26:2H-12.25b

LEGISLATIVE HISTORY CHECKLIST

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LAWS OF: 2009 **CHAPTER:** 122

NJSA: 26:2H-12.25b (Requires DHSS to report certain patient safety indicators on a hospital by hospital basis and prohibits hospitals from charging for certain medical errors)

BILL NO: S2471 (Substituted for A1264)

SPONSOR(S) Vitale and Others

DATE INTRODUCED: January 13, 2009

COMMITTEE: **ASSEMBLY:** Health and Senior Services

SENATE: Health, Human Services and Senior Citizens

AMENDED DURING PASSAGE: Yes

DATE OF PASSAGE: **ASSEMBLY:** May 21, 2009

SENATE: June 18, 2009

DATE OF APPROVAL: August 31, 2009

FOLLOWING ARE ATTACHED IF AVAILABLE:

FINAL TEXT OF BILL (Second Reprint of Senate Committee Substitute enacted)

S2471

SPONSOR'S STATEMENT: (Begins on page 3 of original bill) Yes

COMMITTEE STATEMENT: **ASSEMBLY**: Yes

SENATE: Yes 1-26-09
3-10-09

(Audio archived recordings of the committee meetings, corresponding to the date of the committee statement, ***may possibly*** be found at www.njleg.state.nj.us)

FLOOR AMENDMENT STATEMENT: No

LEGISLATIVE FISCAL ESTIMATE: No

A1264

SPONSOR'S STATEMENT: (Begins on page 8 of original bill) Yes

COMMITTEE STATEMENT: **ASSEMBLY**: Yes

SENATE: No

FLOOR AMENDMENT STATEMENT: No

LEGISLATIVE FISCAL ESTIMATE: No

(continued)

VETO MESSAGE: No

GOVERNOR'S PRESS RELEASE ON SIGNING: Yes 8-31-09

FOLLOWING WERE PRINTED:

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[Second Reprint]

SENATE COMMITTEE SUBSTITUTE FOR
SENATE, No. 2471

STATE OF NEW JERSEY
213th LEGISLATURE

ADOPTED JANUARY 26, 2009

Sponsored by:
Senator JOSEPH F. VITALE
District 19 (Middlesex)
Senator STEPHEN M. SWEENEY
District 3 (Salem, Cumberland and Gloucester)
Senator LORETTA WEINBERG
District 37 (Bergen)
Assemblyman PAUL D. MORIARTY
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Assemblywoman LINDA R. GREENSTEIN
District 14 (Mercer and Middlesex)
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District 5 (Camden and Gloucester)
Assemblyman JOSEPH VAS
District 19 (Middlesex)
Assemblyman DOUGLAS H. FISHER
District 3 (Salem, Cumberland and Gloucester)
Assemblyman ANTHONY CHIAPPONE
District 31 (Hudson)

Co-Sponsored by:
Senators Sarlo, Ruiz, Gordon, Rice, Whelan, Buono, Connors, Girgenti, Stack, Turner, Van Drew, Assemblywoman Lampitt, Assemblymen Albano, Green, Burzichelli, Diegnan, Assemblywoman Vainieri Huttle, Assemblymen Giblin, Holzapfel, Wolfe, Assemblywoman Voss, Assemblymen Scalera, Schaer, Prieto, Bramnick, Assemblywoman Wagner, Assemblymen L.Smith, Johnson, Assemblywoman Oliver, Assemblyman Biondi, Assemblywoman Vandervalk, Assemblymen Van Pelt, Rumpf, Assemblywoman Angelini, Assemblymen P. Barnes, III, Thompson, Milam, Ramos, Polistina, Munoz, Conners and DeAngelo

SYNOPSIS

Requires DHSS to report certain patient safety indicators on a hospital by hospital basis and prohibits hospitals from charging for certain medical errors.

CURRENT VERSION OF TEXT

As reported by the Assembly Health and Senior Services Committee on May 7, 2009, with amendments.

(Sponsorship Updated As Of: 5/22/2009)

AN ACT concerning patient safety and supplementing Title 26 of the Revised Statutes.

BE IT ENACTED *by the Senate and General Assembly of the State of New Jersey:*

1. a. The Department of Health and Senior Services shall include in the New Jersey Hospital Performance Report issued annually by the department hospital-specific data from hospital procedure and diagnosis codes concerning the following patient safety indicators:

(1) Foreign body left during procedure (PSI 05);

(2) Iatrogenic pneumothorax (PSI 06);

(3) Postoperative hip fracture (PSI 08);

(4) Postoperative hemorrhage or hematoma (PSI 09);

(5) Postoperative deep vein thrombosis (DVT) or pulmonary embolism (PE) (PSI 12);

(6) Postoperative sepsis (PSI 13);

(7) Postoperative wound dehiscence (PSI 14);

(8) Accidental puncture or laceration (PSI 15);

(9) Transfusion reaction (PSI 16);

(10) Birth trauma (PSI 17);

(11) Obstetric trauma-vaginal delivery with instrument (PSI 18);

(12) Obstetric trauma- vaginal delivery without instrument (PSI 19);

(13) Air embolism; and

(14) Surgery on the wrong side, wrong body part, or wrong person, or wrong surgery performed on a patient.

b. The Commissioner of Health and Senior Services, in consultation with the Quality Improvement Advisory Committee in the Department of Health and Senior Services, may include additional patient safety indicators in the annual report, by regulation. The commissioner shall consider indicators that: (1) are recommended by the federal Agency for Healthcare Research and Quality or the Centers for Medicare and Medicaid Services; (2) are suitable for comparative reporting and public accountability, and are risk adjusted; (3) have a strong evidence base with no substantial evidence against their use for comparative reporting; and (4) can be measured through data that are available through hospital procedure and diagnosis codes.

c. The commissioner shall request the Quality Improvement Advisory Committee to study and make recommendations to the commissioner on how to expand public reporting by the department

EXPLANATION – Matter enclosed in bold-faced brackets [thus] in the above bill is not enacted and is intended to be omitted in the law.

Matter underlined thus is new matter.
Matter enclosed in superscript numerals has been adopted as follows:
[1] Senate SHH committee amendments adopted March 10, 2009.
[2] Assembly AHE committee amendments adopted May 7, 2009.

of patient pressure ulcers, patient infections due to hospital care, and falls by patients in general hospitals.

d. The commissioner shall, in accordance with the "Administrative Procedure Act," P.L.1968, c.410 (C.52:14B-1 et seq.), adopt such rules and regulations as the commissioner deems necessary to carry out the provisions of this act.

2. a. A general hospital licensed pursuant to P.L.1971, c.136 (C.26:2H-1 et seq.) shall not seek to obtain payment from a patient or any third party payer for costs associated with [2][a hospital acquired condition subject to the hospital acquired condition payment provisions of the Medicare program, as established by regulation of the Centers for Medicare and Medicaid Services] any of the following conditions or events subject to the hospital acquired condition payment policy for the Medicare program established by the Centers for Medicare and Medicaid Services: transfusion reaction; air embolism; foreign body left during the procedure; surgery on the wrong side, wrong body part, or wrong person; or wrong surgery performed on a patient[2]. Notwithstanding the payment prohibition in this subsection, the hospital shall file claim information that accurately reflects all services provided. [2]The provisions of this subsection shall not be construed to prohibit a hospital from seeking to obtain payment from a patient or any third party payer for any services that the hospital provides for which it is otherwise permitted to seek to obtain payment.[2]

b. [2][A physician licensed by the State Board of Medical Examiners pursuant to Title 45 of the Revised Statutes, who acknowledges responsibility for [1][causing][1] a condition for which a hospital is prohibited from obtaining payment from a patient or any third party payer pursuant to subsection a. of this section, shall not charge or otherwise seek to obtain payment from a patient or any third party payer for costs associated with the condition.

c.][2] A general hospital shall be required to notify its patients of the provisions of this section.

[2][d.] c.[2] Nothing in this section shall be construed to deny any party access to any existing payment appeals process.

[2][[1]e.] d.[2] In any civil action alleging professional negligence against a general hospital [2][or physician][2], the provisions of this section shall not modify the requirement, where applicable, for expert testimony in accordance with the established case law of this State.

[2][[1]f.] e.[2] The Commissioners of Health and Senior Services and Banking and Insurance [2][and the Director of the Division of Consumer Affairs in the Department of Law and Public Safety][2] shall collaborate in developing standards for [2][health care

providers] general hospitals[2] and third party payers to implement the provisions of this section.[1]

3. This act shall take effect on the 180th day after enactment, but the Commissioner of Health and Senior Services may take such anticipatory administrative action in advance thereof as shall be necessary for the implementation of this act.

SENATE, No. 2471

STATE OF NEW JERSEY

213th LEGISLATURE

INTRODUCED JANUARY 13, 2009

Sponsored by:
Senator JOSEPH F. VITALE
District 19 (Middlesex)
Senator STEPHEN M. SWEENEY
District 3 (Salem, Cumberland and Gloucester)
Senator LORETTA WEINBERG
District 37 (Bergen)

Co-Sponsored by:
Senators Sarlo, Ruiz, Gordon, Rice and Whelan

SYNOPSIS

Requires DHSS to report certain patient safety indicators on a hospital by hospital basis and prohibits hospitals and physicians from charging patient for certain medical errors.

CURRENT VERSION OF TEXT

As introduced.

(Sponsorship Updated As Of: 1/27/2009)

AN ACT concerning patient safety and supplementing Title 26 of the Revised Statutes.

BE IT ENACTED *by the Senate and General Assembly of the State of New Jersey:*

1. a. The Department of Health and Senior Services shall include in the New Jersey Hospital Performance Report issued annually by the department hospital-specific data from hospital procedure and diagnosis codes concerning the following patient safety indicators:

(1) Foreign body left during procedure;

(2) Iatrogenic pneumothorax;

(3) Postoperative hip fracture;

(4) Postoperative hemorrhage or hematoma;

(5) Postoperative deep vein thrombosis (DVT) or pulmonary embolism (PE);

(6) Postoperative sepsis;

(7) Postoperative wound dehiscence;

(8) Accidental puncture or laceration;

(9) Transfusion reaction;

(10) Birth trauma;

(11) Obstetric trauma- vaginal delivery with instrument;

(12) Obstetric trauma- vaginal delivery without instrument;

(13) Air embolism; and

(14) Surgery on the wrong side, wrong body part, or wrong person, or wrong surgery performed on a patient.

b. The Commissioner of Health and Senior Services, in consultation with the Quality Improvement Advisory Committee in the Department of Health and Senior Services, may include additional patient safety indicators in the annual report, by regulation. The commissioner shall consider indicators that: (1) are recommended by the federal Agency for Healthcare Research and Quality or the Centers for Medicare and Medicaid Services; (2) are suitable for comparative reporting and public accountability, and are risk adjusted; (3) have a strong evidence base with no substantial evidence against their use for comparative reporting; and (4) can be measured through data that are available through hospital procedure and diagnosis codes.

2. a. A general hospital licensed pursuant to P.L.1971, c.136 (C.26:2H-1 et seq.) shall not charge or otherwise seek to obtain payment from a patient for costs associated with a hospital acquired condition subject to the hospital acquired condition payment provisions of the Medicare program, as established by regulation of the Centers for Medicare and Medicaid Services.

b. A physician licensed by the State Board of Medical Examiners pursuant to Title 45 of the Revised Statutes, who was the

attending physician responsible for causing a condition for which a hospital is prohibited from charging or seeking payment from a patient pursuant to subsection a. of this section, shall not charge or otherwise seek to obtain payment from a patient for costs associated with the condition.

c. A general hospital shall be required to notify its patients of the provisions of this section on a form and in a manner prescribed by the Commissioner of Health and Senior Services.

3. The Commissioner of Health and Senior Services shall request the Quality Improvement Advisory Committee to study and make recommendations to the commissioner on how to expand public reporting by the department of patient pressure ulcers, patient infections due to hospital care, and falls by patients in general hospitals.

4. The Commissioner of Health and Senior Services shall, in accordance with the "Administrative Procedure Act," P.L.1968, c.410 (C.52:14B-1 et seq.), adopt such rules and regulations as the commissioner deems necessary to carry out the provisions of this act.

5. This act shall take effect on the 180th day after enactment, but the Commissioner of Health and Senior Services may take such anticipatory administrative action in advance thereof as shall be necessary for the implementation of this act.

SPONSOR'S STATEMENT

This bill directs the Department of Health and Senior Services (DHSS) to include in the New Jersey Hospital Performance Report issued annually by DHSS hospital-specific data concerning the following 14 patient safety indicators:

-- Foreign body left during procedure;
-- Iatrogenic pneumothorax;
-- Postoperative hip fracture;
-- Postoperative hemorrhage or hematoma;
-- Postoperative deep vein thrombosis (DVT) or pulmonary embolism (PE);
-- Postoperative sepsis;
-- Postoperative wound dehiscence;
-- Accidental puncture or laceration;
-- Transfusion reaction;
-- Birth trauma;
-- Obstetric trauma- vaginal delivery with instrument;
-- Obstetric trauma- vaginal delivery without instrument;
-- Air embolism; and

-- Surgery on the wrong side, wrong body part, or wrong person, or wrong surgery performed on a patient.

DHSS will use data from procedure and diagnosis codes recorded in hospital bills to compile the required information on patient safety indicators. Most of the patient safety indicators listed in the bill are currently risk adjusted, by age, sex, diagnosis, and comorbidities, and are externally validated as suitable for hospital quality comparisons. With the exception of air embolism and wrong surgery, the patient safety indicators listed in the bill were developed by the Agency for Healthcare Research and Quality. The air embolism and wrong surgery indicators are added because they are already included by the Centers for Medicare and Medicaid Services in the list of hospital-acquired conditions or "never" events that are not eligible for payment under the Medicare or Medicaid programs.

The bill also authorizes the Commissioner of Health and Senior Services, in consultation with the Quality Improvement Advisory Committee in DHSS, to include additional patient safety indicators in the annual report, by regulation. The commissioner shall consider indicators that: (1) are recommended by the federal Agency for Healthcare Research and Quality or the Centers for Medicare and Medicaid Services; (2) are suitable for comparative reporting and public accountability, and are risk adjusted; (3) have a strong evidence base with no substantial evidence against their use for comparative reporting; and (4) can be measured through data that are available through hospital procedure and diagnosis codes.

Since the conditions identified in the patient safety indicators are generally preventable medical errors, the bill seeks to insure hospital and physician accountability by providing that a general hospital shall not charge or otherwise seek to obtain payment from a patient for costs associated with a condition that is subject to the hospital acquired condition payment provisions of the Medicare program, as established by regulation of the Centers for Medicare and Medicaid Services. Similarly, a physician who was the attending physician responsible for causing a condition for which a hospital is prohibited from seeking payment, shall not charge or otherwise seek to obtain payment from a patient for costs associated with the condition.

The bill provides that a general hospital shall be required to notify its patients of the provisions of the bill on a form and in a manner prescribed by the commissioner.

Finally the bill directs the commissioner to request the Quality Improvement Advisory Committee in DHSS to study and make recommendations to the commissioner on how to expand public reporting by DHSS of patient pressure ulcers, patient infections due to hospital care, and falls by patients in general hospitals.

The bill takes effect on the 180th day after enactment, but the commissioner is authorized to take such anticipatory administrative

action in advance thereof as shall be necessary for the implementation of the bill.

SENATE HEALTH, HUMAN SERVICES AND SENIOR CITIZENS COMMITTEE

STATEMENT TO

SENATE COMMITTEE SUBSTITUTE FOR
SENATE, No. 2471

STATE OF NEW JERSEY

DATED: JANUARY 26, 2009

The Senate Health, Human Services and Senior Citizens Committee reports favorably a Senate Committee Substitute for Senate Bill No. 2471.

This substitute directs the Department of Health and Senior Services (DHSS) to include in the New Jersey Hospital Performance Report issued annually by DHSS hospital-specific data concerning the following 12 patient safety indicators (PSI) developed by the Agency for Healthcare Research and Quality, as well as two patient safety indicators describing events that occur while the patient is in the hospital for which the federal Centers for Medicare and Medicaid Services (CMS) do not provide reimbursement:

(1) Foreign Body Left During Procedure (PSI 5) Discharges with foreign body accidentally left in during procedure per 1,000 discharges;

(2) Iatrogenic Pneumothorax (PSI 6) Cases of iatrogenic pneumothorax per 1,000 discharges. Excludes trauma, thoracic surgery, lung or pleural biopsy, or cardiac surgery patients, and MDC 14;

(3) Postoperative Hip Fracture (PSI 8) Cases of in-hospital hip fracture per 1,000 surgical discharges. Excludes patients in MDC 8, with conditions suggesting fracture present on admission and MDC 14;

(4) Postoperative Hemorrhage or Hematoma (PSI 9) Cases of hematoma or hemorrhage requiring a procedure per 1,000 surgical discharges. Excludes MDC 14;

(5) Postoperative PE or DVT (PSI 12) Cases of deep vein thrombosis or pulmonary embolism per 1,000 surgical discharges. Excludes obstetric patients;

(6) Postoperative Sepsis (PSI 13) Cases of sepsis per 1,000 elective surgery patients, with length of stay more than three days. Excludes principal diagnosis of infection, or any diagnosis of immunocompromised state or cancer, and obstetric admissions;

(7) Postoperative Wound Dehiscence (PSI 14) Cases of reclosure of postoperative disruption of abdominal wall per 1,000 cases of abdominopelvic surgery. Excludes obstetric admissions;

(8) Accidental Puncture or Laceration (PSI 15) Cases of technical difficulty (e.g., accidental cut or laceration during procedure) per 1,000 discharges. Excludes obstetric admissions;

(9) Transfusion Reaction (PSI 16) Cases of transfusion reaction per 1,000 discharges;

(10) Birth Trauma— Injury to Neonate (PSI 17) Cases of birth trauma, injury to neonate, per 1,000 liveborn births. Excludes some preterm infants and infants with osteogenic imperfecta;

(11) Obstetric Trauma— Vaginal Delivery with Instrument (PSI 18) Cases of obstetric trauma (3rd or 4th degree lacerations) per 1,000 instrument-assisted vaginal deliveries;

(12) Obstetric Trauma— Vaginal Delivery without Instrument (PSI 19) Cases of obstetric trauma (3rd or 4th degree lacerations) per 1,000 vaginal deliveries without instrument assistance;

(13) Air embolism; and

(14) Surgery on the wrong side, wrong body part, or wrong person, or wrong surgery performed on a patient.

DHSS will use data from procedure and diagnosis codes recorded in hospital bills to compile the required information on patient safety indicators. Most of the patient safety indicators listed in the substitute are currently risk-adjusted by age, sex, diagnosis, and comorbidities, and are externally validated as suitable for hospital quality comparisons. With the exception of air embolism and wrong surgeries, the patient safety indicators listed in the substitute were developed by the Agency for Healthcare Research and Quality. The air embolism and wrong surgery indicators are added because they are already included by CMS in the list of hospital-acquired conditions or "never" events that are not eligible for payment under the Medicare or Medicaid programs.

The substitute also authorizes the Commissioner of Health and Senior Services, in consultation with the Quality Improvement Advisory Committee in DHSS, to include additional patient safety indicators in the annual report, by regulation. The commissioner shall consider indicators that: (1) are recommended by the federal Agency for Healthcare Research and Quality or CMS; (2) are suitable for comparative reporting and public accountability, and are risk adjusted; (3) have a strong evidence base with no substantial evidence against their use for comparative reporting; and (4) can be measured through data that are available through hospital procedure and diagnosis codes.

The substitute also seeks to insure hospital and physician accountability with respect to hospital acquired conditions that are not eligible for payment under CMS regulations by providing that a general hospital shall not seek to obtain payment from a patient or any third party payer for costs associated with a condition that is subject to

the hospital acquired condition payment provisions of the Medicare program. A physician who acknowledges responsibility for causing a condition for which the hospital cannot seek to obtain reimbursement is likewise prohibited from seeking payment. The substitute further provides that hospitals shall file claim information that accurately reflects all services provided, and shall notify their patients of the non-payment provisions. In addition, the substitute specifies that nothing in the billing prohibition is to be construed to deny any party access to any existing payment appeals process.

Currently CMS does not reimburse the extra cost of treating the following categories of conditions that occur while the patient is in the hospital:

- pressure ulcer stages III and IV;
- certain falls and trauma;
- surgical site infection after bariatric surgery for obesity, certain orthopedic procedures, and bypass surgery (mediastinitis);
- vascular-catheter associated infection;
- catheter-associated urinary tract infection;
- administration of incompatible blood;
- air embolism; and
- foreign object unintentionally retained after surgery.

In addition, CMS issued three National Coverage Determinations establishing non-coverage for any services related to surgery on the wrong side, wrong body part, wrong person, or wrong surgery performed on a patient.

Finally, the substitute provides that the commissioner shall request the Quality Improvement Advisory Committee in DHSS to recommend how to expand public reporting by DHSS of patient pressure ulcers, patient infections due to hospital care, and falls by patients.

The substitute takes effect on the 180th day after enactment.

SENATE HEALTH, HUMAN SERVICES AND SENIOR CITIZENS COMMITTEE

STATEMENT TO

SENATE COMMITTEE SUBSTITUTE FOR
SENATE, No. 2471

with committee amendments

STATE OF NEW JERSEY

DATED: MARCH 10, 2009

The Senate Health, Human Services and Senior Citizens Committee reports favorably and with committee amendments the Senate Committee Substitute for Senate, No. 2471.

As amended by committee, this substitute directs the Department of Health and Senior Services (DHSS) to include in the New Jersey Hospital Performance Report issued annually by DHSS hospital-specific data concerning the following 12 patient safety indicators (PSI) developed by the Agency for Healthcare Research and Quality, as well as two patient safety indicators describing events that occur while the patient is in the hospital for which the federal Centers for Medicare and Medicaid Services (CMS) do not provide reimbursement:

(1) Foreign Body Left During Procedure (PSI 5) Discharges with foreign body accidentally left in during procedure per 1,000 discharges;

(2) Iatrogenic Pneumothorax (PSI 6) Cases of iatrogenic pneumothorax per 1,000 discharges. Excludes trauma, thoracic surgery, lung or pleural biopsy, or cardiac surgery patients, and MDC 14;

(3) Postoperative Hip Fracture (PSI 8) Cases of in-hospital hip fracture per 1,000 surgical discharges. Excludes patients in MDC 8, with conditions suggesting fracture present on admission and MDC 14;

(4) Postoperative Hemorrhage or Hematoma (PSI 9) Cases of hematoma or hemorrhage requiring a procedure per 1,000 surgical discharges. Excludes MDC 14;

(5) Postoperative PE or DVT (PSI 12) Cases of deep vein thrombosis or pulmonary embolism per 1,000 surgical discharges. Excludes obstetric patients;

(6) Postoperative Sepsis (PSI 13) Cases of sepsis per 1,000 elective surgery patients, with length of stay more than three days.

Excludes principal diagnosis of infection, or any diagnosis of immunocompromised state or cancer, and obstetric admissions;

(7) Postoperative Wound Dehiscence (PSI 14) Cases of reclosure of postoperative disruption of abdominal wall per 1,000 cases of abdominopelvic surgery. Excludes obstetric admissions;

(8) Accidental Puncture or Laceration (PSI 15) Cases of technical difficulty (e.g., accidental cut or laceration during procedure) per 1,000 discharges. Excludes obstetric admissions;

(9) Transfusion Reaction (PSI 16) Cases of transfusion reaction per 1,000 discharges;

(10) Birth Trauma— Injury to Neonate (PSI 17) Cases of birth trauma, injury to neonate, per 1,000 liveborn births. Excludes some preterm infants and infants with osteogenic imperfecta;

(11) Obstetric Trauma— Vaginal Delivery with Instrument (PSI 18) Cases of obstetric trauma (3rd or 4th degree lacerations) per 1,000 instrument-assisted vaginal deliveries;

(12) Obstetric Trauma— Vaginal Delivery without Instrument (PSI 19) Cases of obstetric trauma (3rd or 4th degree lacerations) per 1,000 vaginal deliveries without instrument assistance;

(13) Air embolism; and

(14) Surgery on the wrong side, wrong body part, or wrong person, or wrong surgery performed on a patient.

DHSS will use data from procedure and diagnosis codes recorded in hospital bills to compile the required information on patient safety indicators. Most of the patient safety indicators listed in the substitute are currently risk-adjusted by age, sex, diagnosis, and comorbidities, and are externally validated as suitable for hospital quality comparisons. With the exception of air embolism and wrong surgeries, the patient safety indicators listed in the substitute were developed by the Agency for Healthcare Research and Quality. The air embolism and wrong surgery indicators are added because they are already included by CMS in the list of hospital-acquired conditions or "never" events that are not eligible for payment under the Medicare or Medicaid programs.

The substitute also authorizes the Commissioner of Health and Senior Services, in consultation with the Quality Improvement Advisory Committee in DHSS, to include additional patient safety indicators in the annual report, by regulation. The commissioner shall consider indicators that: (1) are recommended by the federal Agency for Healthcare Research and Quality or CMS; (2) are suitable for comparative reporting and public accountability, and are risk adjusted; (3) have a strong evidence base with no substantial evidence against their use for comparative reporting; and (4) can be measured through data that are available through hospital procedure and diagnosis codes.

The substitute also seeks to insure hospital and physician accountability with respect to hospital acquired conditions that are not eligible for payment under CMS regulations by providing that a

general hospital shall not seek to obtain payment from a patient or any third party payer for costs associated with a condition that is subject to the hospital acquired condition payment provisions of the Medicare program. A physician who acknowledges responsibility for a condition for which the hospital cannot seek to obtain reimbursement is likewise prohibited from seeking payment. The substitute further provides that hospitals shall file claim information that accurately reflects all services provided, and shall notify their patients of the non-payment provisions.

With respect to the billing prohibition described above, the substitute specifies that:

-- nothing in the billing prohibition is to be construed to deny any party access to any existing payment appeals process;

-- in any civil action alleging professional negligence against a general hospital or physician, the payment provisions of the substitute shall not modify the requirement, where applicable, for expert testimony in accordance with the established case law of this State; and

-- the Commissioners of Health and Senior Services and Banking and Insurance and the Director of the Division of Consumer Affairs in the Department of Law and Public Safety shall collaborate in developing standards for health care providers and third party payers to implement the billing prohibition provisions of the substitute.

Currently CMS does not reimburse the extra cost of treating the following categories of conditions that occur while the patient is in the hospital:

- pressure ulcer stages III and IV;
- certain falls and trauma;
- surgical site infection after bariatric surgery for obesity, certain orthopedic procedures, and bypass surgery (mediastinitis);
- vascular-catheter associated infection;
- catheter-associated urinary tract infection;
- administration of incompatible blood;
- air embolism; and
- foreign object unintentionally retained after surgery.

In addition, CMS issued three National Coverage Determinations establishing non-coverage for any services related to surgery on the wrong side, wrong body part, wrong person, or wrong surgery performed on a patient.

Finally, the substitute provides that the commissioner shall request the Quality Improvement Advisory Committee in DHSS to recommend how to expand public reporting by DHSS of patient pressure ulcers, patient infections due to hospital care, and falls by patients.

The substitute takes effect on the 180th day after enactment.

The committee amended the substitute to:

-- clarify that a physician who acknowledges responsibility for a condition, rather than for causing a condition, as the substitute originally provided, shall not charge or otherwise seek to obtain payment for costs associated with the condition;

-- add language concerning expert testimony in civil actions alleging professional negligence against a general hospital or physician; and

-- require the Commissioners of Health and Senior Services and Banking and Insurance and the Director of the Division of Consumer Affairs to collaborate in developing standards for health care providers and third party payers to implement the billing prohibition provisions of the substitute.

ASSEMBLY HEALTH AND SENIOR SERVICES COMMITTEE

STATEMENT TO

[First Reprint]

SENATE COMMITTEE SUBSTITUTE FOR
SENATE, No. 2471

with committee amendments

STATE OF NEW JERSEY

DATED: MAY 7, 2009

The Assembly Health and Senior Services Committee reports favorably and with committee amendments the Senate Committee Substitute for Senate Bill No. 2471 (1R).

As amended by the committee, this committee substitute requires the Department of Health and Senior Services (DHSS) to report certain patient safety indicators (PSIs) on a hospital-by-hospital basis and prohibits hospitals from charging a patient or third party payer for certain medical errors.

The substitute provides specifically as follows:

- DHSS is directed to include in the New Jersey Hospital Performance Report, issued annually by DHSS, hospital-specific data concerning the 12 PSIs developed by the federal Agency for Healthcare Research and Quality (AHRQ) and two PSIs describing events that occur while the patient is in the hospital and for which the federal Centers for Medicare and Medicaid Services (CMS) does not provide reimbursement. These PSIs include:

  (1) Foreign Body Left During Procedure (PSI 5) Discharges with foreign body accidentally left in during procedure per 1,000 discharges;

  (2) Iatrogenic Pneumothorax (PSI 6) Cases of iatrogenic pneumothorax per 1,000 discharges. Excludes trauma, thoracic surgery, lung or pleural biopsy, or cardiac surgery patients, and MDC 14;

  (3) Postoperative Hip Fracture (PSI 8) Cases of in-hospital hip fracture per 1,000 surgical discharges. Excludes patients in MDC 8, with conditions suggesting fracture present on admission and MDC 14;

  (4) Postoperative Hemorrhage or Hematoma (PSI 9) Cases of hematoma or hemorrhage requiring a procedure per 1,000 surgical discharges. Excludes MDC 14;

(5) Postoperative PE or DVT (PSI 12) Cases of deep vein thrombosis or pulmonary embolism per 1,000 surgical discharges. Excludes obstetric patients;

(6) Postoperative Sepsis (PSI 13) Cases of sepsis per 1,000 elective surgery patients, with length of stay more than three days. Excludes principal diagnosis of infection, or any diagnosis of immunocompromised state or cancer, and obstetric admissions;

(7) Postoperative Wound Dehiscence (PSI 14) Cases of reclosure of postoperative disruption of abdominal wall per 1,000 cases of abdominopelvic surgery. Excludes obstetric admissions;

(8) Accidental Puncture or Laceration (PSI 15) Cases of technical difficulty (e.g., accidental cut or laceration during procedure) per 1,000 discharges. Excludes obstetric admissions;

(9) Transfusion Reaction (PSI 16) Cases of transfusion reaction per 1,000 discharges;

(10) Birth Trauma— Injury to Neonate (PSI 17) Cases of birth trauma, injury to neonate, per 1,000 liveborn births. Excludes some preterm infants and infants with osteogenic imperfecta;

(11) Obstetric Trauma— Vaginal Delivery with Instrument (PSI 18) Cases of obstetric trauma (3rd or 4th degree lacerations) per 1,000 instrument-assisted vaginal deliveries;

(12) Obstetric Trauma— Vaginal Delivery without Instrument (PSI 19) Cases of obstetric trauma (3rd or 4th degree lacerations) per 1,000 vaginal deliveries without instrument assistance;

(13) Air embolism; and

(14) Surgery on the wrong side, wrong body part, or wrong person, or wrong surgery performed on a patient.

- DHSS is to use data from procedure and diagnosis codes recorded in hospital bills to compile the required information on PSIs. Most of the PSIs listed in the substitute are currently risk-adjusted, by age, sex, diagnosis, and comorbidities, and are externally validated as suitable for hospital quality comparisons. With the exception of air embolism and wrong surgery, the PSIs listed in the substitute were developed by AHRQ. The air embolism and wrong surgery PSIs are included in the substitute because they are already included by CMS in the list of hospital-acquired conditions or "never" events that are not eligible for payment under the Medicare and Medicaid programs.
- The Commissioner of Health and Senior Services, in consultation with the Quality Improvement Advisory Committee in DHSS, is to include additional PSIs in the annual report, by regulation, taking into consideration those indicators that:

-- are recommended by AHRQ or CMS;

-- are suitable for comparative reporting and public accountability, and are risk adjusted;

-- have a strong evidence base with no substantial evidence against their use for comparative reporting; and

-- can be measured through data that are available through hospital procedure and diagnosis codes.

- A general hospital is prohibited from charging or otherwise seeking to obtain payment from a patient for costs associated with any of the following conditions or events subject to the hospital acquired condition payment policy for the Medicare program established by CMS: transfusion reaction; air embolism; foreign body left during the procedure; surgery on the wrong side, wrong body part, or wrong person; or wrong surgery performed on a patient.
- The provisions of the substitute are not to be construed to prohibit a hospital from seeking to obtain payment from a patient or any third party payer for any services that the hospital provides for which it is otherwise permitted to seek to obtain payment.
- A general hospital is required to notify its patients of the provisions of the substitute.
- Nothing in the substitute is to be construed to deny any party access to any existing payment appeals process.
- In any civil action alleging professional negligence against a general hospital, the provisions of the substitute are not to modify the requirement, where applicable, for expert testimony in accordance with the established case law of this State.
- The Commissioners of Health and Senior Services and Banking and Insurance are to collaborate in developing standards for general hospitals and third party payers to implement the billing prohibition provisions of the substitute.
- The commissioner is to request the Quality Improvement Advisory Committee in DHSS to study and make recommendations to the commissioner on how to expand public reporting by DHSS of patient pressure ulcers, patient infections due to hospital care, and falls by patients in general hospitals.
- The substitute takes effect on the 180th day after enactment, but the commissioner is authorized to take anticipatory administrative action in advance as necessary for its implementation.

As reported by the committee, this substitute is identical to the Assembly Committee Substitute for Assembly Bill Nos. 1264, 3371 and 3633 (Moriarty/Greenstein/Conaway/Greenwald/Cruz-Perez/Vas/Fisher), which the committee also reported on this date.

COMMITTEE AMENDMENTS

The committee amendments to the substitute:

-- limit its billing prohibition provisions (in section 2) to cover only general hospitals, and to apply only to the following conditions or events subject to the hospital acquired condition payment policy for the Medicare program established by CMS: transfusion reaction; air embolism; foreign body left during the procedure; surgery on the wrong side, wrong body part, or wrong person; or wrong surgery performed on a patient; and

-- stipulate that the provisions of the substitute are not to be construed to prohibit a hospital from seeking to obtain payment from a patient or any third party payer for any services that the hospital provides for which it is otherwise permitted to seek to obtain payment.

ASSEMBLY, No. 1264

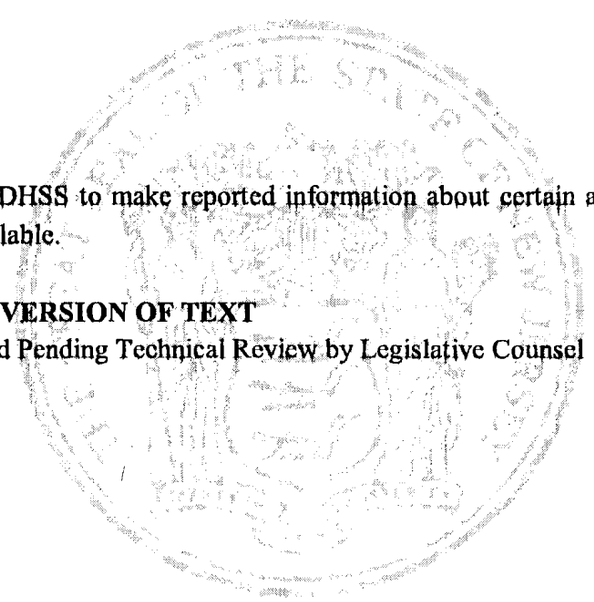
STATE OF NEW JERSEY

213th LEGISLATURE

PRE-FILED FOR INTRODUCTION IN THE 2008 SESSION

Sponsored by:
Assemblyman PAUL D. MORIARTY
District 4 (Camden and Gloucester)
Assemblywoman LINDA R. GREENSTEIN
District 14 (Mercer and Middlesex)
Assemblyman DOUGLAS H. FISHER
District 3 (Salem, Cumberland and Gloucester)

Co-Sponsored by:
Assemblywoman Lampitt, Assemblymen Albano, Green, Burzichelli, Diegnan, Assemblywoman Vainieri Huttle, Assemblymen Giblin, Holzapfel, Wolfe, Assemblywoman Voss, Assemblymen Scalera, Schaer, Prieto, Chiappone, Bramnick, Assemblywoman Wagner, Assemblymen L.Smith, Johnson, Assemblywoman Oliver, Assemblyman Biondi, Assemblywomen Vandervalk, Cruz-Perez, Assemblymen Van Pelt, Rumpf and Assemblywoman Angelini



SYNOPSIS
Requires DHSS to make reported information about certain adverse events publicly available.

CURRENT VERSION OF TEXT
Introduced Pending Technical Review by Legislative Counsel

(Sponsorship Updated As Of: 11/14/2008)

AN ACT concerning information about adverse events in health care facilities and amending P.L.2004, c.9.

BE IT ENACTED *by the Senate and General Assembly of the State of New Jersey:*

1. Section 3 of P.L.2004, c.9 (C.26:2H-12.25) is amended to read as follows:

3. a. As used in this act:

"Adverse event" means an event that is a negative consequence of care that results in unintended injury or illness, which may or may not have been preventable.

"Anonymous" means that information is presented in a form and manner that prevents the identification of the person filing the report.

"Commissioner" means the Commissioner of Health and Senior Services.

"Department" means the Department of Health and Senior Services.

"Event" means a discrete, auditable and clearly defined occurrence.

"Health care facility" or "facility" means a health care facility licensed pursuant to P.L.1971, c.136 (C.26:2H-1 et seq.) and a State psychiatric hospital operated by the Department of Human Services and listed in R.S.30:1-7.

"Health care professional" means an individual who, acting within the scope of his licensure or certification, provides health care services, and includes, but is not limited to, a physician, dentist, nurse, pharmacist or other health care professional whose professional practice is regulated pursuant to Title 45 of the Revised Statutes.

"Near-miss" means an occurrence that could have resulted in an adverse event but the adverse event was prevented.

"Preventable event" means an event that could have been anticipated and prepared against, but occurs because of an error or other system failure.

"Serious preventable adverse event" means an adverse event that is a preventable event and results in death or loss of a body part, or disability or loss of bodily function lasting more than seven days or still present at the time of discharge from a health care facility.

b. In accordance with the requirements established by the commissioner by regulation, pursuant to this act, a health care facility shall develop and implement a patient safety plan for the purpose of improving the health and safety of patients at the facility.

EXPLANATION – Matter enclosed in bold-faced brackets [thus] in the above bill is not enacted and is intended to be omitted in the law.

Matter underlined thus is new matter.

The patient safety plan shall, at a minimum, include:

(1) a patient safety committee, as prescribed by regulation;

(2) a process for teams of facility staff, which teams are comprised of personnel who are representative of the facility's various disciplines and have appropriate competencies, to conduct ongoing analysis and application of evidence-based patient safety practices in order to reduce the probability of adverse events resulting from exposure to the health care system across a range of diseases and procedures;

(3) a process for teams of facility staff, which teams are comprised of personnel who are representative of the facility's various disciplines and have appropriate competencies, to conduct analyses of near-misses, with particular attention to serious preventable adverse events and adverse events; and

(4) a process for the provision of ongoing patient safety training for facility personnel.

The provisions of this subsection shall not be construed to eliminate or lessen a hospital's obligation under current law or regulation to have a continuous quality improvement program.

c. A health care facility shall report to the department or, in the case of a State psychiatric hospital, to the Department of Human Services, in a form and manner established by the commissioner, every serious preventable adverse event that occurs in that facility.

d. A health care facility shall assure that the patient affected by a serious preventable adverse event or an adverse event specifically related to an allergic reaction, or, in the case of a minor or a patient who is incapacitated, the patient's parent or guardian or other family member, as appropriate, is informed of the serious preventable adverse event or adverse event specifically related to an allergic reaction, no later than the end of the episode of care, or, if discovery occurs after the end of the episode of care, in a timely fashion as established by the commissioner by regulation. The time, date, participants and content of the notification shall be documented in the patient's medical record in accordance with rules and regulations adopted by the commissioner. The content of the documentation shall be determined in accordance with the rules and regulations of the commissioner. If the patient's physician determines that the disclosure would seriously and adversely affect the patient's health, then the facility shall assure that the family member, if available, is notified in accordance with rules and regulations adopted by the commissioner. In the event that an adult patient is not informed of the serious preventable adverse event or adverse event specifically related to an allergic reaction, the facility shall assure that the physician includes a statement in the patient's medical record that provides the reason for not informing the patient pursuant to this section.

e. (1) A health care professional or other employee of a health care facility is encouraged to make anonymous reports to the department or, in the case of a State psychiatric hospital, to the Department of Human Services, in a form and manner established by the commissioner, regarding near-misses, preventable events and adverse events that are otherwise not subject to mandatory reporting pursuant to subsection c. of this section.

(2) The commissioner shall establish procedures for and a system to collect, store and analyze information voluntarily reported to the department pursuant to this subsection. The repository shall function as a clearinghouse for trend analysis of the information collected pursuant to this subsection.

f. Any documents, materials or information received by the department, or the Department of Human Services, as applicable, pursuant to the provisions of subsections c. and e. of this section concerning serious preventable adverse events, near-misses, preventable events and adverse events that are otherwise not subject to mandatory reporting pursuant to subsection c. of this section, shall not be:

(1) subject to discovery or admissible as evidence or otherwise disclosed in any civil, criminal or administrative action or proceeding;

(2) considered a public record under P.L.1963, c.73 (C.47:1A-1 et seq.) or P.L.2001, c.404 (C.47:1A-5 et al.); or

(3) used in an adverse employment action or in the evaluation of decisions made in relation to accreditation, certification, credentialing or licensing of an individual, which is based on the individual's participation in the development, collection, reporting or storage of information in accordance with this section. The provisions of this paragraph shall not be construed to limit a health care facility from taking disciplinary action against a health care professional in a case in which the professional has displayed recklessness, gross negligence or willful misconduct, or in which there is evidence, based on other similar cases known to the facility, of a pattern of significant substandard performance that resulted in serious preventable adverse events.

The information received by the department, or the Department of Human Services, as applicable, shall be shared with the Attorney General in accordance with rules and regulations adopted pursuant to subsection j. of this section, and may be used by the department, the Department of Human Services and the Attorney General for the purposes of this act and for oversight of facilities and health care professionals; however, the departments and the Attorney General shall not use the information for any other purpose.

In using the information to exercise oversight, the department, Department of Human Services and Attorney General, as applicable, shall place primary emphasis on assuring effective

corrective action by the facility or health care professional, reserving punitive enforcement or disciplinary action for those cases in which the facility or the professional has displayed recklessness, gross negligence or willful misconduct, or in which there is evidence, based on other similar cases known to the department, Department of Human Services or the Attorney General, of a pattern of significant substandard performance that has the potential for or actually results in harm to patients.

g. Any documents, materials or information developed by a health care facility as part of a process of self-critical analysis conducted pursuant to subsection b. of this section concerning preventable events, near-misses and adverse events, including serious preventable adverse events, and any document or oral statement that constitutes the disclosure provided to a patient or the patient's family member or guardian pursuant to subsection d. of this section, shall not be:

(1) subject to discovery or admissible as evidence or otherwise disclosed in any civil, criminal or administrative action or proceeding; or

(2) used in an adverse employment action or in the evaluation of decisions made in relation to accreditation, certification, credentialing or licensing of an individual, which is based on the individual's participation in the development, collection, reporting or storage of information in accordance with subsection b. of this section. The provisions of this paragraph shall not be construed to limit a health care facility from taking disciplinary action against a health care professional in a case in which the professional has displayed recklessness, gross negligence or wilful misconduct, or in which there is evidence, based on other similar cases known to the facility, of a pattern of significant substandard performance that resulted in serious preventable adverse events.

h. Notwithstanding the fact that documents, materials or information may have been considered in the process of self-critical analysis conducted pursuant to subsection b. of this section, or received by the department or the Department of Human Services pursuant to the provisions of subsection c. or e. of this section, the provisions of this act shall not be construed to increase or decrease, in any way, the availability, discoverability, admissibility or use of any such documents, materials or information if obtained from any source or context other than those specified in this act.

i. The investigative and disciplinary powers conferred on the boards and commissions established pursuant to Title 45 of the Revised Statutes, the Director of the Division of Consumer Affairs in the Department of Law and Public Safety and the Attorney General under the provisions of P.L.1978, c.73 (C.45:1-14 et seq.) or any other law, rule or regulation, as well as the investigative and enforcement powers conferred on the department and the

commissioner under the provisions of Title 26 of the Revised Statutes or any other law, rule or regulation, shall not be exercised in such a manner so as to unduly interfere with a health care facility's implementation of its patient safety plan established pursuant to this section. However, this act shall not be construed to otherwise affect, in any way, the exercise of such investigative, disciplinary and enforcement powers.

j. The commissioner shall, pursuant to the "Administrative Procedure Act," P.L.1968, c.410 (C.52:14B-1 et seq.), adopt such rules and regulations necessary to carry out the provisions of this act. The regulations shall establish: criteria for a health care facility's patient safety plan and patient safety committee; the time frame and format for mandatory reporting of serious preventable adverse events at a health care facility; the types of events that qualify as serious preventable adverse events and adverse events specifically related to an allergic reaction; the circumstances under which a health care facility is not required to inform a patient or the patient's family about a serious preventable adverse event or adverse event specifically related to an allergic reaction; and a system for the sharing of information received by the department and the Department of Human Services pursuant to subsections c. and e. of this section with the Attorney General. In establishing the criteria for reporting serious preventable adverse events, the commissioner shall, to the extent feasible, use criteria for these events that have been or are developed by organizations engaged in the development of nationally recognized standards.

The commissioner shall consult with the Commissioner of Human Services with respect to rules and regulations affecting the State psychiatric hospitals and with the Attorney General with respect to rules and regulations regarding the establishment of a system for the sharing of information received by the department and the Department of Human Services pursuant to subsections c. and e. of this section with the Attorney General.

k. Nothing in this act shall be construed to increase or decrease the discoverability, in accordance with Christy v. Salem, No. A-6448-02T3 (Superior Court of New Jersey, Appellate Division, February 17, 2004)(2004 WL291160), of any documents, materials or information if obtained from any source or context other than those specified in this act.

1. (1) The commissioner, in consultation with the Commissioner of Human Services, shall make available to members of the public, on the official Internet website of the Department of Health and Senior Services, a report on hospital performance on patient safety measures with appropriate statistical risk adjustments based upon significant hospital characteristics and covariates of patient clinical outcomes.

(a) The report shall include, at a minimum, the risk-adjusted rate of occurrence of serious preventable adverse events that have

resulted in death or loss of a body part, or disability or loss of bodily function lasting more than seven days or still present at the time of discharge from a health care facility. In providing this information, the commissioner shall take into consideration not only the number of events but their rate of occurrence and how this rate compares nationwide, if applicable.

(b) The report shall not provide any identifying information about any person connected with any such event and shall not include the day or month on which any such event occurred.

(c) The report shall be presented in such a format as the commissioner deems appropriate to enable comparison among health care facilities in particular facility categories with respect to the information, and, as it pertains to general hospitals, shall be included in the New Jersey Hospital Performance Report annually issued by the commissioner that measures the performance of general hospitals in the State.

(2) The commissioner and the Commissioner of Human Services shall jointly issue an annual report to the Governor, and to the Legislature pursuant to section 2 of P.L.1991, c.164 (C.52:14-19.1), to be made available on the official Internet website of the department, which assesses the progress made by health care facilities in effectuating the purposes of P.L.2004, c.9 (C.26:2H-12.23 et seq.) and makes such recommendations for operational changes in health care facilities, and specifically for changes by regulation or legislation, as either or both commissioners determine appropriate.

(cf: P.L.2004, c.9, s.3)

2. This act shall take effect one year after the date of enactment or one year after the adoption of regulations by the Commissioner of Health and Senior Services to implement the provisions of P.L.2004, c.9 (C.26:2H-12.23 et seq.) in all health care facilities to which the provisions of that act apply, whichever date is later.

SPONSORS STATEMENT

This bill amends the "Patient Safety Act," P.L.2004, c.9 (C.26:2H-12.23 et seq.) to make publicly available certain information reported by health care facilities concerning medical errors and other adverse events that occur at those facilities. The facilities covered under the law include health care facilities licensed by the Department of Health and Senior Services (DHSS) and State psychiatric hospitals operated by the Department of Human Services.

The bill requires the Commissioner of Health and Senior Services, in consultation with the Commissioner of Human Services, to make available to members of the public, on the DHSS

Internet website, a report on hospital performance on patient safety measures with appropriate statistical risk adjustments based upon significant hospital characteristics and covariates of patient clinical outcomes.

- The report is to include, at a minimum, the risk-adjusted rate of occurrence of serious preventable adverse events that have resulted in death or loss of a body part, or disability or loss of bodily function lasting more than seven days or still present at the time of discharge from a health care facility. In providing this information, the Commissioner of Health and Senior Services is to take into consideration not only the number of events but their rate of occurrence and how this rate compares nationwide, if applicable.
- The report is not to provide any identifying information about any person connected with any such event and is not to include the day and month on which any such event occurred.
- The report is to be presented in such a format as the Commissioner of Health and Senior Services deems appropriate to enable comparison among health care facilities in particular facility categories with respect to the information, and, as it pertains to general hospitals, is to be included in the New Jersey Hospital Performance Report annually issued by the commissioner that measures the performance of general hospitals in the State.

The bill also requires the Commissioner of Health and Senior Services and the Commissioner of Human Services to jointly issue an annual report to the Governor and Legislature, to be made available on the DHSS Internet website, which assesses the progress made by health care facilities in effectuating the purposes of the "Patient Safety Act" and makes such recommendations for operational changes in health care facilities, and specifically for changes by regulation or legislation, as either or both commissioners determine appropriate.

The bill takes effect one year after the date of enactment or one year after the adoption of regulations by the Commissioner of Health and Senior Services to implement the provisions of the "Patient Safety Act" in all health care facilities to which the provisions of that law apply, whichever date is later.

ASSEMBLY HEALTH AND SENIOR SERVICES COMMITTEE

STATEMENT TO

ASSEMBLY COMMITTEE SUBSTITUTE FOR
ASSEMBLY, Nos. 1264, 3371 and 3633

STATE OF NEW JERSEY

DATED: MAY 7, 2009

The Assembly Health and Senior Services Committee reports favorably an Assembly Committee Substitute for Assembly Bill Nos. 1264, 3371 and 3633.

This committee substitute requires the Department of Health and Senior Services (DHSS) to report certain patient safety indicators (PSIs) on a hospital-by-hospital basis and prohibits hospitals from charging a patient or third party payer for certain medical errors.

The substitute provides specifically as follows:

- DHSS is directed to include in the New Jersey Hospital Performance Report, issued annually by DHSS, hospital-specific data concerning the 12 PSIs developed by the federal Agency for Healthcare Research and Quality (AHRQ) and two PSIs describing events that occur while the patient is in the hospital and for which the federal Centers for Medicare and Medicaid Services (CMS) does not provide reimbursement. These PSIs include:

  (1) Foreign Body Left During Procedure (PSI 5) Discharges with foreign body accidentally left in during procedure per 1,000 discharges;

  (2) Iatrogenic Pneumothorax (PSI 6) Cases of iatrogenic pneumothorax per 1,000 discharges. Excludes trauma, thoracic surgery, lung or pleural biopsy, or cardiac surgery patients, and MDC 14;

  (3) Postoperative Hip Fracture (PSI 8) Cases of in-hospital hip fracture per 1,000 surgical discharges. Excludes patients in MDC 8, with conditions suggesting fracture present on admission and MDC 14;

  (4) Postoperative Hemorrhage or Hematoma (PSI 9) Cases of hematoma or hemorrhage requiring a procedure per 1,000 surgical discharges. Excludes MDC 14;

  (5) Postoperative PE or DVT (PSI 12) Cases of deep vein thrombosis or pulmonary embolism per 1,000 surgical discharges. Excludes obstetric patients;

  (6) Postoperative Sepsis (PSI 13) Cases of sepsis per 1,000 elective surgery patients, with length of stay more than three days.

Excludes principal diagnosis of infection, or any diagnosis of immunocompromised state or cancer, and obstetric admissions;

(7) Postoperative Wound Dehiscence (PSI 14) Cases of reclosure of postoperative disruption of abdominal wall per 1,000 cases of abdominopelvic surgery. Excludes obstetric admissions;

(8) Accidental Puncture or Laceration (PSI 15) Cases of technical difficulty (e.g., accidental cut or laceration during procedure) per 1,000 discharges. Excludes obstetric admissions;

(9) Transfusion Reaction (PSI 16) Cases of transfusion reaction per 1,000 discharges;

(10) Birth Trauma— Injury to Neonate (PSI 17) Cases of birth trauma, injury to neonate, per 1,000 liveborn births. Excludes some preterm infants and infants with osteogenic imperfecta;

(11) Obstetric Trauma— Vaginal Delivery with Instrument (PSI 18) Cases of obstetric trauma (3rd or 4th degree lacerations) per 1,000 instrument-assisted vaginal deliveries;

(12) Obstetric Trauma— Vaginal Delivery without Instrument (PSI 19) Cases of obstetric trauma (3rd or 4th degree lacerations) per 1,000 vaginal deliveries without instrument assistance;

(13) Air embolism; and

(14) Surgery on the wrong side, wrong body part, or wrong person, or wrong surgery performed on a patient.

- DHSS is to use data from procedure and diagnosis codes recorded in hospital bills to compile the required information on PSIs. Most of the PSIs listed in the substitute are currently risk-adjusted, by age, sex, diagnosis, and comorbidities, and are externally validated as suitable for hospital quality comparisons. With the exception of air embolism and wrong surgery, the PSIs listed in the substitute were developed by AHRQ. The air embolism and wrong surgery PSIs are included in the substitute because they are already included by CMS in the list of hospital-acquired conditions or "never" events that are not eligible for payment under the Medicare and Medicaid programs.
- The Commissioner of Health and Senior Services, in consultation with the Quality Improvement Advisory Committee in DHSS, is to include additional PSIs in the annual report, by regulation, taking into consideration those indicators that:

-- are recommended by AHRQ or CMS;

-- are suitable for comparative reporting and public accountability, and are risk adjusted;

-- have a strong evidence base with no substantial evidence against their use for comparative reporting; and

-- can be measured through data that are available through hospital procedure and diagnosis codes.

- A general hospital is prohibited from charging or otherwise seeking to obtain payment from a patient for costs associated with any of the following conditions or events subject to the hospital acquired

condition payment policy for the Medicare program established by CMS: transfusion reaction; air embolism; foreign body left during the procedure; surgery on the wrong side, wrong body part, or wrong person; or wrong surgery performed on a patient.

- The provisions of the substitute are not to be construed to prohibit a hospital from seeking to obtain payment from a patient or any third party payer for any services that the hospital provides for which it is otherwise permitted to seek to obtain payment.
- A general hospital is required to notify its patients of the provisions of the substitute.
- Nothing in the substitute is to be construed to deny any party access to any existing payment appeals process.
- In any civil action alleging professional negligence against a general hospital, the provisions of the substitute are not to modify the requirement, where applicable, for expert testimony in accordance with the established case law of this State.
- The Commissioners of Health and Senior Services and Banking and Insurance are to collaborate in developing standards for general hospitals and third party payers to implement the billing prohibition provisions of the substitute.
- The commissioner is to request the Quality Improvement Advisory Committee in DHSS to study and make recommendations to the commissioner on how to expand public reporting by DHSS of patient pressure ulcers, patient infections due to hospital care, and falls by patients in general hospitals.
- The substitute takes effect on the 180th day after enactment, but the commissioner is authorized to take anticipatory administrative action in advance as necessary for its implementation.

As reported by the committee, this substitute is identical to the Senate Committee Substitute for Senate Bill No. 2471 (1R) ACA (Vitale/Sweeney/Weinberg), which the committee also reported on this date.

JON S. CORZINE
Governor

For Immediate Release:
Date: August 31, 2009

For More Information:
Robert Corraels

Phone: 609-777-2600

Governor Corzine Signs Legislation Improving Patient Safety

PRINCETON - In an important step toward even safer health care in New Jersey, Governor Jon S. Corzine today signed legislation requiring public reporting of each hospital's patient safety performance and rates of serious medical errors.

Related Links

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"New Jersey is a national leader in protecting consumers and promoting quality health care," Governor Corzine said. "Today, we are enacting legislation that represents an important step forward for the health and safety of our citizens. By doing so, we will be helping people make more informed health care decisions and helping hospitals prevent medical errors."

The bill, S2471/A1264, requires the Department of Health and Senior Services to publish in its annual New Jersey Hospital Performance Report hospital-specific results on measures of patient safety. These measures, which have been endorsed by national experts, include such serious adverse events as objects left inside patients during surgery, accidental cuts and punctures to patients, or hip fractures suffered in a post-surgery fall.

"While the federal government continues to debate the best form for universal care, we must do everything we can on the State level to ensure patient safety in the health care setting," said Senator Joseph F. Vitale, (D-Middlesex), and Chairman of the Senate Health, Human Services and Senior Citizens Committee. "By publicizing patient safety data, we can empower health care consumers to make the best choices for themselves and their families, and bring free market principles to bear in creating a safer health care climate in New Jersey. This new law will encourage underperforming hospitals to do better, and will help patients and their families make informed decisions about their health care."

"When most people buy a car or a home appliance, they do some research to make sure they're getting the best deal for their money," said Senate Majority Leader Steve Sweeney, (D-Gloucester, Cumberland and Salem). "However, with health care, consumers are essentially left in the dark, unaware of their hospital's track record on even the most basic patient safety indicators which are already collected by the industry and the State. It's time that we share this information with the public, to let them make the best decisions possible and control their own health care destiny."

The 2009 New Jersey Hospital Performance Report released later this year will be the first to include the newly available patient safety data.

"Patients and families have a right to know which hospitals have the higher and lowest error rates so they can compare and make responsible health care choices," said Assemblyman Paul Moriarty (D-Gloucester/Camden). "Consumers deserve meaningful health quality information and that's what this law will give them. Patients rightly expect that their safety and wellbeing will be protected when they visit a hospital. When that expectation is invalidated because of a medical error that should have never occurred, the hospital where the error was made - not the patient - should be on the hook."

Last fall, Governor Corzine convened a Hospital Reporting Work Group, and charged it with developing a public, hospital-specific reporting strategy that built on patient safety legislation proposed in the Senate and Assembly. Participating in the group were legislative leaders as well as representatives of the AARP, the New Jersey Hospital Association, Health Professionals and Allied Employees Union and New Jersey Health Care Quality Institute.

"Under the Governor's leadership, key stakeholders joined forces to strengthen New Jersey's patient safety protections," said Health and Senior Services Commissioner Heather Howard. "We know that public reporting of

hospital performance improves quality and promotes excellence in patient safety-as we have seen with dramatic decreases in cardiac surgery deaths. This legislation is an important step forward for consumers."

New Jersey will report numbers of adverse events and rates, by hospital, along with statewide and national comparisons. Fourteen measures were chosen based on work of federal Agency for Healthcare Research and Quality and the Centers for Medicare and Medicaid.

"Providing the public with information about medical errors at each hospital will increase transparency for consumers and ensure patients are informed about the facility where they and their families seek medical care," said Assemblywoman Linda Greenstein (D-Middlesex/Mercer). "People can find out all sorts of safety information about cars and household appliances. They should be able to access that same information about hospitals."

The Legislature also decided to leverage a new policy of nonpayment of errors, used by Medicare, New Jersey's Medicaid program and a growing number of insurance companies, to protect consumers. Hospitals will now be prohibited from charging consumers and their insurance companies for serious medical errors.

"Hospital-specific reporting will improve patient safety and be more even-handed for hospitals because it will be limited to truly preventable conditions while providing the state with the means to track incidence rates, transmission and reduction of these conditions," said Assemblyman Herb Conaway, M.D. (D-Burlington/Camden).

This is the latest in a series of initiatives to improve health care quality through public reporting on performance and health outcomes. Cardiac Surgery in New Jersey - which reports on patient mortality rates and other performance measures for both hospitals and individual cardiac surgeons - has helped reduce cardiac bypass surgery mortality by more than 50 percent since reporting began.

"When preventable medical mistakes occur, hospitals should not be rewarded," said Assemblyman Louis Greenwald (D-Camden). "Denying payment for these types of errors will send a message loud and clear: when dealing with matters of life and death we will not tolerate any margin of error."

The Hospital Performance Report monitors how well hospitals treat heart attack, pneumonia and heart failure patients, and how well they prevent surgical infections. DHSS also publishes a report on Inpatient Quality Indicators, which are used to measure hospital performance in treating a number of common medical conditions.

"Unfortunately, medical mistakes occur but the patient should have peace of mind that they will not have to pay the price for preventable hospital errors that result in serious health conditions," said Assemblywoman Nilsa Cruz-Perez (D-Camden).

"This landmark legislation addresses many of the concerns that AARP New Jersey raised in the more than two years we worked on this issue: quality, transparency, choice, and the empowerment of health care consumers," Sy Larson, AARP New Jersey State President said. "It is estimated that nationwide 9.3 billion dollars are spent every year in excess charges due to preventable medical errors. Our thanks to the Governor, Commissioner Howard, and all the legislators and community leaders who worked so hard to see this through."

To ensure that New Jersey's patient safety reporting stays current with best practices nationally, the law requires that the Department's Quality Improvement Advisory Committee (QIAC) study and recommend ways to include new patient safety indicators in the public reporting. QIAC advises DHSS on hospital quality and performance monitoring initiatives.

"New Jersey's health care consumers have a fundamental right to know whether their hospital is doing everything it can to guarantee patient safety," said Senator Loretta Weinberg, (D-Bergen), Vice Chairwoman of the Senate Health Committee. "This is probably one of the most important and effective reforms we can enact to ensure the safety and quality of health care in the Garden State. Through this new law, we can make sure that hospitals feel the pain of lax patient safety in their bottom lines, and do everything they can to reduce medical errors and employee mistakes."

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