Trauma Safety Net Status Not Tied to Mortality

BY FRAN LOWRY
Orlando Bureau

LAKE BUENA VISTA, FLA. — Trauma patients treated at trauma safety net hospitals—those that care for the highest percentage of uninsured patients—have equivalent in-hospital mortality as trauma patients treated at non–trauma safety net hospitals—those that care for a predominantly insured clientele.

In a retrospective analysis of trauma patients aged 18-64 years included in the National Trauma Data Bank for the years 2001-2005, the adjusted odds ratio of death was 0.93 (95% confidence interval, 0.65-1.32) for both types of facilities.

The result indicates that disparate trauma outcomes because of insurance status are not explained by differences between treating institutions, Dr. Anit S. Vettukattil of Georgetown University Hospital, Washington, said at the annual meeting of the Eastern Association for the Surgery of Trauma.

Trauma safety net hospitals were defined as facilities whose patient population was at least 47% uninsured trauma patients; non–trauma safety net hospitals were facilities with less than 47% uninsured trauma patients. Only adults between the ages of 18 and 64 years with moderate to severe injuries were included. The study adjusted for differences in patients' age, sex, insurance status, injury severity, severe head injury, hypotension upon arrival in the emergency department, and type and mechanism of injury.

A variety of subset analyses also were performed to rule out any possible con-

Disparate trauma outcomes due to insurance status are not explained by differences between treating institutions.

DR. VETTUKATTIL

founding effect of different trauma center types. These analyses focused on university teaching hospitals, public hospitals, and level 1 trauma centers, Dr. Vettukattil said.

The analysis looked at 36,774 patients treated at 46 trauma safety net hospitals, and 306,279 patients treated at 413 non–trauma safety net hospitals. A mean of 61% of patients were uninsured at the trauma safety net hospitals, and a mean of 26% of patients were uninsured at the non–trauma safety net hospitals.

The majority of patients at both types of hospital were male (78% at trauma safety net vs. 73% at non–trauma safety net hospitals), and the mean ages were also similar (36 years at trauma safety net vs. 38 years at non–trauma safety net hospitals). However, 55% of the patients treated at safety net hospitals were black or Hispanic, compared with 27% of patients treated at non–safety net hospitals.

The unadjusted mortality rate was greater in trauma safety net hospitals, compared with non–trauma safety net hospitals (6.8% vs. 4.6%, *P* less than .05). However, after controlling for patient and hospital type, patients at both kinds of facility had the same odds ratio of death of 9.3.

Patients treated at hospitals that care for the highest percentage of uninsured patients have been shown to be at risk for worse outcomes. These results show, however, that such disparities are not because of the care these patients receive at safety net hospitals, coauthor Dr. Adil H. Haider said in an interview.

"We were very careful in doing our analysis. Our results were very consistent. Every time we analyzed the data, we got the same result. There is no difference in mortality between safety net and non–safety net hospitals. The fact that this stood up to every single statistical test we could think of makes us very confident in concluding that the disparities in

'Our results were very consistent. Every time we analyzed the data, we got the same result.'

DR. HAIDER

outcome between insured and uninsured patients is not explained by differences between the treating institutions," said Dr. Haider, who is codirector of the Trauma Outcomes Research Group at Johns Hopkins University, Baltimore.

He added that trauma safety net hospitals must be supported. "These centers are providing excellent care. If they are to close because of financial troubles, we will really be disenfranchising a tremendous number of patients."

Neither Dr. Vettukattil nor Dr. Haider disclosed any conflicts of interest. ■

Medicare Payment Policy Excludes Wrong-Site Surgery

BY ALICIA AULT
Associate Editor, Practice Trends

As expected, the Center for Medicare and Medicaid Services has issued a final decision that it will not pay for wrong surgery performed on a patient, surgery performed on the wrong body part, or surgery performed on the wrong patient.

The agency issued the proposal for nonpayment in December. The three surgical errors are considered preventable and are on the National Quality Forum's list of serious reportable events, the CMS said.

"These policies have the potential to reduce causes of serious illness or deaths to beneficiaries and reduce unnecessary costs to Medicare," CMS Acting Administrator Kerry Weems said in a statement.

Efforts to reduce wrong-site surgeries are widespread. The Joint Commission established a Universal Protocol for Preventing Wrong Site, Wrong Procedure and Wrong Person Surgery in 2004. An updated version went into effect on Jan. 1.

There are few data on the frequency of surgical never events. The CMS cited a 9-year study that reported an incidence of 1 in 112,994 for wrong-site surgeries not involving the spine (Arch. Surg. 2006;141:353-7). Extrapolating data reported to the Pennsylvania Patient Safety Authority by facilities in that state, Dr. John Clarke, clinical director of the reporting system, estimates that there are four or five wrong-site surgeries each day in the United States. The Pennsylvania data are in the Quarterly Update on the Preventing Wrong-Site Surgery Project, posted on the authority's Web site, www.patientsafetyauthority.org.

After the CMS published its proposal, it received comments from 17 individuals and groups. Some said that the agency should establish an appeals process for procedures that are medically necessary but do not exactly match the informed consent. The agency said that the appeals process is the same as for any other noncovered item or service.

The American College of Cardiology, the American Medical Association, the American College of Surgeons, and the American Association of Neurological Surgeons all commented that the CMS needed to clarify how physicians could appeal a noncoverage decision.

These organizations also objected to the CMS using the national coverage decision process to determine payment policy for wrong-site surgery. The ACS wrote that the CMS should develop "a clear payment policy outlining circumstances under which surgery claims would not be payable by Medicare." Both the ACS and the AANS also urged the agency to remove wrong spine level from the noncoverage determination.

The CMS said that it believes that the national coverage decision process "is appropriate." The noncoverage decision is effective immediately. Instructions on how to process claims will be issued in the future, the agency said. ■

MedPAC Recommendations Would Increase Payments

BY ALICIA AULT
Associate Editor, Practice Trends

WASHINGTON — Medicare advisers voted to increase hospital payments by the projected increase in the market basket, and to reward high-quality, high-performing facilities with a larger, unspecified increase.

The Medicare Payment Advisory Commission—better known as MedPAC—is charged with advising Congress on setting payment rates for physicians, hospitals, and other health care providers. Its recommendations are included in twice-yearly reports issued in March and June.

The panel agreed to reduce the indirect medical education (IME) payment by 1%, which would put it at 4.5% per 10% increment in the resident:bed ratio. MedPAC staff said that the IME payment was a roughly $3 billion subsidy with little required accountability in return. The staff also said that the current rate was set at more than twice the impact of teaching on hospital costs, allowing academic centers to reap higher profits than do nonteaching facilities.

The American Hospital Association said it was happy with the vote to increase payments overall. But the IME reduction would "negatively affect the education, clinical care and research missions of teaching hospitals, including their ability to train high-quality physicians," AHA Vice President for Policy Don May said in a statement.

Payment increases to ambulatory surgery centers (ASC) have been frozen since 2003, but an increase is required by law in 2010. Although the centers are generally seen by Medicare as more efficient and less costly than hospital inpatient or outpatient departments, spending per beneficiary and the number of procedures per beneficiary continue to rise. The Centers for Medicare and Medicaid Services estimates that ASC spending will grow from $2.9 billion in 2007 to $3.9 billion in 2009.

MedPAC recommended that ASC payments increase by 0.6% in 2010, but also that the facilities be required to report on cost and quality data so that the CMS can better evaluate the adequacy of payments. The data collection had been recommended in 2004, but was put on hold as a new payment system was introduced for 2008. ■

INDEX OF ADVERTISERS