The Hidden Cost of Regulation: The Administrative Cost of Reporting Serious Reportable Events

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Background: More than half of the 50 states (27) and the District of Columbia require reporting of Serious Reportable Events (SREs). The goal is to hold providers accountable and improve patient safety, but there is little information about the administrative cost of this reporting requirement. This study was conducted to identify costs associated with investigating and reporting SREs.

Methods: This qualitative study used case study methods that included interviewing staff and review of data and documents to investigate each SRE occurring at one academic medical center during fiscal year 2013. A framework of tasks and a model to categorize costs was created. Time was summarized and costs were estimated for each SRE.

Results: The administrative cost to process 44 SREs was estimated at $353,291, an average cost of $8,029 per SRE, ranging $6,653 for an environmental-related SRE to $21,276 for a device-related SRE. Care management SREs occurred most frequently, costing an average $7,201 per SRE. Surgical SREs, the most expensive on average, cost $9,123 per SRE. Investigation of events accounted for 64.5% of total cost; public reporting, 17.2%; internal reporting, 10.2%; finance and administration, 6.0%; and 2.1%, other. Even with 26 states mandating reporting, the 17.2% incremental cost of public reporting is substantial.

Conclusion: Policy makers should consider the opportunity costs of these resources, averaging $8,029 per SRE, when mandating reporting. The benefits of public reporting should be collectively reviewed to ensure that the incremental costs in this resource-constrained environment continue to improve patient safety and that trade-offs are acknowledged.
is available to the public. In addition, when an event is determined to be preventable, hospitals are required to refrain from billing the charges related to the services that were provided which led to the event as well as the charges for services required to address the injury.7

There is an incomplete literature that begins to describe the costs associated with adverse events, the costs associated with fulfilling aspects of state regulatory requirements, and the costs associated with malpractice payments. We know that hospitals spend upward of $4.4 billion annually in health care delivery costs as a result of SREs and other adverse events, as many patients receive additional health care services and stay in the hospital longer.8 In 2008 one study estimated the cost of all medical errors to be approximately $17 billion a year, with an estimated total cost of $3.7 billion for SREs or what Medicare calls “never events,” 22% of the total cost of medical errors.9 Some recent studies have begun to look at the cost of quality and safety programs and the reporting of quality metrics to various credentialing agencies and to payers. One study, for example, estimated that $15.4 billion is spent by physician practices for credentialing agencies and payers. Onestudy, for example, estimated that $15.4 billion is spent by physician practices on quality reporting.10

SRE reporting requirements, while potentially an important tool to improve patient safety, are time consuming, potentially redundant with other reporting activities, and costly to the provider. Although we are beginning to understand the hospital infrastructure costs to monitor adverse and safety events and to create a culture of safety, the costs of investigating and reporting SREs are unknown.

The objective of this study was to identify the administrative costs incurred to investigate and report SREs, using the experience at one academic medical center (AMC) as a case study. Although hospitals can estimate the revenue lost and the additional health care delivery costs incurred, there is limited understanding of the administrative financial cost incurred when an SRE occurs.

METHODS

Setting

Using case study methods,11 we conducted a study to estimate the administrative cost of investigating, processing, and reporting SREs at one AMC and its physicians’ organization with an established Center for Quality and Safety (CQS). The CQS had well-documented processes and procedures in place, was known to be transparent, and had established a model of national interest.12 While not necessarily generalizable, this hospital’s cost should be similar to that of other AMCs and directionally similar to hospitals in general. This study, which we conducted during fiscal years (FyS) 2014 and 2015, examined the SREs that occurred during FY 2013 (October 2012 through September 2013.) These SREs were reported to the Massachusetts DPH and are included among the calendar year events on the AMC’s public Internet website.13

Approach

Case study methods included extensive interviewing of staff to identify tasks and time to process each SRE, reviewing case file documentation and e-mails, and reviewing financial and accounting data. Prior to the specific investigation (for this study) of the time and effort spent by hospital staff processing each SRE, two of the authors [B.B.B., B.A.] interviewed senior and administrative CQS staff to understand both the timing and the tasks that occur when an SRE is reported to CQS. We created a framework to identify detailed tasks performed and to categorize tasks into broad areas or cost classifications. This task-based framework was used to conduct semistructured interviews across the hospital, which we now describe.

SRE Interviews and Estimating Time

Two authors [B.B.B. and B.A.] together interviewed, in a series of individual sessions, hospital staff (that is, nurses and physicians on the hospital floor or ambulatory setting where the event occurred, as well as supervisors, patient care services, managers, and others), asking for recall of time and effort associated with the investigation of the event. They then, together, conducted a second set of interviews of staff (CQS, compliance, risk management, legal, accounting, and other staff) responsible for processing and investigating each specific SRE. Time and effort data were again collected in the second set of interviews.

Semistructured interview techniques were used to identify the time spent on each task, in 15-minute intervals, required to process the SRE. Self-reported times were identified after staff reviewed e-mail, case files, and notes. The specific staff person or job category was noted so that subsequent allocation of salaries would be accurate. Estimated time was aggregated by individual SRE, SRE type, and cost classification to allow for analysis.

Key stakeholders, including frontline clinical staff, quality chairs, compliance and risk management staff, CQS staff, finance, and others, validated the documented processes and estimates of time. Summaries of tasks and times were reviewed with CQS staff and compared by authors to paper SRE files that included documentation and e-mails in order to validate the recall of the staff interviewed.

Calculating Cost

The primary costs associated with each SRE are the direct labor costs associated with the time (minutes/hours) invested by staff to process each SRE. Direct labor costs, including salaries and institutional fringe benefits, were estimated using job categories and benefit and salary information obtained from department managers and human resources. Labor costs, which were allocated to the aggregated summary of time for each staff person, were estimated using a modified time-driven activity-based costing
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