HHS OIG: *Adverse Events Incidence Data*

PCAST:
Opportunities to Improve Patient Safety

Sept 21, 2022

Office of Inspector General
U.S. Dept of Health and Human Services

Congressional Request

- Tax Relief and Health Care Act of 2006
  - OIG determine incidence and cost of **"never events"**
  - Spoke with 85 experts and stakeholders
- Broadened to "all cause" harm
  - Adverse events defined as harm in the provision of healthcare
  - Acts of both commission and omission, preventable or not
  - Full medical record review: (1) incidence, (2) type, (3) severity, (4) contributing factors, (5) preventability, and (6) cost

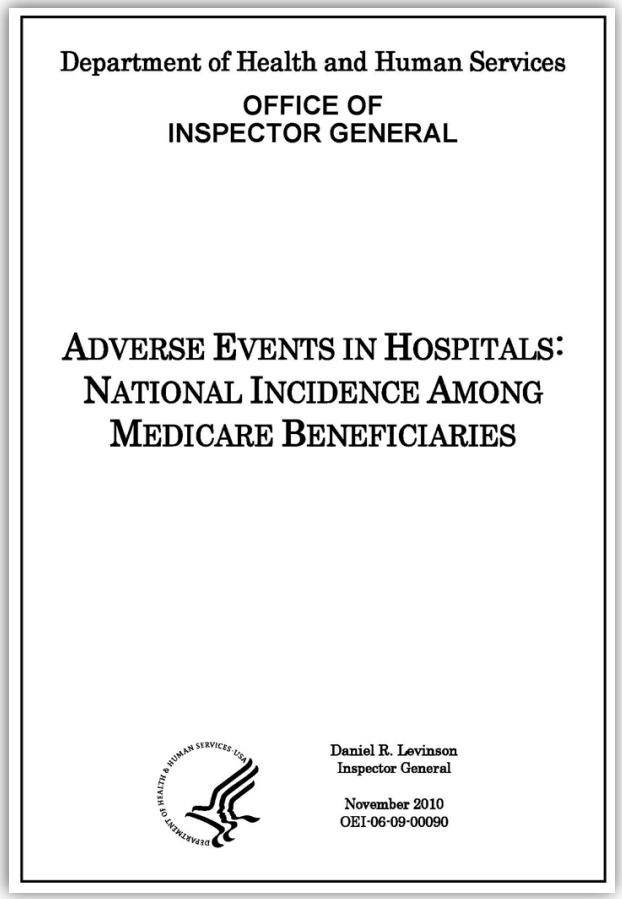
OIG Medical Record Review - *5 steps*

Steps	Method
1	Abstractors: organize the record by components
2	Nurses: ID “triggers” in the record as clues to harm
3	Physicians: conduct full review to assess harm
4	Physician panel: hold meetings for consensus
5	Medical coders: re-code claims without the event

Adverse Events in Hospitals – *Nov 2010*

Records: October 2008

- **27%** of Medicare patients harmed during their hospital stays
- **Wide range of harm** related to medication, patient care, infections, and surgery
- **267,710** estimated patients harmed
- **44%** preventable
- **14%** identified by the hospitals


Department of Health and Human Services

OFFICE OF
INSPECTOR GENERAL

ADVERSE EVENTS IN HOSPITALS:
NATIONAL INCIDENCE AMONG
MEDICARE BENEFICIARIES

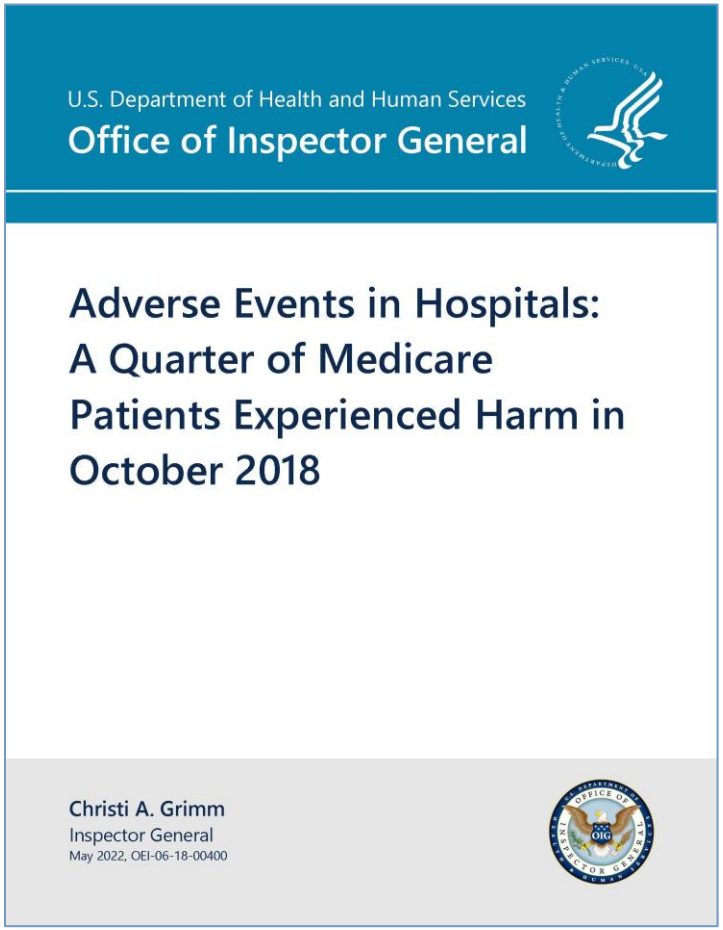
Daniel R. Levinson
Inspector General

November 2010
OEI-06-09-00090

Adverse Events in Hospitals – *May 2022*

Records: October 2018

- **25%** of Medicare patients harmed during their hospital stays
- **258,323** patients estimated harmed
- Same **wide range** of events
- **46%** preventable
- **5%** on CMS payment incentive lists



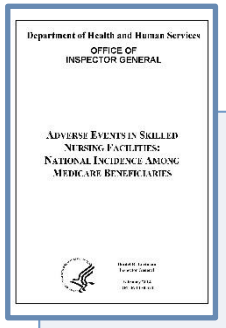
Severity of Adverse Events

Level of Harm	% of Events
F Level – prolonged care Resulted in a prolonged hospital stay, elevation in the level of care, transfer to another facility, or subsequent admission	**74%**
G Level – permanent harm Contributed to or resulted in permanent patient harm	**10%**
H Level – life-sustaining intervention Required intervention to sustain the patient's life	**7%**
I Level – contributed to death Contributed to or resulted in patient death	**10%**

Clinical Categories of Harm

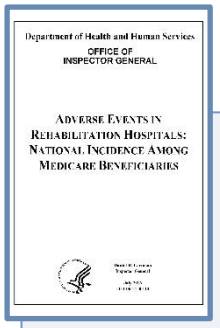
Category of Harm	% of Events
Medication Ex: Delirium, significant hypoglycemia, acute kidney injury	**43%**
Patient Care Ex: Pressure injury, fluid disorder, patient fall with injury	**23%**
Procedure or Surgery Ex: Excessive bleeding, hypotension, embolism	**22%**
Infection Ex: Respiratory, surgical site, central line infections, sepsis, *c. diff*	**11%**

Adverse Events in Post-Acute Care



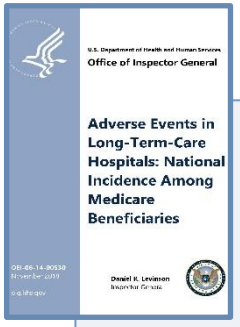
33%

Nursing Homes - *2014*



29%

Rehab Hospitals - *2016*



46%

Long-term Care Hospitals - *2018*

OIG Recommendations to CMS

#1. Event Lists: update and broaden its lists of events for payment incentives and detection

#2. Test Metrics: expand the use of patient safety metrics for payment policies and service delivery

#3. Surveyors: develop interpretive guidance to hospital surveyors in assessing compliance to track and monitor harm

OIG Recommendations to AHRQ

#1. HHS Plans: coordinate efforts to update HHS Quality Strategic Plans

#2. Surveillance: optimize use of the event surveillance system, including automating data capture

#3. Guidelines: develop effective models to disseminate national clinical practice guidelines

#4. Research: develop new strategies to prevent common harm events

Key Takeaways

Key Takeaway #1:

High rates of patient harm persist.

Key Takeaway #2:

The range of harm is much wider than what may be captured by research, oversight and tracking efforts.

Where to learn more and upcoming

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Adverse Events | HHS-OIG

UPCOMING OIG WORK

- ✓ Adverse Events Tool Kit – Dec 2022
- ✓ Nursing Home Reporting to CDC's NHSN – March 2023
- ✓ Adverse Events in Medicaid Labor and Delivery – proposal development