HHS OIG: *Adverse Events Incidence Data*

Association of Health Care Journalists *(AHCJ)*

March 10, 2023

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

HHS Operating Divisions

HHS IG – Christi Grimm

- Confirmed February 2022
- OIG Composition
  - Counsel
  - Audit
  - Investigations
  - Evaluation
- Priority Areas
  - Nursing Homes
  - Managed Care

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

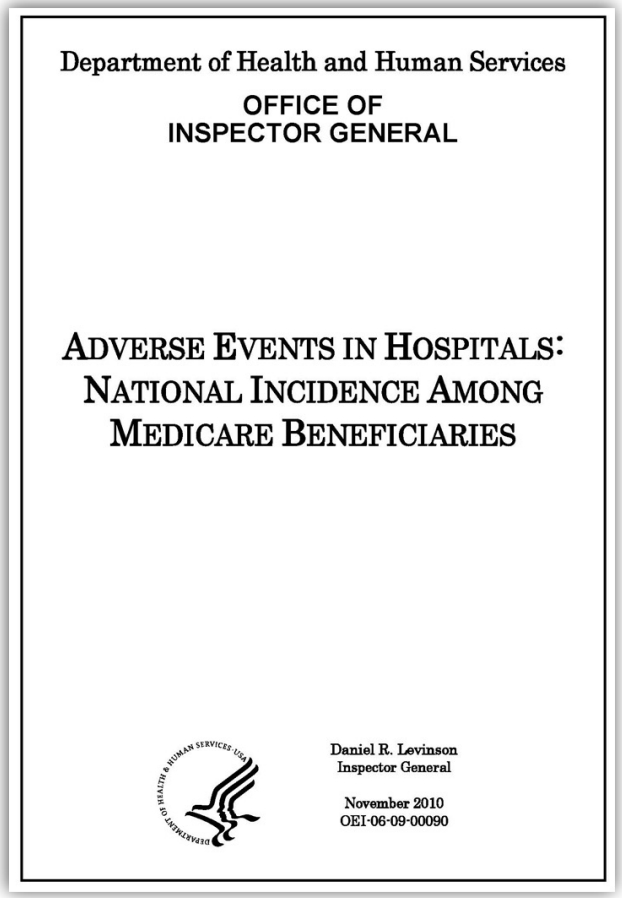
OIG Medical Record Review - *5 steps*

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

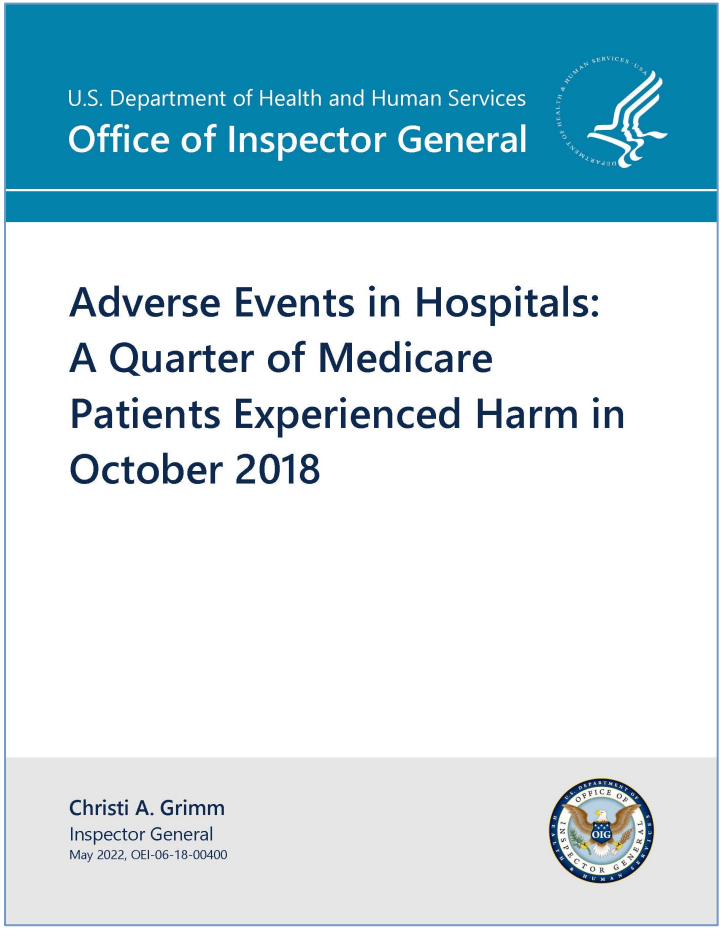
Daniel R. Levinson
Inspector General

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



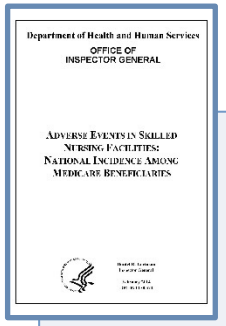
Severity of Adverse Events

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

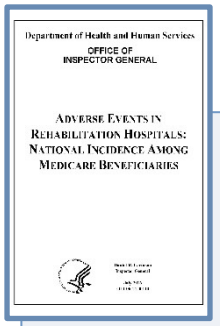
Category of Harm	% of Events
Medication Ex: Delirium, significant hypoglycemia, acute kidney injury	**43%**
Patient Care Ex: Pressure injury, fluid disorder, patient fall with injury	**23%**
Procedure or Surgery Ex: Excessive bleeding, hypotension, embolism	**22%**
Infection Ex: Respiratory, surgical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

Adverse Events in Post-Acute Care



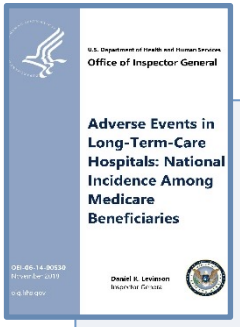
33%

Nursing Homes - *2014*



29%

Rehab Hospitals - *2016*



46%

Long-term Care Hospitals - *2018*

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.

OIG Recommendations

1. Update and broaden event lists
2. Expand the use of safety metrics
3. Develop surveyor guidance

1. Coordinate efforts across HHS
2. Optimize surveillance systems
3. Develop clinical practice guidelines
4. Research new strategies

Please reach out – *dozens of topics*

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Adverse Events | HHS-OIG

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UPCOMING OIG WORK

- ✓ Adverse Events Tool Kit and Clinical Guidance – May 2023
- ✓ Nursing Home Reporting to CDC's NHSN System – July 2023
- ✓ Harm in Medicaid Labor & Delivery – 2024