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Prompt Resolution of Patient Grievances (per CMS)

By: Marie Howatt,
Risk Consultant

In 2005 CMS (Center for Medicare and Medicaid Services) revised its Interpretive Guidelines for the Medicare Hospital Conditions of Participation (CoPs) to address the hospital requirements for a grievance process, including documentation of resolution; in 2008 CMS added requirements for the hospital-issued notice of non-coverage (HINN). The intent of the HINN was for Medicare patients to express their dissatisfaction with a premature discharge.

CMS defines a **patient grievance** as "a formal or informal written or verbal complaint that is made to the hospital by a patient, or the patient's representative, regarding the patient's care (when the complaint is not resolved at the time of the complaint by staff present), abuse or neglect, issues related to the hospital's compliance with the CMS Hospital Conditions of Participation (CoPs), or a Medicare beneficiary billing complaint related to rights and limitations provided by 42 CFR 489."

CoP Interpretive Guidelines Clarifications:

- ✔ If the complaint is not immediately resolved by staff present and requires further investigation and/or actions for resolution the complaint is considered a grievance.
- ✔ Billing issues are considered grievances if it is a Medicare beneficiary complaint related to rights and limitations as stated in its definition.
- ✔ A written complaint is always considered a grievance whether it is from inpatients, outpatients, a released/discharged patient, or from a patient's representative and pertains to the care provided to the patient, abuse or neglect, or the hospitals compliance with the CoPs.

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The hospital policies and procedures should reflect that the governing body is responsible for approval of the hospital's grievance process and oversight of its process, unless the governing body designates another source as oversight, such as a grievance committee.

- ✔ Information obtained from patient satisfaction surveys is considered a grievance if the identified patient writes or attaches a written complaint to the survey whether or not the patient requested resolution.
- ✔ Telephone complaints from the patient or patient representative are considered grievances if they are related to the patient's care or with allegations of abuse or neglect, or if the hospital fails to comply with one or more of the CoPs, or other CMS requirements.
- ✔ All complaints (written or verbal) regarding abuse, neglect, patient harm, or hospital compliance with CMS requirements are considered grievances.
- ✔ The hospital is required to inform all patients/patient's representatives of the State agency telephone number to voice complaints.
- ✔ The hospital is required to provide the patient/patient's representative with a written notice of its resolution decision and the notice should include the name of the hospital's contact person, the steps taken by the hospital on behalf of the patient to investigate the grievance, the results of the investigation, and the date of its completion.

Hospital Policy and Procedure

Hospitals should review their policies and procedures for compliance with the CMS CoPs for resolution of complaints and grievances. Staff should also be educated on the hospitals handling of complaints and grievances.

- ✔ The hospital policies and procedures should reflect that the governing body is responsible for approval of the hospital's grievance process and oversight of its process, unless the governing body designates another source as oversight, such as a grievance committee.
- ✔ The guidelines indicate that the complaint/grievance resolution process should be a part the hospital's QA/PI (Quality Assurance/Performance Improvement) program and should include review and analysis.
- ✔ The hospital's grievance policies and procedures must specify reasonable time frames for review and resolution of complaints/grievances (CMS indicates that a reasonable time frame of 7 days is appropriate).

According to CMS, a grievance is considered resolved when the patient/patient's representative is satisfied with the actions taken. CMS realizes that after the hospital has taken reasonable steps and actions to resolve the complaint/grievance, there still may be dissatisfaction expressed by the patient/patient's representative; in these situations the hospital may consider the grievance closed.

The Hospital's grievance policies and procedures must specify reasonable time frames for review and resolution of complaints/grievances.

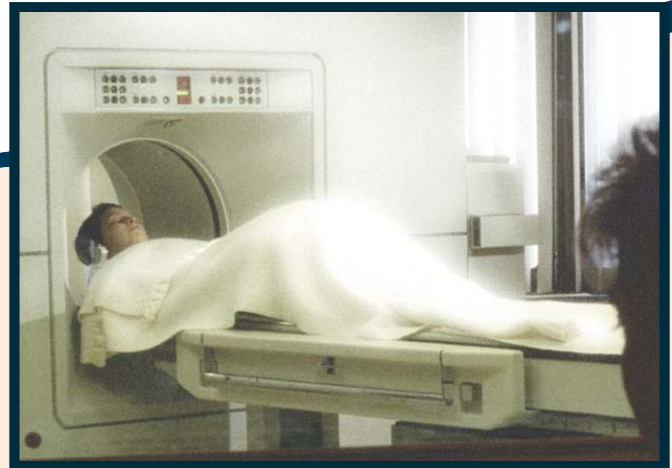
When surveyors receive a complaint from patients/patient's representatives or as a part of their survey certification process they may review the hospital's process for adherence to the interpretive guidelines and the hospital's policies and procedures.

For anyone who would like CMS guidelines referenced in this article, you can e-mail me at mhowatt@coastalins.org.

Reference: CMS Conditions of Participation (6/09) 482.13(a) (2) i-iii

HOW DO YOU COMPARE?
The new quality initiatives under PPACA

By: Daniel McBrayer and Angela Cameron of
Johnston Barton Proctor & Rose LLP



The Patient Protection and Affordable Care Act ("PPACA") implements a number of new quality initiatives for health care providers. These initiatives are intended to further one of PPACA's goals: to drive reimbursement based on quality initiatives – a move away from quantity toward quality. The bulk of these incentives are contained in Title III of PPACA, which is entitled "Improving the Quality and Efficiency of Health Care." This article will discuss several of the major quality initiatives, and what hospitals may expect in the coming years.

A. Hospital Value-Based Purchasing

The Hospital Value-Based Purchasing program extends the efforts of the Centers for Medicare & Medicaid Services ("CMS") to shift Medicare's role from a passive payer of claims to an active purchaser of care. Under the Value-Based Purchasing program, CMS will make incentive payments to hospitals that meet certain performance standards, identified by "measures" selected by the Secretary of Health and Human Services. The first set of measures, beginning in fiscal year 2013, relate to five medical conditions – acute myocardial infarction, heart failure, pneumonia, surgeries (pursuant to the Surgical Care Improvement Project) and health care associated infections. For each of these sets, a number of criteria must be met. For example, whether a patient diagnosed with an acute MI is prescribed aspirin at discharge or whether a pneumonia patient receives a pneumococcal vaccination. If a hospital does not provide services related to the "measure" then the measure will be excluded. CMS will begin these incentive payments for discharges beginning in October, 2012.

Effective 2014, the quality measures will include efficiency standards as well. Such standards will be based in part on Medicare spending per beneficiary. The efficiency measures will be adjusted based on age, sex, race, severity of illness and any other factor the Secretary deems appropriate.

CMS will score hospitals based on their "achievement threshold" (the number of criteria the hospital has met) and their "improvement threshold" (the hospital's improvement from the previous year). The hospital's score will be based on the higher of its achievement or improvement threshold, encouraging both good performance and improvement. If a hospital meets or exceeds its performance standards, then CMS will increase the hospital's DRG payments for each discharge occurring in the applicable fiscal year by a set value-based incentive payment amount.

There will be a process by which a hospital can appeal the calculation of its performance assessment with respect to performance standards and its performance score. Unfortunately, the basis upon which a hospital can appeal will be limited.

On May 6, 2011, CMS released its final rule for the administration of the Value-Based Purchasing program. See Medicare Program; Hospital Inpatient Value-Based Purchasing Program; Final Rule, 76 Fed. Reg. 26489 (May 6, 2011).

B. Payment Adjustment for Conditions Acquired in Hospital

Medicare will also begin adjusting DRG payments for certain hospital-acquired conditions. According to CMS, hospital-acquired conditions are (a) high-cost or high-volume or both, (b) result in the assignment of a case to a DRG that has a higher payment when present as a secondary diagnosis and (c) could reasonably have been

prevented through the application of evidence-based guidelines. CMS has identified 10 categories of hospital-acquired conditions:

- foreign object retained after surgery
- air embolism
- blood incompatibility
- stage III and IV pressure ulcers
- falls and trauma
- manifestations of poor glycemic control
- catheter-associated urinary tract infection
- vascular catheter-associated infection
- surgical site infection following certain surgeries
- deep vein thrombosis/pulmonary embolism.

See http://www.cms.gov/hospitalacqcond/06_hospital-acquired_conditions.asp

Beginning in fiscal year 2015, hospitals shown to be in the top quartile of facilities with hospital-acquired infections will have their DRG payments reduced by 1% for discharges occurring in the applicable fiscal year. Information related to hospital-acquired conditions will be made available to the public and included on the Hospital Compare website.

C. Data Collection and Dissemination

For a number of years, CMS has been increasing its efforts to collect data associated with all providers, from efficiency and quality measures, to public health reporting measures. As part of its role in collecting quality data, CMS has unveiled its "Quality Care Finder" website (http://www.medicare.gov/quality-care-finder/). This website will serve as a hub of information for Medicare beneficiaries who will now be able to access data regarding hospitals, nursing homes, dialysis facilities, physicians, and home health agencies.

The Quality Care Finder incorporates already existing websites such as the Nursing Home Compare and Hospital Compare. On these websites, users are able to review, in detail, the reportable quality measures that each facility has been required to report to Medicare. This includes the number of hospital-acquired conditions and other potentially negative statistics. Next to each statistic, the Compare website shows the facility's performance measured against the national and state averages.

In using the website, the consumer enters a zip code for the area of interest and can choose the type of care or condition of interest, such as surgery or medical conditions. The website then narrows the search for providers to a range for distance for the consumer's location (25 miles for instance) and then allows the consumer to select up to three hospitals to compare. The areas compared include patient satisfaction surveys, patient outcomes, process of care, and Medicare payment and volume.

Importantly for providers, the information collected and disseminated by CMS is available for review by the provider before it is published, and the hospital can submit corrections if the information is inaccurate.

From a litigation standpoint, these and other provisions of PPACA provide a wealth of quality-based evidence that hospitals will be forced to defend in court.

D. Conclusion

Though PPACA contains a large number of fragmented provisions affecting the administration of America's health care, the intention of Congress and CMS is clear: they want health care providers to focus on quality and efficiency. They also want health care consumers to have access to quality data.

While it may promote efficiency, access to data can be a detriment to providers. What happens when potential plaintiffs gain access to a data set that reveals that a hospital has had its payments reduced as a result of poor quality? From a litigation standpoint, these and other provisions of PPACA provide a wealth of quality-based evidence that hospitals will be forced to defend in court. Providers should be familiar with their quality-based performance scores and should expect such measures to be produced as evidence in litigation.

Above all, providers should focus on providing high quality care, both to increase payments and to rebut possible presumptions of poor quality care.

HWCF To Sponsor Annual Workers' Compensation Claims Seminar

By: Dawn W. Adams
Vice President, Claims

The Healthcare Workers' Compensation Fund will be hosting a complimentary one day educational seminar for our members on October 28, 2011. The seminar will be held at our offices located at 509 Oliver Road, Montgomery, Alabama. Registration for the seminar will begin at 9:00 a.m. and the program will conclude at 3:00 p.m. A buffet luncheon will also be provided for attendees.

The program will include timely topics which will be beneficial to administrators, department managers, human resource directors, employee health nurses, safety directors, risk managers, and office/business managers in your facilities. The agenda is designed to meet the following objectives:

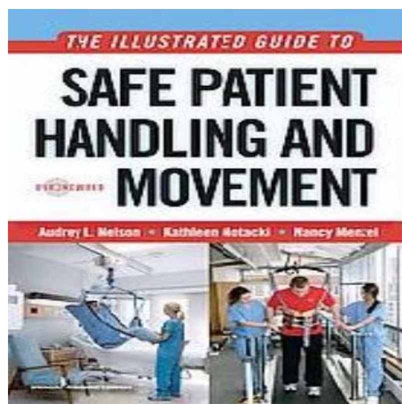
- Learn how to respond appropriately when dealing with litigation or threatened litigation claims
- Receive an update on recent workers' compensation case law
- Understand the benefits and implications of surgery vs. conservative treatment of meniscal tears
- Obtain knowledge to help improve your company's loss experience through better hiring practices

For a complete list of speakers and topics or to obtain a registration form, please visit our website, **www.hwcf.net**. Please contact Shannon Cole, ext. 4124, or Dawn Adams, ext. 4131, at 1-800-821-9605, if you have additional questions. Your attendance and participation is encouraged. We look forward to seeing you on October 28th.

Healthcare Workers' Compensation Self-Insurance Fund HWCF

Healthcare Workers' Compensation Self-Insurance Fund & Coastal Insurance present:

Safe Patient Handling – Facts, Benefits and Program Development
Wednesday, October 26, 2011
10:00 – 10:30 am CT



Join us for this free web seminar as we discuss why safe patient handling is so important to healthcare organizations and learn how you can develop your own best practice program.

Slips, Trips and Falls… Unpreventable?
Why Do They Occur And How Can We Prevent Them?

By: Jack Posey, CHSP,
Vice President-Risk Management

"the incident rate of days away from work, or lost workdays is 90% higher in healthcare organizations than in all other private industry"

The prevention of slips, trips, and falls, (STF's) in your facility should have a major place in your safety program. Not only will STF's cause personal injuries, lost workdays and potentially expensive work comp claims, they hinder your ability to provide adequate patient care. And top-notch patient care is what we all strive for.

One statistic that points to just how acute and frequent STF's are in healthcare comes from the Bureau of Labor Statistics (BLS). According to the BLS, the incident rate of days away from work, or lost workdays is 90% higher in healthcare organizations than in all other private industry.

One common myth is that STF's are most often unpreventable and that there is no pro-active approach that can be taken. **Not so!!** Start by taking a closer look at what the causes are for STF's in your facility.

Complete a walk-around at your facility looking for:

- *Wet floors*
- *Inadequate lighting*
- *Uneven walking surfaces*
- *Loose cords or medical tubing*
- *Loose handrails in stairwells*
- *Misplaced stepstools and ladders*
- *Floor mats and runners*

Now that you've seen the hazards, the remediation process can begin.

There is an excellent publication available for your use from our friends at NIOSH. This an excellent publication that will make implementing a comprehensive program aimed at preventing STF's. Get on the internet and point your browser to:

www.cdc.gov/niosh/docs/2011-123.

Slips, trips and falls may never be totally eliminated, but with a little more attention, the numbers and severity may be reduced, resulting in fewer injuries and lost workdays.

HWCF Workers Compensation Renewals

By: Rachel Bigley

As the current year winds down, preparation for the renewal year begins to make way. With this comes the renewal of workers compensation coverage. As usual procedure, renewal applications will be mailed out in early October. Please complete the application and return it to our office within 30 days from the day the application is received. This will allow enough time to process the information to better serve you.

When completing the renewal application here are some important things to remember:

Always include employee's estimated **annual** payrolls instead of hourly pay rates. Hourly pay rates are not recommended and will slow down the application process. If there are questions as to what is or is not payroll, please contact our office for assistance.

Also, if an Executive Officer is to be excluded from workers compensation coverage, this should be indicated on the renewal application and a Corporate Officer Exemption Form must be completed. Once coverage is bound, an officer cannot retroactively refuse coverage.

If you have any questions in regard to the renewal process do not hesitate to call our office. We are here for you!

We look forward to continuing our business relationship with you!

All the "To-Do" About Social Media

By: Shannon Masterson,
Square Root Interactive

Over the last decade, technology has brought a number of major changes – for better or worse – to our doorsteps. Slowly, e-mail has replaced the handwritten letter, 500 CDs worth of music can be stored on a device smaller than the palm of your hand, coupons aren't just made of paper anymore, and social media tools such as Twitter, Facebook, foursquare and Yelp, have centralized all of the information that was previously gleaned from a phone call with a family member, a chance meeting with an old friend, and or recommendations on everything from restaurants and plumbers form co-workers.

What do you want users of social media to know about your company? Is it something as simple as location and hours…

As these social tools generate increasing enrollment, the pressure on companies to respond by throwing their hats into the ring is also increasing. Many companies react hastily, creating accounts in every variety of social media, inviting their clients, competitors and the general public into each of the social circles -- all with the best of intentions. As time goes by, however, the users' conversations go unchecked, the pages are updated sporadically, and the content begins to stagnate. The key to success for any good social media endeavor – personal or private – is to have a plan.

First, determine what benefit social media would have for you and your company, and then select the social media platform that best gets your message across and engages the users that you are targeting. For example, Yelp and Foursquare, which are primarily used to share reviews and information about leisure activities, might not be the best social platforms for a hospital. Whereas LinkedIn might be a great tool for hospital activities like disseminating information about job openings. Hospitals could use Facebook to pass along information on upcoming events and classes, post press releases and announcements, and gather people with commonalities (ex. mothers of multiples, patients recovering from heart surgery) into self-selected communities for support and experience sharing. Patients and staff could also be involved in making suggestions for improvements on private, monitored forums.

The next step would be to determine responsibility. Who will be updating the site, monitoring the content and responding to the users? Without a commitment of both time and energy, companies' social media presence tends to lag. Consider rotating the responsibility between marketing and IT personnel, or develop an interdepartmental group to manage your sites.

Finally, make certain you have a clear message and some clear goals. What do you want users of social media to know about your company? Is it something as simple as location and hours… or do you want people to know about your mission statement, free classes, full website and worth within the community? Whatever it is, make sure it is easy to find and easy to understand.

Social media is an ever-growing platform filled with different tools and different users. Before creating any social media account, make sure that you've developed a plan, determined your audience and message, allocated resources and outlined some goals. With all of that in place, your interactions should be more confident, and your successes more likely!

Who will be updating the site, monitoring the content and responding to the users?

INSURANCE – 2012

By: Melvin L. Capell, CPCU, ARM, MBA
President and CEO

What is going to happen to insurance during 2012? I do not have a crystal ball and certainly am not privy to accurate knowledge of the future.

The most common topic in current insurance journals is – What is going to happen to insurance during 2012? I do not have a crystal ball and certainly am not privy to accurate knowledge of the future. However, I do read a lot of insurance journals and attend a lot of presentations. Briefly let's look at some lines of insurance business that are important to healthcare entities.

Workers' Compensation is probably the most interesting. Pricing for workers' compensation has been dropping for several years. There has been lots of availability with price competition being rampant. Consensus of the prognosticators is that pricing has bottomed out. In reporting this, they point out that the overall workers' compensation insurance industry is losing money. This is the result of inadequate premium and rising medical cost for claims. It would appear that pricing would start to rise to cover these losses. But, no one is willing to be the first to raise prices at this time. So going into 2012, prices will remain about the same as 2011. However, as 2012 progresses, the consensus is that prices will start to rise.

Medical Malpractice has not followed the same path as workers' compensation. The medical malpractice insurance industry has been competitive. But, they have used service and coverage as vehicles to compete, not pricing. Thus, medical malpractice business is still profitable for the insurance industry. The number of claims is remaining in line with the number of claims over the last few years. And, even though the cost of claims is rising it is within expected levels of increase. Looking into 2012 the prognosticators are saying that there will be sufficient availability with pricing very similar to 2011. However, one difference from workers' compensation is that pricing is not expected to rise during 2012.

Of course all of this is dependent on things remaining about the same. Several catastrophes occurring anywhere in the world would change things quickly. And, a significant change in how healthcare is provided in the United States would change medical malpractice coverage and pricing.

CIRRG and HWCF look forward to continuing to serve you through 2012 and beyond.

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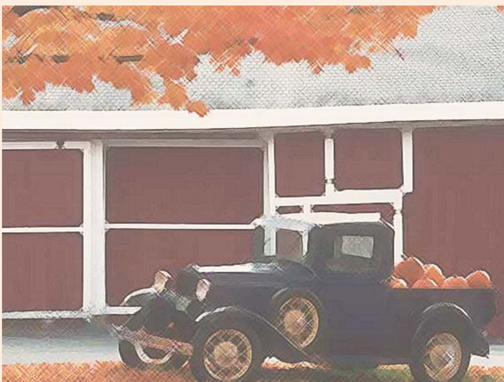
THE PROOF OF THE INSURANCE IS IN THE CERTIFICATE

By Sandra Campbell (AIS)

Each year at renewal we know how important it is to you that we get your updated certificates of proof-of – insurance to your individual certificate holders. We always make it a top priority to send them as quickly as possible. We ask you to remember that your policy is not automatically renewed and certificates cannot be updated and sent out until renewal payment is received in our office.

Over the years many have added more and more certificates to their policies and we are always more than happy to do this for you. We also feel that there are quite a few COI that may no longer be needed. Please help us do some major COI housekeeping by reviewing you COI copies provided on the left hand side of your renewal packet, write "delete" and your initials across the top of those no longer needed and return (no cover letter is needed) to us which ever method is easiest for you. My contact information is below. As always, we appreciate your business and thank you in advance for your help.



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