OIG Finds 22% of Medicare Beneficiaries in Skilled Nursing Facilities Experienced Adverse Events

Alan C. Horowitz

According to the U.S. Department of Health and Human Services' Office of Inspector General (OIG), 22% of Medicare beneficiaries in skilled nursing facilities (SNF) experienced adverse events. In its February 2014 report, *Adverse Events in Skilled Nursing Facilities: National Incidence Among Medicare Beneficiaries*, OIG defines "adverse events" as "harm to a patient as a result of medical care."[1] Apart from the 22% of Medicare residents who experienced adverse events, an additional 11% were exposed to temporary harm, resulting in a cost of $208 million for one month. OIG estimated that the hospital-related cost from resident harm in fiscal year 2011 was $2.8 billion. When physician reviewers analyzed both adverse events and temporary harm events, they found that 59% of those events were either clearly or likely preventable.

The study included Medicare beneficiaries who were admitted to a SNF within one day of discharge from a hospital and had a length of stay of 35 days or less for the period ending in August 2011. OIG estimated the national incidence of SNF resident harm based on its review of 653 beneficiaries who met the above criteria without taking into account whether the harm was preventable. The medical record review was a two-stage process with the first stage performed by a nurse practitioner and four nurses. Each record was reviewed by one of the OIG-trained nurse screeners. A total of 262 beneficiaries were "flagged" for additional screening. The second stage was conducted by five physicians who independently reviewed the 262 medical records as well as a control cohort.

Levels and Categories of Harm

OIG divided the adverse events into four levels of harm, those that resulted in: 1) a prolonged SNF stay or transfer to a hospital; 2) permanent harm; 3) harm requiring life-sustaining intervention; and 4) death. The majority of adverse events (79%) resulted in an extended SNF stay or transfer to a hospital. The remainder required life-sustaining interventions to save a resident's life (14%) or contributed to a resident's death (6%).

The study categorized the adverse events into three broad areas: 1) events related to medication (37%), events related to resident care (37%) and those events related to infections (26%). OIG noted that while some events, such as pressure ulcers and hypoglycemia have been a known concern of post-acute caregivers, others such as gastrointestinal bleeding caused by anticoagulant overdose were not typically associated with nursing homes. Half of the fall-related adverse events were associated with medications where the primary cause of the fall was delirium or hallucinations caused by medications such as psychotropic drugs. The other half of the fall events was associated with what the OIG termed as "inadequate resident care."

OIG Recommendations

OIG recommends that the Agency for Healthcare Research and Quality (AHRQ) and the Centers for Medicare and Medicaid Services (CMS) coordinate their efforts to reduce harm to residents by methods similar to those used to promote hospital safety. Specifically, AHRQ and CMS should

1 *Adverse Events in Skilled Nursing Facilities: National Incidence Among Medicare Beneficiaries*, HHS Office of the Inspector General, OEI-06-11-00370 February 2014. Available at: http://oig.hhs.gov/oei/reports/oei-06-11-00370.pdf. Last accessed March 6, 2014.

create and promote a list of potentially reportable events for nursing homes, while emphasizing that additional reporting of such events is not required. Additionally, OIG noted that the Affordable Care Act requires nursing facilities to develop Quality Assurance Performance Improvement (QAPI) programs that address quality of care concerns. CMS is currently in the rulemaking process regarding the requirement that facilities have a QAPI program. Further guidance from CMS regarding QAPI will be forthcoming in 2014 and OIG recommends that it include the following: a definition of "adverse events," a list of potential adverse events, strategies for detecting and measuring adverse events as well as "best practices" for reporting and enhancing awareness of adverse events.

Two other recommendations seem to be on a collision course. On the one hand, OIG recommends that AHRQ and CMS encourage nursing homes to report adverse events to Patient Safety Organizations (PSO). Pursuant to the Patient Safety and Quality Improvement Act of 2005, healthcare organizations that voluntarily report adverse events, considered "patient safety work product," are afforded confidentiality. Material disclosed to a PSO is not discoverable in civil lawsuits. On the other hand, OIG recommends that CMS instruct surveyors to examine evidence that a facility identified and reduced adverse events.

CMS' official response highlights what it sees as the "challenges" involved with utilizing the PSO framework. CMS notes that it has encountered situations where facilities claimed they could not demonstrate compliance with Medicare's Conditions of Participation without disclosing information believed to be protected because it was submitted to a PSO. CMS claims it would be "impossible" to assess a facility's adverse event identification and reduction process if it could not examine a facility's internal incident reporting system. It remains to be seen how the recommendations regarding voluntarily reporting adverse events to PSOs is harmonized with CMS' requirements regarding a facility's quality assurance committee and certain mandatory reporting and investigation requirements. Regardless, providers should expect to see heightened scrutiny by surveyors concerning their QAPI activities related to identifying and reducing adverse events.

Comments from LeadingAge highlight the two possibly inconsistent recommendations by the OIG. Dr. Cheryl Phillips, senior vice president of public policy and advocacy agreed with "the OIG's recommendations to develop Patient Safety Organizations, where tracking safety-related events can occur without the hammer of punishment and citations."[2] However, Dr. Phillips "disagree[d] with the report that looks to surveyors to 'reduce adverse events,'" noting that, "We have yet to see evidence that a punitive oversight process, that is built on fines and punishment, is a driver of excellence and safety."[3]

Additional Recommendations

The OIG report underscores a significant concern for long term care providers. Many organizations committed to improving the quality of care in nursing homes have undertaken major initiatives and provide valuable resources for providers. For example, the Society for Post-Acute and Long-Term Care Medicine (AMDA) provides a host of resources targeting resident safety. "AMDA promotes the quality of care residents receive by providing education, advocacy, professional development, clinical practice guidelines, partnerships with national initiatives and the credentialing of medical directors as Certified Medical Directs (CMD). Our goal is to promote quality person-centered care in a compassionate manner that optimizes outcomes," according to Daniel Haimowitz, MD, FACP, CMD, a member of the AMDA Board of Directors.[4] AMDA notes that the OIG report "should serve as a springboard for a national discussion on the care of frail elders and how it can be improved." Likewise, the American Health Care Association (AHCA) supports a number of patient safety initiates and also provides a wealth of valuable tools for providers. Additionally, AHRQ provides free webinars, training and guidance in the area of improving safety in long term care facilities.[5]

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2 *Adverse Events in Skilled Nursing Facilities: LeadingAge Response to OIG Report*, February 27, 2014. Available at: http://www.leadingage.org/Adverse_Events_in_Skilled_Nursing_Facilities.aspx. Last accessed on March 6, 2014.

3 *Id.*

4 Email from Daniel Haimowitz, MD, FACP, CMD (Board of Directors, AMDA) to Alan C. Horowitz (March 8, 2014) (on file with author).

5 *See e.g., Improving Patient Safety in Nursing Homes: A Resource List for Users of the AHRQ Nursing Home Survey on Patient Safety Culture*, Publication # 11-0012-1-EF, Available at: http://www.ahrq.gov/professionals/quality-patient-safety/patientsafetyculture/nursing-home/resources/nhimpptsaf.html. Last accessed on March 6, 2014.

Providers should consider voluntarily reporting adverse events to a PSO in addition to the mandatory reporting requirements of CMS. (Not all adverse events necessarily require mandatory reporting to CMS.) According to Michael Cohen, President of the Institute for Safe Medication Practices (ISMP), which is a PSO, "Confidential voluntary reporting to a PSO is an effective tool that helps determine the causes of adverse events and reduces their frequency."[6]

"The recommendations in this [OIG] report can help us strengthen our efforts to reduce adverse events and continue to improve patient safety," according to David Gifford, MD, senior vice president for quality at AHCA.[7] As the OIG report illustrates and industry leaders agree, the need exists to further promote a "culture of safety" and a redoubling of efforts aimed at reducing preventable adverse events.

6 Email from Michael Cohen, (President, ISMP) to Alan C. Horowitz (March 7, 2014) (on file with author).

7 *Inspector General Finds Nearly One-Third of Rehab Patients Suffer Adverse Events*, Provider Long Term & Post Acute Care, March 3, 2014. Available at: http://www.providermagazine.com/news/Pages/0314/Inspector-General-Finds-Nearly-One-Third-of-Rehab-Patients-Suffer-%E2%80%9CAdverse-Events%E2%80%9D.aspx. Last accessed on March 7, 2014.

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