nursing staff perform a skin assessment as part of the intake assessment. Nursing may document that a patient's pressure ulcers were present on admission, but unless the physician documents the condition, coders cannot code it that way.

"For quality improvement as well as reimbursement, we need to differentiate between comorbidities that are present on admission and complications that develop in the hospital. This is particularly true because comorbidities are often used for risk-adjustment purposes when calculating expected values for mortality, LOS and cost. So, the EHR can function as an

electronic flag for the physician to take note of it and document it," he says.

A second level of IT involvement can occur after a case is discharged, by building a feedback loop to monitor the incidence of conditions that are reported as "developed in hospital." Regan notes, "That's not just for reimbursement but for public reporting. Reputation is so important. We don't want to have negative report cards, especially if they're not true." Such retrospective data can tell you how many cases are POA and how many occurred after admission.

IT can also be used to validate a charge before final billing. "This is coded, but let's take a second look at it. You're about to drop a bill. It would flag that you double-check that you've indeed properly coded the conditions that were identified as hospital acquired. I don't think anybody's doing that. We develop monthly reports here at the close of each month and do some follow-up as a learning feedback loop but the best approach is to do concurrent case review," he says.

A third level of IT-enabled improvement could come from identifying patients at-risk for ulcers. "When you're looking at a patient who comes in with clear skin, what's your practice to prevent ulcers from occurring? You can identify high-risk patients such as the elderly and others through lab tests such as pre-calcitonin predictors. There are ways to build treatment protocols into the system to avoid these hospital-acquired conditions. Of course, there's a category of patients at risk no matter what you do, especially with pressure ulcers, which comes under the category of organ failure involving skin as the body's largest organ," says Regan.

Finally, IT can be used to identify secondary diagnoses upon admission. For example, if a patient comes in with a heart attack, IT can help identify and document secondary diagnoses like diabetes and high blood pressure. "As long as you have one other condition or comorbidity the reimbursement rate may be higher, even after the suppression of the complication code," he says.

For example, a patient who comes into the hospital with a heart attack without any comorbidities might accrue a flat charge of $8,000. With a complication—whether it's two or 20—that rate could jump to $10,000. "The heart-attack patient most likely has other complications," says Regan, and that makes it critical to document them at the point of admission. "Your doctors are going to want an IT structure in terms of documenting these multiple comorbidities," he says.

"This is part of the reason IT is so important. Some of these like urinary-tract infections are not preventable. You may be coming from a nursing home where the catheter has gotten infected and two days later you get hospitalized for a broken arm. The infection may take two days to appear. This is how complicated it gets. That's why IT is so critical," says Regan.

Norton

For some CEOs, new reimbursement factors such as Never Events and clinical documentation requirements are merely the next chapter in the quest for quality and safety. "We've had a real head-start on so-called Never Events," says Kevin Wardell, President of Norton Hospital in Louisville, Ky. "We're looking at the best ways we can address Never Events, either through previously established mechanisms or new ones," he says.

Upcoming Events continued

October 9
Building Business Analytics from Healthcare IT Systems
- Anthony J. Senagore, MD, MS, MBA, VP, Research and Education, Spectrum Health, Grand Rapids, Mich. and Professor of Surgery, Michigan State University/CHM,
- Scott Bauman, director, Enterprise Business Intelligence, Spectrum Health, Grand Rapids, Mich.

October 16
Closed-Loop Processes to Facilitate Transparency and Enhance Patient Safety
- Donna Willeumier, administrator, Safety and Regulatory Compliance, Advocate Health Care, Oak Brook, Ill.
- Kate Kovich, director, Patient Safety and Regulatory Compliance, Advocate Health Care, Oak Brook, Ill.

October 22
The Legal EHR: Definitions and Beyond
- Barry S. Herrin, FACHE, Smith Moore Leatherwood, LLP, Atlanta

October 23
Making Inroads with Speech Recognition
- Ben Brown, research director, KLAS Enterprises, Orem, Utah

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Norton has been working on a number of areas, including initiatives to reduce glucose levels in pre-operative and post-operative patients with excessive glucose levels. Norton uses IT to achieve this in the OR and ICU, by incorporating dosing calculators in its systems. Some of these ideas and approaches came directly from front-line clinical staff.

NORTON HEALTHCARE

Kevin Wardell, CEO, Norton Hospital, Louisville, KY

Norton is comparing Never Events to NQF and CMS indicators for avoidable outcomes such as central-line infections and falls. "These are steps everyone is taking," says Wardell. The Joint Commission's National Safety Goals directly contribute to reducing Never Events through such techniques as time-outs, hourly rounding and inter-rated reliability monitoring.

"We've been working on a number of areas," he says, including initiatives to reduce glucose levels in pre-operative and post-operative patients with excessive glucose levels. Norton uses IT to achieve this in the OR and ICU, by incorporating dosing calculators in its systems. Some of these ideas and approaches came directly from frontline clinical staff. Norton just invested several million dollars in new "smart" IV pumps that incorporate drug dictionaries, dose calculation and wireless capability that will soon plug into the EHR. The IV pump initiative has required a significant educational and training effort (four hours for every nurse in the hospital); however, the patient safety advantages are compelling and support desirable outcomes for the patient.

Medication reconciliation is a particularly tough nut to crack. "Somehow our IT systems must better support the process for physicians and staff, but today it's difficult and time-consuming," acknowledges Wardell. The next upgrade to the clinical documentation system will incorporate "hard stops" that will force the bedside nurse to chart within predetermined fields prior to being able to continue charting on that patient. Additional upgrades such as a dictionary formulary will improve accuracy of the medication reconciliation process at the time the patient is admitted and discharged.

Norton's IS department has collaboratively applied business intelligence approaches to clinical and operational improvements with nursing, respiratory care and anesthesia. The team developed and implemented a screening assessment tool within the clinical documentation system that identifies patients at risk for post-operative sleep apnea. The assessment is completed in a pre-admission testing area. "There are a lot of indications that if sleep apnea goes unrecognized it can cause complications during and/or after surgery, even sudden death," says Wardell. Again, a pop-up screen appears on the computer display and tells the nurse there needs to be an assessment before being able to complete documentation in the EHR.

"Another real obvious way we use IT is in our clinical data repository. We call them 'data-driven patient-care improvements.' The data measures the success of individual process changes that are intended to reduce Never Events and infection rates. We use data drawn directly from the EHR. Now we can get real granular data, especially around 'Core Measure bundles.' The bundle(s) can combine up to eight or nine individual clinical indicators.

All indicators within the bundle must be met or the entire bundle fails. Instead of looking at each individually and trying to improve one indicator within the bundle to 89 percent and another indicator to 90 percent, the bundled strategy asks what percent of patients we got 100 percent right. It demands perfection. It's a different perspective on the same data," says Wardell.

Conclusion

THR's Velasco says Never Events are just a piece of the larger question of changing reimbursement—and that eliminating hospital-acquired complications due to preventable errors has much greater financial impact on a hospital. "The significant dollars are with the POA condition, not Never Events, which are much rarer."

In some ways it's the simple logic of marketplace capitalism finally being applied to healthcare. Says Velasco: "When I buy a new car, any repairs from defects in the manufacturing process are covered by the warranty. In contrast, with healthcare, we were historically reimbursed for complications resulting from errors. There were incentives such as hospital reputation and, of course, quality of care but no financial incentives for reducing error rates. Now there are."

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