



**American Hospital  
Association**

**Serious Adverse Events and  
Payment**

**Nancy Foster**

# Serious Events - What Are They?

## National Quality Forum definition of serious events:

- **Clearly identifiable**
- **Adverse**
- **Indicative of a problem in an organization's safety systems**
- **Important for public credibility or accountability**



# To Err IS Human



# Background

- **Hospitals work hard to ensure safe, high quality care every day**
- **Still, sometimes preventable errors do occur and patients are harmed**
- **What is our obligation to the patient?**
  - **Openly disclose what happened**
  - **Understand sources of error and opportunities to prevent future occurrences**
  - **Care for the patient, family, and staff involved**
  - **Make appropriate financial accommodations**
- **Recently, insurers, employers, and others have focused on payments when these rare, but serious events occur**



# The Changing Scene

## Prior to Payer Action

- **Many hospitals have policies to make adjustments to bills on a case by case basis**
- **But policies may not widely be known**
- **Policies not consistent across hospitals**



# The National Quality Forum's 28 Events that Should Be Reported for Accountability

## **Surgical**

- **Surgery on wrong body part**
- **Surgery on wrong patient**
- **Wrong surgical procedure**
- **Retained foreign object**
- **Intraoperative or immediate post op death in ASA Class 1 patient**

## **Product or Device**

- **Death or disability with contaminated drugs or devices**
- **Death or disability with device used as other than intended**
- **Intravascular air embolism**



# The National Quality Forum's 28 Events that Should Be Reported for Accountability

## Patient Protection

- Infant discharged to wrong patient
- Death or disability with patient elopement
- Suicide or attempted suicide in a health care facility

## Care Management

- Death or disability with medication errors
- Death or disability with blood incompatibility
- Maternal death or disability in low risk pregnancy

- Death or disability with hypoglycemia
- Death or disability with hyperbilirubinemia
- Stage 3 or 4 pressure ulcers occurring in a health care facility
- Death or disability with spinal manipulative therapy
- Artificial insemination with the wrong sperm or egg



# The National Quality Forum's 28 Events that Should Be Reported for Accountability

## Environmental Events

- Death or disability with electric shock
- Line with gas for patient contains wrong gas or is contaminated
- Death or disability with a burn occurring in a facility
- Death or disability from fall
- Death or disability with restraints

## Criminal Events

- Impersonating a physician
- Abduction of a patient
- Sexual assault on a patient
- Death or disability from an assault on hospital campus



**PRIVATE  
PARKING**  
UNAUTHORIZED  
VEHICLES WILL BE  
WORKED OVER WITH  
A SLEDGEHAMMER,  
FLIPPED OVER BY  
AN ANGRY MOB,  
SET ON FIRE, AND  
SPRAY PAINTED  
WITH RUDE SLOGANS  
IMMEDIATELY AFTER  
BEING USED AS A  
GETAWAY CAR IN AN  
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## Payers Take the Lead



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# Conditions for Which CMS Will Not Pay More in FY 2009

1. Catheter-associated UTI
2. Pressure ulcers
3. Object left in during surgery
4. Air embolism
5. Blood incompatibility
6. Selected surgical infections
7. Hospital acquired injuries
8. Vascular catheter associated infections
9. Blood glucose levels in certain surgical patients
10. Deep vein thrombosis/ pulmonary embolism

**MORE MAY BE ADDED NEXT YEAR**



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# AHA Adopted Principles

- **Must be preventable**
- **Must have occurred within the control of the hospital**
- **Must be the result of a mistake in care**
- **Must result in significant harm**
- **Must be clearly defined**





# Payers Should Proceed With Caution



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# Recommended Hospital Actions

- **Review AHA Policies with leadership team and Board**
- **Review existing hospital policies and practices against AHA Principles to identify areas for potential change**
- **Identify list of cases to which policies will apply**
- **Review list and potential changes with leadership team and Board**
- **Implement any needed policy and practice changes**
- **Track adherence to policies if a serious adverse event occurs and evaluate hospital's response**



# In The End...

- For **hospitals**, it is about doing the right thing for our patients
- For **patients**, it is about getting care right and being respected
- For **payers** ....



not



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**Thank You!**

**Nancy Foster**

**Vice President for Quality and Patient  
Safety Policy**

**[nfoster@aha.org](mailto:nfoster@aha.org)**



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