CMS Cracking Down on Infection Documentation

BY MIRIAM E. TUCKER
Senior Writer

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% 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]."

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, 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 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 mandated reporting for 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 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. ■

Uninsured Rate Falls as Government Programs Enroll More

BY MARY ELLEN SCHNEIDER
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The number of Americans without health insurance coverage dropped to 45.7 million in 2007, down from 47 million in 2006, mainly because of increased enrollment in government-funded health insurance programs, according to new data from the U.S. Census Bureau.

The percentage of uninsured Americans fell from 15.8% in 2006 to 15.3% in 2007.

The Census data also showed that fewer U.S. children went without health insurance in 2007. The number of uninsured children fell from 8.7 million in 2006 (11.7%) to 8.1 million in 2007 (11%).

The new figures, which were released by the Census Bureau on Aug. 26, come from the Annual Social and Economic Supplement to the Current Population Survey.

While Census officials are still researching why the number of uninsured Americans has decreased, the data point toward increased enrollment in government-funded health insurance programs. For example, the number of Americans covered by private health insurance stayed about the same at 202 million, but the number of individuals covered by government health insurance programs rose to 83 million from 80.3 million in 2006.

There were statistically significant increases in the percentage of people covered by both Medicare and Medicaid. The number of people with Medicare coverage increased from 40.3 million (13.6%) in 2006 to 41.4 million (13.8%) in 2007, and the number enrolled in Medicaid increased from 38.3 million (12.9%) in 2006 to 39.6 million (13.2%) in 2007.

"The expansion in public coverage is really what's driving this reduction," said Len Nichols, Ph.D., an economist and director of the health policy program at the New America Foundation, a nonpartisan public policy institute.

As the economy has weakened, more people who previously could not afford private coverage became eligible for public programs, he said. The good news is that the public programs safety net has caught these individuals, Dr. Nichols said, but the downside is that more and more people will drift into government-sponsored coverage if the government remains stalled on health care reform.

The private health insurance system is 'hanging on by its fingernails' and is in need of reform.

DR. NICHOLS

A careful analysis of the Census figures shows that the private health insurance system in the United States is "hanging on by its fingernails," Dr. Nichols said, and is in need of reform.

There are worrisome trends in the Census data that could soon cause the number of uninsured Americans to go back up, said Mark A. Goldberg, senior vice president for policy and strategy at the National Coalition on Health Care. The organization is a nonpartisan coalition focused on achieving coverage for all Americans.

Even though the number of uninsured Americans declined in 2007, the percentage of individuals who were able to obtain either employer-based or individual coverage also dropped. If the current economic downturn continues, safety net programs like Medicaid will be vulnerable to state-level budget cuts, Mr. Goldberg said, and could be unable to keep up with demand.

The latest uninsured figures highlight the need to shore up the employer-based health insurance system, said Karen Davis, Ph.D., president of the Commonwealth Fund. Policy makers need to find ways to make coverage more affordable for employers who want to offer it to their workers and for individuals purchasing their own, she said. Leaders should consider the range of options for expanding coverage under a mixed public-private system, whether it is requiring employers to offer coverage or contribute to it, or requiring individuals to obtain coverage and offering assistance to pay for it, she said.

"The problem is real and the public wants their leaders to do something about it," Dr. Davis said. ■