

## ACP Hospitalist

### Medicare takes aim at hospital-acquired conditions

*New reimbursement rules could put hospitalists in the driver's seat*

**By Susan FitzGerald**

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Medicare's recent announcement that it will stop paying for some hospital-acquired conditions has hospitals ramping up their quality improvement efforts, and some experts predict that hospitalists are likely to find themselves center stage.

**Sidebar:**

[Quality improvement can be its own incentive](#)

Under rules scheduled to take effect Oct. 1, 2008, Medicare will no longer pay for the extra cost of treating eight conditions acquired in the hospital, including certain infections, falls and pressure ulcers. The new policy by CMS is part of an unfolding effort to push hospitals to improve medical quality and enhance patient safety while holding the line on costs.

#### The basics

The eight conditions targeted by Medicare for reimbursement denial beginning October 2008 include three "serious preventable events," sometimes called "never events":

- object left in a patient after surgery,
- air embolism and
- blood incompatibility.

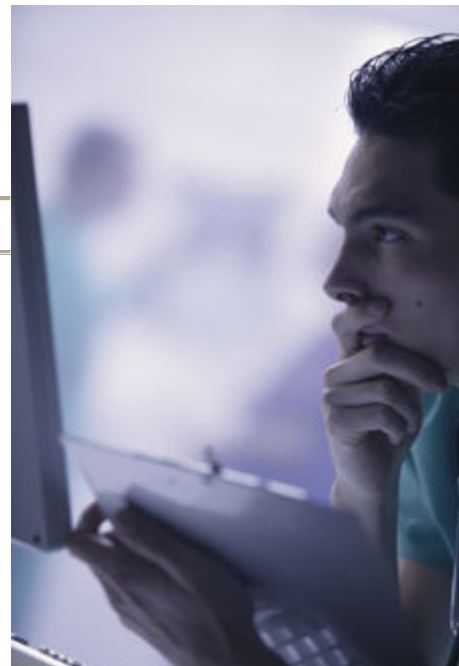
Also on the list are catheter-associated urinary tract infection, vascular catheter-associated infection, pressure ulcers, mediastinitis after coronary artery bypass grafting and falls (covered under specific trauma codes).

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*New Medicare rules may mean increased documentation, experts say.*

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"This plan by CMS is a good way to align financial incentives with quality, to say, 'We are incentivizing hospitals to follow best practices, to deliver the best care possible,'" said Justine M. Carr, MD, senior director for clinical resource management at Beth Israel Deaconess Medical Center in Boston. "There will be an initial



challenge for institutions that have not taken a systems approach to managing adverse outcomes. This CMS initiative will put more pressure on them to make that change."

CMS also is considering withholding payment for three additional secondary conditions: ventilator-associated pneumonia, *Staphylococcus aureus* septicemia and deep venous thrombosis and pulmonary embolism, although the specifics are still being worked out.

"Over time, people may come up with other conditions," said Pat Brooks, a senior technical advisor at CMS. "It's not a static list." Ms. Brooks said CMS has been receiving feedback from a variety of professional groups, including ACP.

Hospitals are also facing another change in Medicare policy. Starting Oct. 1 of this year, CMS began requiring hospitals to have a "Present on Admission" (POA) indicator for all diagnoses reported on reimbursement claims. Hospitals will have a grace period to adapt to the new requirement, but for discharges on or after April 1, 2008, CMS will return claims if the POA coding information is missing. This new reporting method was mandated under the Deficit Reduction Act of 2005.

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## **A nationwide focus**

The more recent CMS initiative comes amid a growing focus nationwide on the extent to which medical errors and other preventable conditions keep patients in the hospital longer, in some cases causing serious disability or death.

In the category of infections alone, according to a report released in May by the CDC, an estimated 1.7 million hospital-related infections occur in the U.S. each year, leading to 99,000 related deaths. Almost one-third of hospital infections are urinary tract infections, the CDC reported.

A recent quality and safety survey by the Leapfrog Group, a Washington-based group which represents corporations and public agencies, found that hospitals still have a long way to go in adopting best practices to prevent these infections. Eighty-seven percent of the 1,300 hospitals who responded to the survey did not follow all of the recommended policies to prevent infection. Only 32.3% of hospitals, for instance, complied with recommended practices to prevent surgical site infections, and 35.6% of hospitals surveyed followed all the recommendations for hand hygiene. Leapfrog noted that hospital-acquired infections add, on average, more than \$15,000 to a patient's hospital bill.

"CMS is sending a loud and clear signal that they're holding hospitals to certain standards of quality and safety," said Rachel Weissburg, program associate at the Leapfrog Group.

Medicare is not the only insurer moving in the direction of linking the quality of care, or so-called performance, to payment. Some private insurers have begun rewarding hospitals for improving certain quality measures, and it's likely, experts say, that the private market will eventually follow Medicare's lead in withholding payment for preventable complications.

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## **Robbing Peter to pay Paul**

While no one disputes that more needs to be done to prevent complications in patients, however, not everyone agrees that Medicare has picked the ideal list of conditions to focus on. And some

doctors say that the initiative, while admirable, could very well lead to more testing and a need for additional staffing, both of which could add to the cost of care.

"You may be stealing from Peter to pay Paul," said William Ford, MD, section chief of hospital medicine for Temple University Hospital in Philadelphia and program medical director for Cogent Healthcare. Doctors will need to be certain to document every potential issue on admission, he said. One example: "I think you'll find an overutilization of urinalysis to detect any sort of signs of infection prior to a patient coming into the hospital."

Toni Brayer, FACP, regional chief medical officer for Sutter Health's Bay Area Region in California, expects that the threat of nonpayment will lead to the ordering of more tests at admission.

"If a patient comes in from a nursing home through the ED and has a catheter, you darn well better get a urine culture to make sure they aren't coming in with a UTI," she said, adding that checking for bed sores will also be critical at the time of admission.

Dr. Brayer also said the new CMS regulations will likely require hospitals to hire more staff, including additional coders to deal with the paperwork and concurrent review nurses to track patients while they are in the hospital.

Peter J. Pronovost, MD, director of adult critical care and medical director for the Center for Innovation in Quality Patient Care at Johns Hopkins University School of Medicine in Baltimore, said certain complications, such as an object left in a patient after surgery and broken bones from a fall, are clear-cut and easy for hospitals to document and gather data on. But he said other conditions, such as air embolism and pressure ulcers, aren't necessarily so straightforward. For instance, it may be difficult to say when pressure ulcers began for a patient who came in from a nursing home. And deep venous thromboses can happen "in spite of the best medical practice," he said.

"We need to define explicit criteria by which to select complications to be included in this effort," Dr. Pronovost said. "As a start, we ought to select complications that are important, measurable and preventable. Many of the complications on this list fall short on both being measurable and preventable."

One potential fallout of Medicare's decision to withhold payment for certain hospital-acquired conditions, said Dr. Pronovost, is that it could inadvertently cause doctors to limit their differential diagnoses, prompting them to adopt a "don't-look" attitude because they might be penalized. "If I'm not going to get paid for it, I might be less likely to label someone with that," he said.

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## **Meeting Medicare's challenge**

At the same time, the new Medicare regulations present hospitalists with an opportunity to play a key role in the development and implementation of new or expanded quality control initiatives at their hospitals, experts say.

"I think hospitalists and intensivists have huge roles and opportunities for leadership in the areas of quality and safety," Dr. Pronovost said. "This isn't going to go away, so the way for hospitalists to go is to assume a leadership role." Many hospitals, in fact, have already established protocols to help prevent complications on the Medicare list, and others are in the process of developing them.

Temple University's Dr. Ford said the new policy to tie payments to performance should not have caught anyone by surprise given the quality improvement trend in health care. "Everyone saw it coming down the pike," he said. The new Medicare policy should give hospitals an added reason to spend committee time and effort to develop prevention protocols, he said. "Sometimes a kick in the pants helps."

His hospital already is focused particularly on how to prevent catheter-associated urinary tract infections and pressure ulcers. Because hospitalists at Temple comanage patients for a number of services, including orthopedics, the burn unit and neurosurgery, they are key to prevention efforts, he said.

Dr. Ford said hospitalists at teaching centers such as his also will play an important role in educating residents about the new policies, teaching them, for instance, the importance of doing "better documentation of physical exams" on admission.

"They need to understand what they'll be facing in practice," he said. "We have a responsibility to help improve the outcomes for our patients and in doing so we'll improve outcomes for the hospital."

Catheter use—who puts them in, how to put them in, how long to leave them in—is a big issue for hospitals and will likely become even bigger with the new Medicare regulations.

Beth Israel Deaconess Medical Center has developed a major initiative to prevent central line infections, for instance, that involves a multidisciplinary approach and is based on input from doctors and nurses all over the hospital—the ED, ICU, patient units, anesthesiology, surgery and infection control, Dr. Carr said. The initiative involves, among other things, the ready availability of kits with barrier supplies so that personnel will always take the proper precautions when placing lines, and a two-person nursing team that goes around to look at all the lines in place. The hospital also has a skills center to teach physicians the best technique for placing lines, Dr. Carr said. She said the hospital's central line infection rate has decreased more than 50% from fiscal year 2005.

"If you want to fix something, you have to do it institutionally," she said. "It has to be a cultural change where people agree, 'This is what we are trying to achieve.'"

Sutter Health's Dr. Brayer said having consistent methods for doing things—for instance, a best practice protocol for central line placement—is key to preventing infections and other problems. "We have way too much variability in how we practice medicine," she said. "But there are some things we can control if we do things in a standardized way."

She said it's also important for hospitals to have a "no-blame culture."

"If there's an error or a problem, you don't focus on who did it," she said. "You look at the whole process around it, break it down step by step and see how you can change the flow, the process, so it doesn't happen again."

Felix Aguirre, MD, vice president for medical affairs for IPC The Hospitalist Company, said his company, which supplies hospitalists to hospitals, has begun to educate its doctors on changes taking hold in the Medicare program. Like Drs. Ford and Brayer, Dr. Aguirre feels that documenting as much as possible on admission will be crucial.

Also, although the current round of Medicare changes targets hospitals, physicians should be aware that "quality initiatives that originate on the facility side eventually migrate to the physician

side," Dr. Aguirre said. "You could easily imagine that in the near future Medicare could start declining payment to physicians for an untoward event."

Hospitals that have already begun working on quality improvement projects have an advantage when it comes to the new Medicare regulations, said Dr. Brayer. But no matter what stage a hospital is at, she said, "hospitalists need to be at the table developing quality initiatives. They need to be in the driver's seat."

*Susan FitzGerald is a freelance writer in Philadelphia.*

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## **Quality improvement can be its own incentive**

For hospitals and payers trying to improve quality, is pay-for-performance the only way to go? Not according to Peter J. Pronovost, MD, director of adult critical care and medical director for the Center for Innovation in Quality Patient Care at Johns Hopkins University School of Medicine in Baltimore, who believes that paying for better quality needs to be part of a more comprehensive solution.

"The evidence to date shows that pay-for-performance produces a modest improvement at best," he said. "The assumption is that simply by not paying the hospital, there is going to be a strong enough incentive to redesign the system and improve things." In fact, he said, it takes a multipronged approach to bring about change.

As an example, Dr. Pronovost cited a December 2006 study in *The New England Journal of Medicine* documenting the results of an effort to reduce catheter-related bloodstream infections (CRBIs) at 108 ICUs in Michigan. In the study, which Dr. Pronovost led, the ICUs implemented five evidence-based practices to prevent infection:

- Hand washing,
- Using full-barrier precautions when inserting central venous catheters,
- Cleaning skin with chlorhexidine,
- Avoiding the femoral site if possible, and
- Removing unnecessary catheters.

In addition, each ICU had at least one physician and one nurse who were designated as team leaders. Clinicians were educated about infection control practices and about the consequences of CRBIs. Procedures were stopped in nonemergency cases when infection control practices were not being followed properly, and teams were given regular feedback on their patients' infection rates. As a result of the initiative, the average infection rate went from 7.7 per 1,000 catheter-days at baseline to 1.4 infections per 1,000 catheter days at 16 to 18 months of follow-up. This reduction was maintained over the 18-month study period.

"We nearly eliminated catheter-related bloodstream infections," Dr. Pronovost said, "and it was done without pay-for-performance and public reporting."