

Subject: Hospital Acquired Conditions Page 1 of 6

Objective:

- I. To facilitate safe patient care for all Tuality Health Alliance (THA) members.
- II. To encourage and support providers' efforts to develop risk reduction strategies and action plans which include measurement of the effectiveness of processes and system improvements to reduce risk.

Definition:

Hospital Acquired Conditions (HAC) also known as "Never Events are adverse occurrences in medical care that are clearly identifiable, preventable and serious in their consequences for patients, and that indicate a real problem in the safety and credibility of health care facility.

The Oregon Association of Hospitals and Health Systems (OAHHS) are committed to delivering safe care. Accordingly, Oregon hospitals agree not to seek payment for costs associated with the occurrence of a serious adverse event if an investigation by the hospital determines that the event was preventable and was within the control of the hospital. This policy includes these serious adverse events as events that will not be considered for payment.

Policy:

- I. Identifying and reporting "Never Events" improves patient care. Hospital facilities should have policies for serious reportable events that address how they will prevent "Never Events" and how they will respond when a patient sustains a serious and likely preventable injury while being cared for in their facility.
- II. In accordance with the Oregon Administrative Rules, THA will notify health care organizations of identified potential adverse events and request information from the organizations in order to perform reviews. All findings from investigations will be shared with health care organizations in order to provide opportunities for process and system improvements.

Subject: Hospital Acquired Conditions Page 2 of 6

- III. THA will not provide payment for identified “Never Events”. Providers should not seek payment for costs associated with “Never Events”. THA will notify the provider if a “Never Event” is identified by THA.
- IV. Should the provider appeal the denial, THA would follow the THA Policy and Procedure V-10 DMAP appeals.
- V. Principles used in identifying and reporting “Never Events” for which payment may be withheld are:
 - A. The event must be preventable.
If there are practices that are effective in preventing a particular harm from occurring, and those practices could have been implemented by the hospital, the error or event would be considered preventable.
 - B. The event must be within the control of the hospital.
Errors that may have occurred in the manufacture of drugs, devices or equipment, well before the material reached a hospital’s doors, are examples of events that would be outside of the hospital’s control.
 - C. The event must be the result of a mistake made in the hospital.
These include errors in which a hospital failed to successfully carry out a practice that would have, in all probability, prevented harm to the patient.
 - D. The event results in serious/significant harm.
The facility policies for identifying preventable adverse events should be limited to those events that yield very serious results.
 - E. The event must be clearly and precisely defined in advance.
A great level of specificity is required to identify events that could result in a hospital foregoing payment.
- VI. THA case management staff will conduct reviews of all identified occurrences of potential “Never Events” based on Centers for Medicare and Medicaid Services and Oregon Associations of Hospitals and Health Systems No Pay lists.
- VII. All findings will be shared with the health care organization or provider where the potential “Never Event” occurred.

Subject: Hospital Acquired Conditions Page 3 of 6

- VIII. The following is a list of events that are considered “Never Events.” These events are clearly identifiable and measurable and are of a nature such that the risk of occurrence is significantly influenced by the policies and procedures of healthcare organizations.
- IX. CMS No Pay Conditions
- A. Foreign object retained after surgery.
 - B. Air embolism.
 - C. Blood incompatibility.
 - D. Pressure ulcers, Stage 3 and 4 unless documented as present on admission.
 - E. Falls and trauma – fractures, dislocations, intracranial injuries, crushing injuries, burns, and electric shock.
 - F. Catheter associated urinary tract infections- unless documented as present on admission.
 - G. Vascular catheter – associated infections.
 - H. Surgical site infection-within 30 days
 - 1. Mediastinitis after CABG
 - 2. Bariatric Surgery complications
 - a. Laparoscopic Gastric Bypass
 - b. Gastroenterostomy
 - c. Laparoscopic Gastric Restrictive Surgery
 - 3. Orthopedic Procedures
 - a. Spine
 - b. Neck
 - c. Shoulder
 - d. Elbow
 - I. Manifestations of poor glycemic control such as
 - 1. Diabetic ketoacidosis
 - 2. Nonketotic Hyperosmolar Coma
 - 3. Hypoglycemic coma
 - 4. Secondary diabetes with ketoacidosis
 - 5. Secondary diabetes with hyperosmolarity

Subject: Hospital Acquired Conditions Page 4 of 6

- J. Deep vein thrombosis or pulmonary embolism associated with total knee, hip replacement and resurfacing procedures.
- K. Hospital-acquired and/or post operative infections.
- X. OAHHS Guidelines for Non-payment for Serious Adverse Events.
 - A. Surgical events
 1. Surgery performed on the wrong body part
 2. Surgery performed on the wrong patient
 3. Wrong surgical procedure performed on a patient
 4. Retention of a foreign object in a patient after surgery or other procedure
 5. Intraoperative or immediately postoperative death in an American Society of Anesthesiologists) ASA class I patient. Class I means a healthy patient, no medical problems.
 - B. Product or Device Event
 1. Patient death or serious injury associated with the use of contaminated drugs, devices or biologics provided by the healthcare facility
 2. Patient death or serious injury associated with the use of a device in patient care in which the device is used or functions other than as intended or difficult to use as intended.
 3. Patient death or serious injury associated with intravascular air embolism that occurs while being cared for in a healthcare facility.
 - C. Patient Protection Events
 1. Infant discharged to the wrong person
 2. Patient death or serious injury associated with patient leaving the facility without permission
 3. Patient suicide, or attempted suicide, resulting in serious injury while being cared for in a healthcare facility.
 - D. Care Management Events
 1. Patient death or serious physical injury associated with a medication error (e.g. errors involving the wrong drug, wrong dose, wrong patient, wrong time, wrong rate, wrong preparation or wrong route of administration)

Subject: Hospital Acquired Conditions Page 5 of 6

2. Patient death or serious injury associated with a hemolytic reaction (abnormal breakdown of red blood cells) due to the administration of ABO incompatible blood or blood products
 3. Maternal death or serious injury associated with labor or delivery in a low-risk pregnancy while being cared for in a healthcare facility
 4. Patient death or serious injury associated with hypoglycemia, the onset of which occurs while the patient is being cared for in a healthcare facility
 5. Death or serious injury associated with failure to identify and treat hyperbilirubinemia (condition where there is a high amount of bilirubin in the blood) in newborns.
 6. Stage 3 or 4 pressure ulcers acquired after admission to a healthcare facility
 7. Patient death or serious injury due to spinal manipulative therapy
 8. Any perinatal death or serious physical injury unrelated to a congenital condition in an infant having a birth weight greater than 2500 grams.
- E. Environmental Events
1. Patient death or serious injury associated with an electric shock while being cared for in a healthcare facility
 2. Any incident in which a line designated for oxygen or other gas to be delivered to a patient contains the wrong gas or is contaminated by toxic substance.
 3. Patient death or serious injury associated with a burn incurred from any source while being cared for in a healthcare facility
 4. Patient death or serious injury associated with a fall while being cared for in a healthcare facility
 5. Patient death or serious injury associated with the use of restraints or bedrails while being cared for in a healthcare facility
- F. Criminal Events
1. Any instance of care ordered by or provided by someone impersonating a physician, nurse, pharmacist, or other licensed healthcare provider
 2. Abduction of a patient of any age

Subject: Hospital Acquired Conditions Page 6 of 6

3. Sexual assault on a patient within or on the grounds of a healthcare facility
4. Death or significant injury of a patient resulting from a physical assault (i.e., battery) that occurs within or on the grounds of a healthcare facility.

Reference: National Quality Forum
Oregon Association of Hospitals and Health Systems (OAHHS)
American Hospital Association
Centers for Medicare and Medicaid Services (CMS)
OAR 410-141-0200
THA Policy V-10 DMAP Appeals

Formulated: October 2009
Revised: December 2011

THA Plan Director

THA Medical Director