

## AHRQ Funds Infection Control

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oration with the Michigan Health and Hospital Association.

In the study of the intervention's effectiveness, the median rate of catheter-related bloodstream infections per 1,000 catheter-days decreased from 2.7 infections at baseline to no infections at 3 months. No infections were then seen through 18 months of follow-up. The mean number of infections dropped from 7.7 at baseline to 1.4 at 16-18 months.

The findings were based on data on infection rates that were collected monthly for up to 18 months (N. Engl. J. Med. 2006;355:2725-32 and J. Crit. Care 2008;23:207-21). The 103 participating Michigan hospitals reported on 1,981 ICU-months of data on 375,757 catheter-days.

"The findings from Michigan were incredibly dramatic. ... This is the largest study published, with the most dramatic

improvements for any of the quality and safety problems facing our nation's health-care system," AHRQ director Dr. Carolyn M. Clancy said, noting that an estimated 250,000 cases of central line catheter-associated bloodstream infections occur every year in hospitals in the United States, leading to 30,000-62,000 deaths.

"These dramatic improvements made everyone sit up and say we can do a whole lot better," Dr. Clancy said.

What makes his study unique, according to Dr. Pronovost, is its scientific focus on the delivery of health care. "Part of the failure to deliver safe care is [a result of the fact that] we haven't viewed in a scientific way how to deliver care. Science is typically limited to finding genes or finding drugs, but that really messy practice of medicine has been relegated to the art, and we dramatically underfund studies of it."

Now that AHRQ has followed up its initial support with the new grant, "We're ready to go full steam ahead" in expanding the program's reach, he said.

Over the next 3 years, AHRQ's funding will be used to train staffs at ICUs in 10 or more hospitals in 10 states, said Dr. John R. Combes, president and chief operating officer of the Center for Healthcare Governance at the AHA. He is also interim president of the AHA's trust that is receiving the grant and that will be conducting the training programs in collaboration with teams from Johns Hopkins, from Michigan, and from state hospital associations.

Ultimately the plan is to expand the intervention to the entire country. "We know this program works, and it provides the proper focus. ... The project has great potential to significantly reduce infections

on a national level," Dr. Combes said.

And, Dr. Pronovost said, the intervention should be applicable to inpatient settings other than ICUs, which were chosen for the study primarily because that's where the majority of central lines are placed and where the most accurate data are collected.

"The strategy was lick 'em in the ICU, show that the rates come down, and then have those teams take this to the operating rooms and emergency departments. That's indeed what happened in Michigan, and that's what we hope will happen [elsewhere]," he said.

Dr. Pronovost, a professor in Johns Hopkins's departments of anesthesiology and critical care medicine, and surgery, won a \$500,000 "genius" fellowship award in 2008 from the John D. and Catherine T. MacArthur Foundation for this work. ■

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## New CMS Rule Poses Infection Documentation Challenge

BY MIRIAM E. TUCKER  
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ARLINGTON, VA. — As hospitals in the United States face the new reality of nonpayment for certain health care-associated infections, ensuring "accurate and appropriate physician documentation on the patient record" is seen by infection control specialists as the area in greatest need of urgent attention.

That finding was among those from a survey of 934 hospital preventionists presented at a conference sponsored by the Association for Professionals in Infection Control and Epidemiology (APIC) and the Premier Healthcare Alliance.

As of Oct. 1, Medicare will no longer pay for care associated with hospital-acquired infections including surgical site infections, catheter-associated urinary tract infections, and vascular catheter-associated infections. Compliance requires documentation of whether the condition was present on admission (POA).

Of the survey respondents, 90% work in infection prevention/control, 2% work in quality/performance improvement, and the rest serve as patient safety experts, as administrators, or in another capacity.

A fourth of the respondents (25%) work in facilities with 100 beds or fewer, 31% work in institutions with 101-250 beds, and 16% work in facilities with 500 or more beds. Most (55%) are located in 1 of the 27 states that currently mandate reporting of health care-acquired infections (HAIs).

Asked which listed activity they believe "needs the most attention to optimize your organization's readiness" for the new payment regulations from the Centers for Medicare and Medicaid Services, 52% responded "accurate/appropriate physician documentation on the patient record."

Another 20% of the respondents listed "accurate coding, including accurate use of new [POA] codes"; 16% checked "interdepartmental collaboration for identification and documentation of health care-acquired conditions"; and 13% selected "physician education on the impact of the CMS rule" on reimbursement for health care-acquired conditions.

"Everybody's worried about the [POA] issue. They view it as intrusive, something that could potentially create new costs and all sorts of other things," Dr. Daniel

Varga, chief medical officer of St. Louis-based SSM Healthcare, said in an interview.

But "it's probably going to be more of an issue of doctors' needing to be educated, and for us to build processes to make it easy to document presence or absence of [HAIs]," Dr. Varga added.

In a keynote speech, Dr. Thomas B. Valuck, medical officer and senior adviser at CMS, described the new rule as part of the agency's overall "value-based purchasing" strategy. The idea, he said, is to transform Medicare "from a passive player to an active purchaser of higher-quality, more-efficient health care."

Until now, "Medicare's fee-for-service schedules and prospective payment systems [were] based on resource consumption and quantity of care, not quality or unnecessary costs avoided," Dr. Valuck noted. If spending continues at the current rate—projected at \$486 billion for 2009—the Part A trust fund will be depleted by 2019, he said.

This is the reason for the focus on hospital-acquired infections, which are estimated to add nearly \$5 billion annually to the national health care tab. A 2007 study found that, in 2002, 1.7 million hospital-acquired infections were associated with 99,000 deaths. Yet that survey, which was conducted by the employer/insurer coalition known as the Leapfrog Group (www.leapfroggroup.org), found that 87% of 1,256 hospitals were not consistently following recommendations that are aimed at preventing many of the most common hospital-acquired infections, Dr. Valuck said.

The three types of infections designated for nonpayment are among a list of 10 health care-acquired conditions that Medicare no longer covers (and for which CMS has been mandating reporting during the last year). The list includes "never events" such as foreign objects retained after surgery, blood incompatibility, and other conditions such as manifestations of poor glycemic control and injury after a fall (HOSPITALIST NEWS, August 2008, p. 1).

All 10 health care-acquired conditions are subject to the "present on admission" documentation requirement, which defines as POA any conditions present at inpatient admission, including those that arose during outpatient encounters in the emergency department, observation, or outpatient surgery.

There are four possible POA indicators:

► Y, which means that the diagnosis was present at the time of admission.

► N, which means that the diagnosis wasn't present.

► U, which means that documentation was insufficient to determine if the condition was present at the time of admission.

► W, which means that the POA status could not be determined despite a full clinical work-up.

Medicare will pay the additional amount for health care-acquired conditions coded as Y or W, but not for those coded as N or U, Dr. Valuck explained.

"The challenge will be to make this a joint effort between the health care provider and the coder," he said.

The APIC survey also highlighted other challenges that hospitals will face as the new rule goes into effect. Nearly two-thirds (59%) of respondents said that their institution's current surveillance process for detecting problem pathogens and potential HAIs that need investigation was "reasonably timely and efficient" but had "room for improvement," while 16% said that the process was "not timely and efficient." Also, 72% said that HAI elimination measures were "moderately" integrated into the tasks of clinicians and other staff; 9% felt that the measures were "very well integrated," and 17% said the measures were "only indirectly integrated."

Asked about the biggest challenge for their organization regarding HAI prevention, 36% listed "measuring compliance with infection prevention practices, such as hand hygiene," and 30% chose "timely and efficient tracking of all or targeted HAIs across the hospital population."

Among specific HAI prevention interventions, removal of unnecessary indwelling urinary catheters was endorsed by 55% of respondents as being the most challenging in their organizations; smaller proportions listed avoidance of central-line-associated infections (22%), antimicrobial prophylaxis for preventing surgical site infections (16%), and interventions for preventing ventilator-associated infections (6%).

Dr. Varga, who also cochairs the National Quality Forum Steering Committee on Healthcare-Acquired Infections, urged hospital-based physicians to become active participants in the development of protocols for preventing health care-acquired conditions. "Be active in the design and engineering of the protocols, of the process, then be an active participant in the feedback loop that evaluates whether that process is working or not," he advised.

"A lot of this doesn't directly impact doctors," Dr. Varga added. "It's the hospital that's not getting paid. But the hospital is going to be all over you to be a participant in this." ■

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