F I S C A L I M P A C T R E P O R T

SPONSOR Anderson **ORIGINAL DATE** 03/14/13 **LAST UPDATED** **HM** 103

SHORT TITLE Consider Reporting Hospital "Never Events" **SB**

ANALYST Chavez

ESTIMATED ADDITIONAL OPERATING BUDGET IMPACT (dollars in thousands)

	FY13	FY14	FY15	3 Year Total Cost	Recurring or Nonrecurring	Fund Affected
Total		NFI	NFI	NFI		

(Parenthesis ( ) Indicate Expenditure Decreases)

SOURCES OF INFORMATION
LFC Files

Responses Received From
Department of Health (DOH)

SUMMARY

Synopsis of Bill

House Memorial 103 (HM 103) requests that the Department of Health (DOH) consider requiring New Mexico hospitals to report "never events" to the DOH and making "never event" data available to the public online. The DOH is requested to report on expanding "never event" reporting by such hospitals to the DOH and on making such information available online to the consuming public to the Legislative Health and Human Services Committee no later than August 31, 2013.

SIGNIFICANT ISSUES

According to HM 103, 80 thousand preventable "never events", such as surgeons leaving a foreign object inside a patient's body after an operation, or a mismatched blood infusion, have happened in the United States between 1990 and 2010. Currently in New Mexico, from among the list of "never events", the DOH requires hospitals to report only two types of health-care associated infections.

Public reporting of "never events" may give consumers information to make more informed choices about where to undergo surgery, according to the memorial.

According to the DOH, the "never events" list in the bill includes three items from the 2011 National Quality Forum "Never Events" list, as well as eight items from the current Centers for

Medicare and Medicaid Services (CMS) Hospital-Acquired Conditions list. Hospital-Acquired Conditions are currently reported to CMS and data is publically available on the Hospital Compare website. There could be a large information technology component to this reporting. A small number of the "never events" referenced in the HM 103 can be accessed through the Hospital Compare website. A NM-specific database would likely need to be developed for collecting data on the remaining "events". The Department does not currently receive ongoing reports from hospitals regarding other types of "adverse" events. The only other adverse events reported to CMS would be through the transmission of complaints to the Division of Health Improvement. The complaint would then follow the established DHI complaint process.

The memorial "never events" list includes some events that are part of the 2011 "never events" National Quality Forum list and other events that are only included under CMS hospital-acquired conditions and not included in the federal "never events" lists.

The DOH continues that implementation of the HM 103 would require the determination of best use of limited resources both at hospitals and in the Department to protect and promote health through collection of new information, sharing of new information sources with the public, and implementation of new healthcare improvement interventions.

ADMINISTRATIVE IMPLICATIONS

The administrative impact on the Department would be significant as an electronic system for collecting, analyzing, and reporting hospital data would likely need to be developed, implemented and supported. Technical support for hospitals would also be a necessary component, according to the DOH.

OTHER SUBSTANTIVE ISSUES

The DOH notes that, as stated in the December 2012 Johns Hopkins report, there is universal professional agreement that "never events" should never happen during surgery. In contrast, they note that there are other mistakes in healthcare that are not totally preventable. As an example, they state that infection rates will likely never get down to zero. Including "never events" along with infections and other conditions not totally preventable would require very clear plans on how to report these distinctions to the public. The Department would need to consider legal, regulatory and appropriate public health responses based on the range of severity of events.

The DOH adds that the proposed legislation does not address the need for culturally and linguistically appropriate dissemination of information. The HM 103 references " . . . making "never event" data available to the public online . . ."; however, it does not suggest that other means of providing the information to the public be considered and does also not suggest a bi- or multi-lingual approach.

ALTERNATIVES

The DOH suggests creating a direct link from the Department website to Hospital Compare to facilitate public access to pre-existing information related to "never events" as well as additional NM hospital patient safety data.

KC/svb