

Pay for Performance

A New Era in Infection Control

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What is "Pay for Performance?"

- It's a reimbursement method (strategy)
- US Govt – CMS – Medicare
- Pertains to Hospital Acquired Conditions
- Affects DRG payment for In-patients only
- Went into effect 10/08



Blame it on Bush !!!!

"Where government goes....."

“Never Events”

- Treatment errors that should “never” happen
- Reasonably preventable
- Prevention guidelines “based in evidence”
- CMS identified 8 “never events” for 2008
- (Added three more for 2009)

“Never Events

- 1. Objects left in the body
- 2. Blood incompatibility
- 3. Falls, burns and other injuries
- 4. Pressure ulcers
- 5. Air emboli
- 6. DVT - joint replacement (2009)
- 7. glycemic control (2009)

“Never Events”

- Hospital Acquired Infections
 1. Catheter associated urinary tract infections
 2. Vascular catheter associated infections
 3. Mediastinitis
 4. Other surgical site infections (2009)

The First Response...

- Anger ☹ Facilities feel it's punitive.
- "It's not fair!!!!!!!!!!!! ☹"
- Is it really "pay for perfection?"
- "How do we know they got it here??"
- "Is it really preventable??"
- "Are there really EB strategies to prevent it?"

Rationale

- Is it really about \$\$\$\$\$?
- Estimated savings aren't that great
- Or is it about quality of care???
- It links payment to quality of care

Scope of the Problem

- 2 million people get nosocomial infections
- Pain and suffering
- ≥ 100K die from nosocomial infections
- Patients are 6x more likely to die

Financial Impact

- The average community hospital - 1 million/yr
- Total for American hospitals – ≥7 billion/yr

Who's on Board?

- IOM – “*To Err in Human*”
- Leapfrog Group – “never events”
- IHI – Rapid Response Teams
- NQF – published the original list
- JCAHO – NPSGs
 - Says Pay for Performance is “reasonable”

Present on Admission?

- “*How do we know they got it here??*”
- A coding system used on admission should document pre-existing problems, but.....

So....What's Happening???

- Resignation replaces anger
- Long-overdue emphasis on Infection Control
- ↑ compliance with EB strategies to ↓infection
- Administrative support
- Links payment of quality of care, so..
- Quality of care is ↑

What's being done?

- Urinary catheter associated infections
 - Use caths only when indicated
 - Remove caths ASAP
 - Antimicrobial and/or antiseptic coated catheters
 - Silver impregnated catheters
 - Monitor, monitor, monitor

What's being done?

- Vascular catheter associated infections
 - a source of septicemia
 - must establish association with catheter

What's being done?

- Vascular catheter associated infections
 - hand hygiene
 - chlorhexidine skin prep (*Hibiclens™*)
 - chlorhexidine treated dressings
 - anti-microbial treated dressings
 - good stabilization
 - monitor, monitor, monitor

What's being done?

- Surgical site infections
 - Appropriate hair removal
 - Chlorhexidine skin prep
 - Assessment of other patient parameters
 - Correct choice of Ab
 - Timing of prophylactic Ab
 - Pharmacy plays an active role
 - SCIP initiative (CMS + CDC-P)

Other "never event" HAIs – 2010?

- Staph aureus septicemia
- C-diff associated problems
- Ventilator-associated pneumonia

VAP

- Pneumonia is the leading cause of death among HAIs
- VAP is a pox on *our* house!
- Increased LOS = \$40K
- IHI – Saving 100,000 lives
- The Ventilator *Bundle*

What is a “Bundle”?

- A grouping of practices
- Although they work individually,
- when applied together, the result is substantially better
- There’s good science (EBM) behind the bundle

The Ventilator Bundle

- Patient positioning
- NG tubes
- Hand hygiene
- Sedation “vacation”
- Stricter weaning policies

The Ventilator Bundle

cont

- Oral care
- Antimicrobial treated ET tubes
- Cuff pressures
- Closed suctioning

What's happened?

- Estimates since implementing the 'bundle'
 - 62% decrease in incidence of VAP
Thru
COMBINED EFFORTS OF RTs and RNs
It had nothing to do with money!
It was just the right thing to do!

Hand Hygiene & Chlorhexidine



Prevention! Prevention!

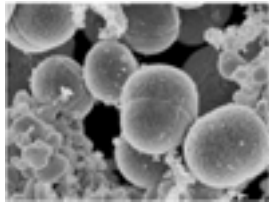
Target 100% compliance
There is a lot that can be done!
Means identifying pts who are at risk!

Monitor! Monitor! Monitor!

- It's the key to success!
- It's painstaking, time-consuming work for IC!
 - Electronic reports
 - Can quickly identify patients at risk
 - Clinical pharmacists
 - Develop stricter policies
 - Can monitor Ab use

Who's at Risk??

- Diagnosis
- Co-morbidities
- Patients with ↑ or ↓ temp
- ↑ WBCs
- Newly order C&S
- New Ab orders
- Patients with devices (ETT, venous or art line, foley caths, etc)



Some bugs will sneak through!

Catch infections early! Treat aggressively!
Blood stream infections, patients are 11x more likely to die

Collaboration works!

- State and National Collaboratives
 - SCIP
 - UTI Collaborative
 - VCI Collaboratives
 - NJHA
- Within and across states, and national efforts

RTs at Work



Let This Be an Opportunity

- Intensify your IC efforts
- Seek out the evidence
- Apply the best practices
- Take an active part in multi-disciplinary efforts
- Recognize your worth as vital team members
- Take pride in the good outcomes!

•Thank you!
