

Primer on Pay for Performance and Quality Measures

Healthcare Law Section

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WHY NOW?

- Consumers
 - Demanding safety
 - Demanding transparency: choice
- Payors
 - Want value for dollars
 - HAC increase LOS/Cost/Mortality/Morbidity
- Providers
 - Patient safety
 - Want to distinguish selves from competition
 - HAI/HAC=increased LOS=throughput problem

National Survey on Consumer's Experiences with Patient Safety and Quality Information

- 55% of consumers are dissatisfied with health care
- 92% believe error reporting should be mandatory
- 63% believe data should be released publicly
- 52% believe mistakes by individuals more important cause of harm than mistakes made by institutions
- 54% favored suspending licenses of physicians/nurses who make medical errors

Telephone survey 2012 adults 6/7-9/5/04 www.kff.org

National Survey on Consumer's Experiences with Patient Safety and Quality Information

- 34% personal medical error
 - 21% serious
 - 16% severe pain
 - 16% loss of activities
 - 23% temporary or long term disability
 - 8% death
- 11% initiated malpractice suit

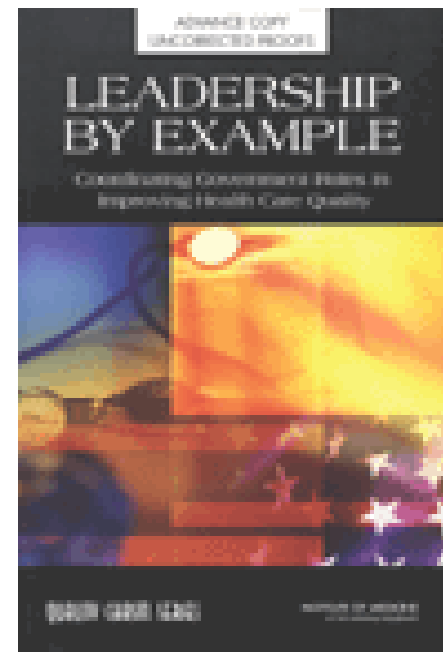
Institute of Medicine - III

Leadership by Example Coordinating Government

Roles in Improving Health Care Quality

20 areas of focus

- Immunization --
 - Vaccine-preventable diseases kill 300 children and 70,000 adults ..target nursing-home residents, minorities, and low-income, inner-city children
- Nosocomial infections - -
 - Wider implementation of the nosocomial infection guidelines from the CDC could save >40,000 lives annually



NQF - National Quality Forum

- NQF: public-private partnership -170 organizations -
 - Part of President's Advisory Commission on Quality '99
- Goal:
 - Develop national strategy for measuring and reporting HC quality data
 - Standardize healthcare performance measures so comparative data available across the US

National Forum for Healthcare Quality Measurement and Reporting
www.qualityforum.org

National Quality Forum

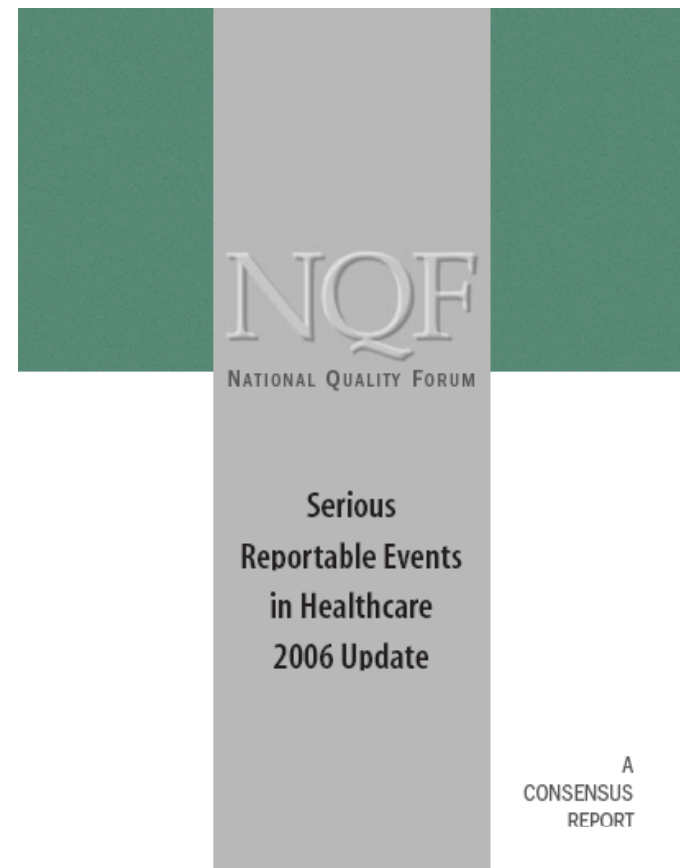
Hospital Care National Performance Measures

Released Jan 2003

- 39 measures
- To permit consumers, providers, purchasers, and QI professionals to compare quality of care in hospitals.
- Voluntary consensus standards
 - so more readily adopted for use by Medicare and other federally-funded programs

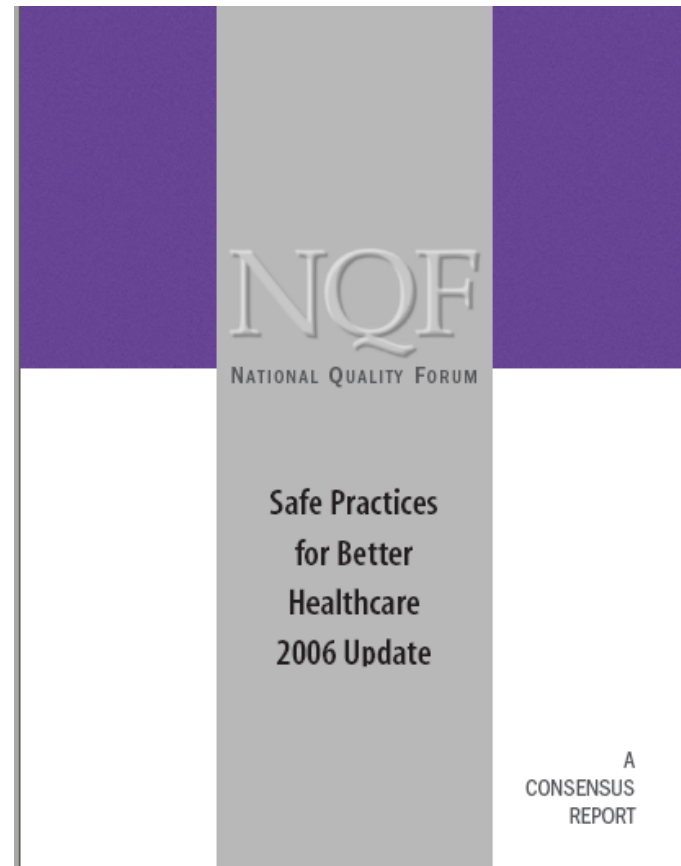
NQF Endorsed Serious Reportable Events in Healthcare: 2006

- Includes categories of events such as medication errors, falls
- List from which Joint commission chooses National Patient Safety Goals
- List from which CMS chose HACs for non-payment



NQF-Endorsed Safe Practices 2006

- Lists 30 Safe Practices all hospitals should follow
- Includes everything from informed consent to specific clinical practices
- List from which CMS chooses quality measures, value-based purchasing starter set



National Quality Forum

- Any additional measures for CMS likely to originate from NQF
- Candidate measures submitted in call for measures then vetted by steering teams, voted upon by members

The screenshot displays the National Quality Forum website. At the top, there is a navigation menu with links for Home, About Us, News, Projects, National Priorities Partnership, Publications, and Why Join?. Below the navigation menu, the page title is 'National Quality Forum'. The main content area is titled 'Publications' and includes a breadcrumb trail: 'Home > Publications > Browse by Topic'. On the left side, there is a sidebar with links for 'Browse by Topic', 'Reports', 'Report Order Form', and 'Help'. Below these links is a 'Member Login' section with a link to login to the members area. The main content area features a 'Browse by Topic' section with a grid of links to various topics, including Adult Diabetes, Ambulatory Care, Behavioral Health, Cardiac Surgery, Child Healthcare Quality, CMS-NQF Conference, Compendium 2000-2005, Home Health, Hospital Care: Additional Priority Areas, Hospital Framework, Information Technology, Informed Consent, Medication Use, Minority Health, National Framework, National Priorities, Nursing Homes, Nursing-Sensitive Care, Patient Perspectives of Hospital Care, Patient Safety Taxonomy, Pay-for-Performance, Pneumonia Mortality Supplement, Safe Practices, Serious Reportable Events, Substance Use Conditions, Tipping Point, Venous Thromboembolism (VTE), and Palliative and Hospice Care. An 'Email Page' link is also visible in the top right corner of the main content area.

Leapfrog Group

- Formed in 2000 in response to the IOM report “*To Err is Human*”
- Initially led by GM
- Voluntary consortium of Fortune 500 companies
- Goal: to promote “leaps” in quality and safety by directing covered lives to higher quality providers

Leapfrog Members

- GM
- Chrysler
- Sprint
- Boeing
- Marriott
- Fed Ex
- IBM
- Toyota
- Motorola

Leapfrog Purchasing Principles

All members of The Leapfrog Group have agreed to implement the following principles, either directly or through the help of intermediaries such as health plans or "purchasing cooperatives":

- Inform and educate employees
- Use comparative rating
- Use substantial incentives
- Focus on discrete leaps in quality and safety
- Hold health plans accountable for leapfrog implementation
- Encourage the support of consultants and brokers

Leapfrog Survey

- Updated annually
- Voluntary
- Publicly available
- Incorporates NQF Safe Practices for Healthcare

Leapfrog Results

Click to Compare ▼ Sort	Prevent Medication Errors ▼ Sort	Appropriate ICU Staffing ▼ Sort	Steps to Avoid Harm ▼ Sort	Reduce Pressure Ulcers ▼ Sort	Reduce In-Hospital Injuries ▼ Sort	Managing Serious Errors ▼ Sort	Transparency Indicator ▼ Sort
Detroit Receiving Hospital & University Health Center Detroit, MI							
Harper-Hutzel Hospital Detroit, MI							Other Reporting Efforts
Henry Ford Hospital Detroit, MI				Declined To Respond	Declined To Respond		Other Reporting Efforts
Providence Hospital & Medical Centers Southfield, MI				Declined To Respond	Declined To Respond		Other Reporting Efforts
St. John Hospital & Medical Center Detroit, MI							Other Reporting Efforts

Leapfrog group

- Developed P-4-P program with assistance from Robert Wood Johnson Foundation to reward hospitals for implementing practices
- Reward program will be evaluated by the Agency for Healthcare Research and Quality (AHRQ) as to effectiveness

Healthgrades

- For profit healthcare rating company
- Utilizes variety of different data sources
- For mortality/quality use MedPar (Medicare only) data so lags 18 months
- Full hospital report available for purchase
- Physician specific report available for purchase

AHRQ

- Developed tools to cull administrative data for
 - Quality indicators
 - Patient safety indicators
- Methodology utilized by several ranking agencies
- Developed Safety Culture Survey

AHRQ


Patient Safety and Quality Improvement Act of 2005
(public law 109-41)

- Creates patient safety organizations (PSO) to collect, aggregate and analyze confidential information voluntarily provided by healthcare organizations in order to improve patient safety
- Defines “patient safety work product” protected from discovery

AHRQ

- Final Rule just released Nov 21, 2008



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Patient Safety Organizations



PSO Home
Legislation and Regulations
Office for Civil Rights (OCR)
PSO Listing Process
Listed PSOs
Common Formats
Network of Patient Safety Databases
PSO Contacts

You Are Here: [PSO Home](#) > [Network of Patient Safety Databases](#)

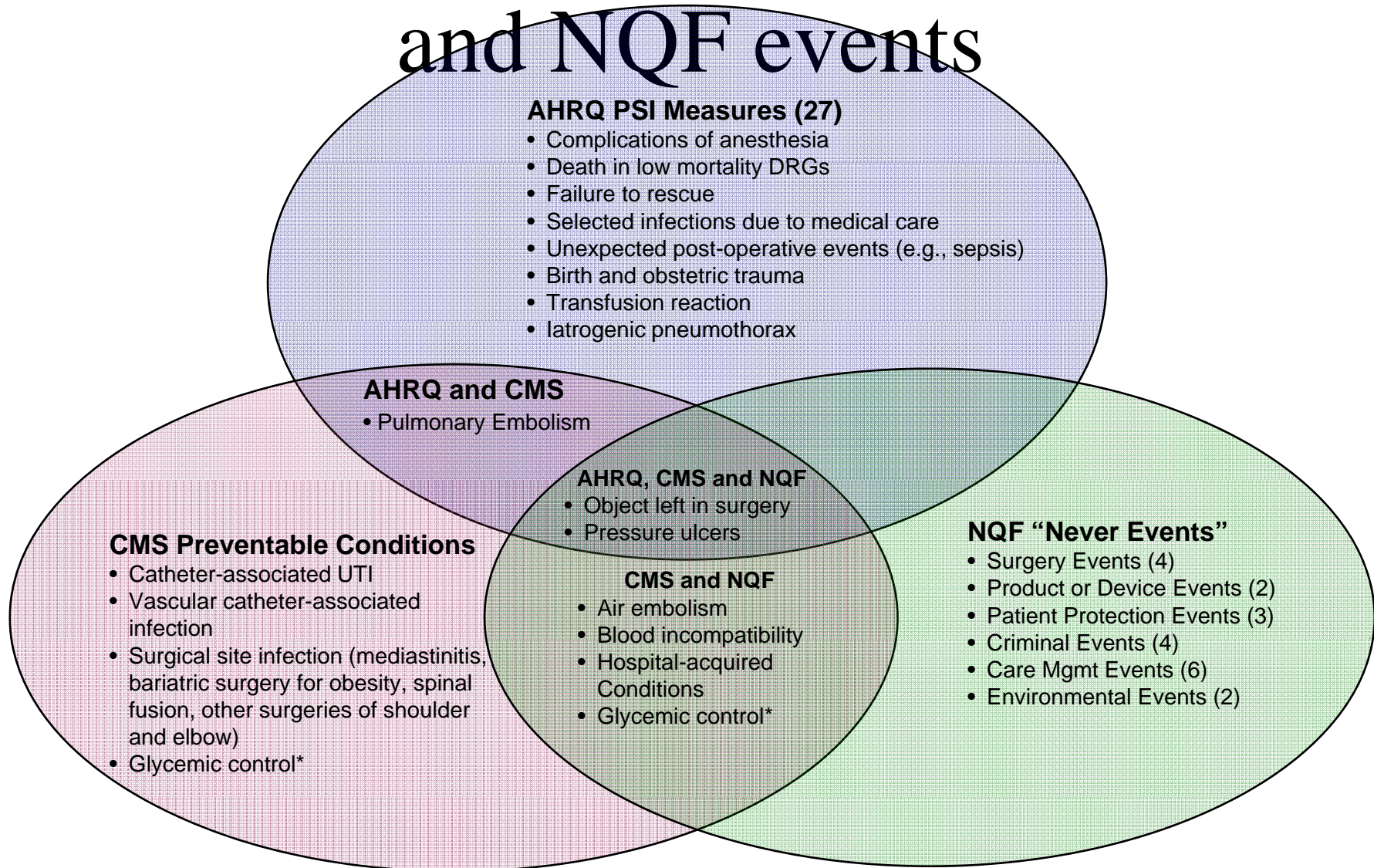
Network of Patient Safety Databases

The Agency for Healthcare Research and Quality (AHRQ) is responsible for Patient Safety Organization (PSO) operations. As data becomes available from PSOs, a Network of Patient Safety Databases (NPSD) will rec analyze, and report on de-identified and aggregated patient safety event information. The goal of the NPSD facilitate aggregation and analyses of patient safety event information to help reduce adverse events and im health care quality.

Who will report data to NPSD?

PSOs, providers, and other entities will voluntarily contribute de-identified patient safety work product to the To simplify reporting and data aggregation, the NPSD will employ common definitions and reporting formats patient safety events. These interoperable terms are referred to as the [Common Formats](#). To provide PSOs resources to de-identify patient safety event information prior to sending the information to the NPSD, AHRQ established the PSO [Privacy Protection Center \(PSO PPC\)](#). Use of the de-identified data is discussed in th Common Formats Overview.

Overlap between AHRQ, CMS and NQF events



*Some codes in CMS policy are not part of NQF policy

Source: CMS DRA, UAB Health System <http://www.uabhealth.org/33800/>, NQF, CMS DRA, UAB Health System <http://www.uabhealth.org/33800/>, AHRQ PSI

CMS

- Hospital compare web site used for quality and Customer Satisfaction data
- Many other organization pull data from CMS but display differently

Medicare Severity DRGs (MS-DRGs)

- The MS-DRGs were implemented 10/1/07
- The MS-DRG system will divide the DRGs into 3 categories:
 - DRG with MCC (Highest Severity / reimbursement)
 - DRG with CC (Mid-range Severity / reimbursement)
 - DRG without MCC/CC (Lowest Severity / reimbursement)
- 538 DRGs increased to 745 MS-DRGs. This further stratified the cases based on severity.

Present on Admission (POA)

- ❖ Present on Admission is defined as any condition present at the time the order for inpatient admission occurs. Conditions that develop during an outpatient encounter, such as the emergency department, observation, or outpatient surgery, are considered present on admission.

Present on Admission

- ❖ Present On Admission (POA):
 - The presence of this indicator is **mandatory on** all claims submitted on or after 1/1/08.
 - Effective 10/1/07, Medicare will begin to accept a POA Indicator for every diagnosis on the inpatient acute care hospital claims.
- ❖ The POA indicator is assigned by Health Information Management (HIM) Coding to all diagnoses, whether principal or secondary for each inpatient stay.

Present on Admission continued

- ❖ The POA indicators will be assigned by HIM based on the **physician documentation** in the medical record.
- ❖ The following are the indicators to be assigned:

Yes: Present at the time of inpatient admission

No: Not present at the time of inpatient admission

Unknown: Documentation insufficient to determine if the condition was present at time of inpatient admission

Clinically Undetermined: The provider is unable to clinically determine whether condition was present at the time of inpatient admission

POA Indicator

- ❖ If any of the “never events” occur **during** the hospitalization, there will be a significant reduction in the Medicare DRG reimbursement.
- ❖ The POA indicator assigned is what will determine if the “never event” was present *on admission or not*.

CMS Identified Impact

- Per CMS this reduces the c.c. capture rate from 77.6% to 40.34%
- This will result in a 2.4% cut to both operating and capital payments in both FY 2008 and 2009
 - \$24 billion over five years

IPPS “Hospital-Acquired Condition” rule

The Deficit Reduction Act 2005 required CMS to:

- Identify by October 1, 2007 at least two “reasonably preventable” complications from hospital care which could cause patients to be assigned to a higher-paying DRG when coded as a secondary diagnosis, and to stop reimbursing at the higher DRG:
 - The conditions must be high cost, high volume or both
 - The conditions must be reasonably preventable by the hospital through the application of evidence-based guidelines
 - (Unofficial rule-there must be specific ICD9 coding corresponding to the condition)

Application of the rule

- A Hospital Acquired Condition (HAC) under the rule must be a Major Complication or Comorbidity (MCC), or a Complication or Comorbidity (CC) typically resulting in a higher secondary MS-DRG
- To determine which HAC occurred after admission, diagnoses present on admission (POA) must now be coded.
- **IN SHORT:** For FY 2009 (beginning with Medicare discharges on or after October 1, 2008), Medicare will no longer assign an inpatient hospital discharge to a higher paying MS-DRG if a selected HAC was not present on admission (e.g., it arose after admission and is considered preventable so no higher reimbursement will be offered)
- Eight HACs were initially identified, but CMS has proposed a second stage of nine more HACs which also may start on October 1, 2009

Application of the Rule

- As part of the HACs, the rule refers to a few as “serious preventable events” which overlap with National Quality Forum “never events” (actually called Serious Reportable Adverse Events), such as “blood incompatibility,” “air embolism” and “object left in after surgery”

[We will refer to all 17 as “HACs” for this presentation]

- The POA indicator requirement and HAC payment provisions only apply to Inpatient Prospective Payment Systems (IPPS) Hospitals.
 - Not these hospitals:
 1. Critical Access Hospitals (CAHs)
 2. Long-term Care Hospitals (LTCHs)
 3. Maryland Waiver Hospitals
 4. Cancer Hospitals
 5. Children's Inpatient Facilities.
- No new penalty provision was created
- CMS may address the full list of NQF never events in the near future

The World of Never Events /HACs/ “Serious Preventable Events”/ “Avoidable Conditions”

NQF Never Events	CMS HAC	MN	MA	Well-point	CIGN A	AET NA
Post operative death		√				√
Contaminated blood/biologic-D/SD		√				√
Device misuse/misfunction-D/SD		√				√
Intravascular air embolism-D/SD	1	√	√	√	√	√
Patient disappearance-D/SD		√				√
Suicide or attempt-SD		√				√
Medication error-D/SD		√	√			√
Maternal injury in L&D-D/SD		√				√
Onset of hypoglycemia-D/SD	2	√				√

These injuries may result without negligence involved. Often require Death or Serious Disability to qualify under NQF or as a “no pay” for insurers

The World of Never Events /HACs/ “Serious Preventable Events”/ “Avoidable Conditions”

NQF Never Events	CMS HAC	MN	MA	Well-point	CIGN A	AET NA
Hyperbilirubin Newborn-D/SD		√				√
Stage 3 or 4 pressure ulcer	1	√		√	√	√
Spinal manipulation injury-D/SD		√				√
Electric shock injury-D/SD		√				√
Burn injury-D/SD		√				√
Patient fall and other trauma-D	1	√		√	√	√
Care from impersonator		√				√
Patient abduction		√				√
Sexual assault		√				√
Physical Assault-D/SD		√				√
Wrong donor egg/sperm		√	√			√
Bedrails or restraints-D/SD		√				√

The World of Never Events /HACs/ “Serious Preventable Events”/ “Avoidable Conditions”

NQF Never Events	CMS HAC	MN	MA	Well-point	CIGN A	AET NA
	1 Catheter UT infection			√	√	
	1 Vascular-catheter infection			√	√	
	1 Mediastinitis post CABG			√	√	
	2 Surgery infection –misc. electives (total knee, gastric bypass, var. veins)					
	2 Legionnaires’ disease					
	2 Iatrogenic pneumothorax					
	2 Delirium					
	2 Vent. Assoc. Pneumonia					
	2 DVT/Pulmonary Embolism					
	2 Staph Aureus septicimia					
	2 Clostridium difficile					

The World of Never Events /HACs/ “Serious Preventable Events”/ “Avoidable Conditions”

Strict Liability*	NQF Never Events	CMS HAC	MN	MA	Well-point	CIGN A	AET NA (Leap Frog)
	Surgery wrong site*			√	√	√	
Surgery wrong patient*			√	√	√		√
Surgery wrong procedure*			√	√	√		√
Surgery retained object*	1		√	√	√	√	√
Infant discharged to wrong person*			√	√			√
ABO incompatible blood-D/SD	1		√	√	√	√	√
Oxygen or other gas line wrong/contaminated (toxic)			√				√

* Negligence likely presumed if these events happen-also not medically necessary

Quality organizations also vary on “never event” focus

Overlapping Measures	AHRQ	CDC	CMS	IHI	NQF
Pressure ulcers	X		X	X	X
Retention of foreign object	X		X	X	X
Blood incompatibility			X	X	X
Catheter-associated UTI		X	X	X	
Central-Line catheter related blood stream infections		X	X	X	
Hospital acquired injuries			X	X	X
Ventilator-associated pneumonia		X	X	X	
Air embolism			X		X
Clostridium difficile			X	X	
Complications of anesthesia	X			X	
DVT/PE			X	X	
Iatrogenic pneumothorax	X		X		
Surgical site infection-Mediastinitis			X	X	
Unexpected post-operative events (e.g., sepsis)	X			X	
Vascular catheter- associated infection			X	X	
Wrong site surgery				X	X

What is the financial impact to hospitals?

- CMS estimates that the original 8 will lower provider payments by \$20M in FY 2009/\$100 M for FYs 09–12
- CMS estimates with 9 new conditions (total of 17) hospital payments reduced \$50M in FY 09/\$270 M for FYs 09–12
 - “Average” loss to 3,500 acute care hospitals:
 - At \$100 M is \$28,511 over four years
 - At \$270 M is \$77,142 over four years
- Much larger losses may be from private payors adopting never events plus CMS 17 **or** some confusing combination
- President’s FY 09 Budget proposed CMS prevent 28 never events being billed, and to require national reporting, but will now become an issue for the next administration

Financial impact in perspective

- \$100 M to \$270 M (five years) is less than .3% of annual \$100 B inpatient budget (this is not a money making attempt by CMS)
- Compare to \$10.8 B estimated in annual payment errors
 - In 3 years the CMS “Recovery Audit Program” is a bigger threat!
 - Already returned \$980 M to CMS in test phase (84% from inpatient hospitals)
 - 11% of cases appealed by hospitals, with 5% success rate
 - Average \$2,000 to appeal overpayment
- Frequency of never events and HACs is relatively low (See Appendix)
- If CMS just wanted a cost savings program, they could increase fraud detection to take a bite out of the estimated \$70 B lost annually to fraud and mismanagement (10% improvement=\$7 B annual savings!)
- Cost of change for hospitals to develop improved clinical protocols to achieve better care and to improve coding and cooperation of independent staff-”priceless”

POA coding and related issues

- POA includes chronic conditions and those which develop during an outpatient encounter, including ED services & observation, outpatient surgery, etc. before admission. **New Codes:**
 - **Code Y** - Dx was present at time of inpatient admission
 - **Code N** - Dx was not present at time of inpatient admission
 - **Code U** - Documentation insufficient to determine if present.
 - **Red flag for CMS and money loser for hospitals**
 - **Code W** - Clinically cannot determine whether or not the condition was present at the time of inpatient admission.
 - **CMS will reimburse for “W” since cannot rule out POA**
 - **Code 1** Unreported/Not used. Exempt from POA reporting.
- **General Rule-no higher paying DRG to be paid by CMS if secondary diagnosis coded as “N” or “U” since HAC arose after admission**
- Some HACs have multiple codes to choose from-use the right codes
- POA can be coded all the way up to time of discharge-physicians may look at entire record to decide what was POA

POA coding and related issues

- “Exceptions” to the general rule:
 - Higher DRG will be paid if other secondary non-HACs also present (payment restricted only when HACs are the sole reason for a reclassification to a higher secondary DRG)
 - HAC can cause serious harm, moving treatment to a different and higher cost DRG (e.g., HAC-infection pushes overall treatment to LTCH bed or “tracheostomy with mechanical ventilation 96 hours or more”-a new DRG)
 - Outlier payments will continue to be made, even if HAC involved (although new regulations lower outlier payment levels overall)
- Only the first nine codes are truncated and submitted to CMS, although 25 can be entered by the hospital. An HAC could “fall off the sheet” if not in the first nine slots
 - No advantage to intentionally doing this, as higher DRG is paid if any non-HACs also present-might also be a red flag for an audit

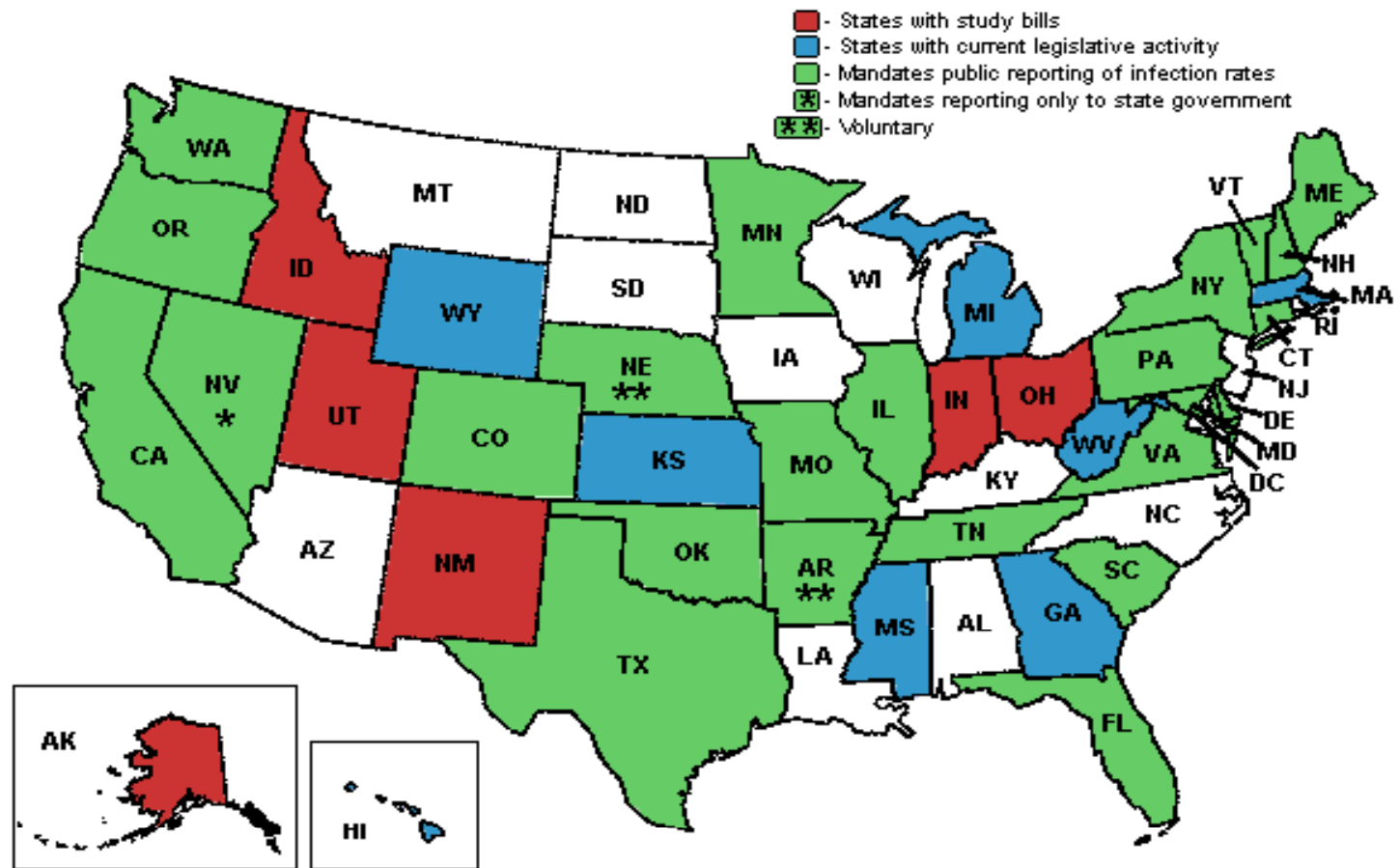
Too far too fast?

- There is little time to implement clinical strategies and coding changes for 10-1-2008 while the list of HACs and new codes are still evolving!
 - Nine HACs recently proposed on April 30, 2008
 - Only four of these were discussed publicly last year
- “Reasonably Preventable” is not defined and some HACs have as low as 40% prevention rate estimate (e.g., delirium and VAP)
- Preventive care guidelines are not all updated/concise/agreed
- Not all conditions can be prevented
- Not all can be diagnosed at admission (infections)
- Not all can be diagnosed before discharge (e.g., DVT or retained object)
- POA analysis may be prevented by patient death, elopement or transfer
- Risk of disproportionate financial impact on some patients and hospitals
- No new appeal mechanism-“always the hospital’s fault”
- Clinical and coding training (including independent physicians) will take significant time-not to mention implementing 17x new protocols!
- No similar change to physician reimbursement- possible disconnect
- Potential cash flow issues as billing delayed by new coding mistakes
- Private payors jumping on the “no-pay” bandwagon before it’s perfected

Potential “unintended” consequences

- Increase in aggressive testing on admission or overuse of prophylactic antibiotics (defensive medicine)- could increase hospital costs
- Code shifting when multiple codes exist for HAC
- Adding more secondary diagnoses to avoid HAC impact
- Bumping high risk patients to other hospitals
- Potential billing delays while POA and related decisions are coordinated by staff relating to new coding changes
- Creation of higher standard of care (litigation issue)
- Potential disparate financial impact on hospitals with higher mix of end stage and high risk patients or higher volume of Medicare participants
- Forcing “required” preventative guidelines to all patients in all circumstances
- Chaos created by private payors seeking financial break and adopting a broad mix of no pay positions without altruistic motives
- Friction with independent providers in key position of POA diagnosis and record documentation, but are outside hospital controls

States mandating public reporting



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Deficit Reduction Act of 2005

Section 5001(b)

- Authorizes DHHS to implement VBP program which must include consideration of:
 - The development and selection of quality and efficiency measures for inpatient setting
 - Reporting, collection and validation of quality data
 - The structure, size, and source of value based payment adjustments
 - Disclosure of information on hospital performance

Should be implemented in a way that DOES NOT increase Medicare spending

Current Program:

Reporting Hospital Quality Data for Annual Payment Update (RHQDAPU)

- Section 501(b) of Medicare Modernization Act of 2003/ DRA Section 5001(a)
- Ties a portion of Annual Payment Update under Inpatient Prospective Payment System to public reporting of data
- Payment at risk has gradually increased
- Will be phased out by the VBP program

Performance Assessment Model

- Hospital performance will be assessed annually
- Total Performance Score computed by combining scores for individual measures across performance domains of:
 - Clinical process-of-care
 - Patient perspectives of care
 - 30-day mortality outcomes
 - Efficiency

Performance Assessment Model

- Individual measures within a domain are weighted equally
- Domains may be weighted differently
- Hospital must submit data for all VBP measures that apply to its patient population and service mix
- Total Performance Score (TPS) determined by aggregating scores across all domains
- TPS then translated into percentage of incentive payment

Model for Payment

- High achievers rewarded for attainment
- Low achievers rewarded for improvement

GOAL: to raise all boats

Vocabulary for VBP

- **Benchmark**= reference point used to define a high level of performance
- **Attainment threshold**=minimum level of performance required to receive attainment points
- **Attainment range**= scale between attainment threshold and benchmark
- **Improvement range**= scale between the hospital's prior year score (baseline) on the measure and the benchmark

Payment

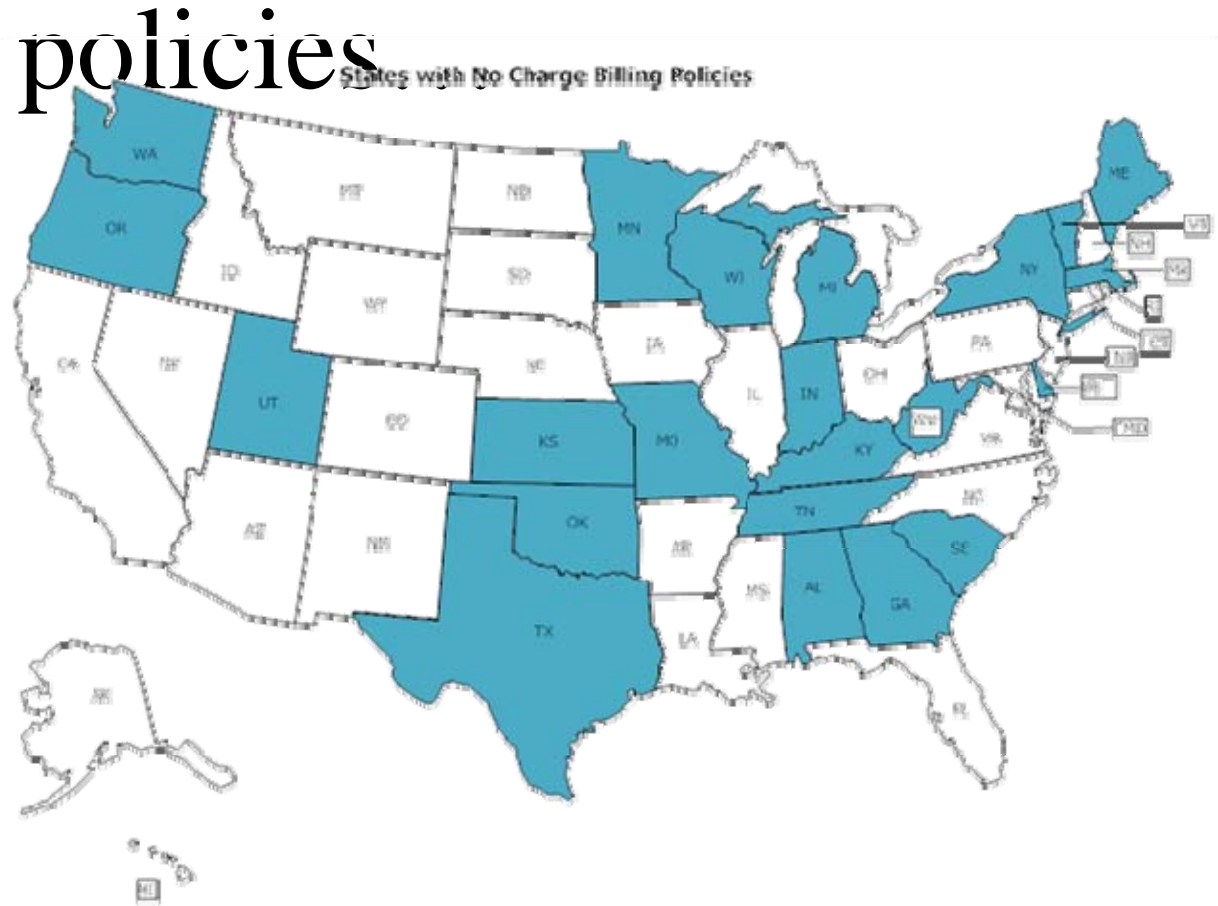
- Total Performance Score would have to be translated into an incentive payment percentage (suggested 2-5%)
- Improving timelines by requiring reporting within 60 days after the close of each quarter (currently allow 4.5 months)
- Improve audit methodology from 5 charts/quarter; utilize random (600 hospitals) and targeted (200 hospitals) audits annually
- Increase minimum sampling

Suggested Starting Measures

- AMI
- CHF
- Pneumonia
- SCIP
- Outcomes
 - 30 day mortality AMI
 - 30 day mortality CHF
- HCAHPS

Broader implications of payment policies

- 36 states with event reporting
- 23 states where patients or plans cannot be billed for treatment of “never events”/HACs
- Private payers adopting such policies include: Aetna, BCBS, Cigna, HealthNet, Kaiser, United Health.



SOURCE: www.MSNBC.com

What's Next?

9th Scope of Work

- DHHS, CDC, CMS, AHRQ co-project
- Voluntary effort through Quality Improvement Organizations (QIOs- the *organizations formerly known as Peer-Review Organizations (PROs)*)
- 53 QIOs- new CMS contract beginning August 1, 2008

WHAT'S NEXT

9th SCOPE of WORK

- Encourages hospitals to enroll in CDC NHSN MDRO module and report MRSA
 - ? Infections versus colonization
- Utilize TeamSTEPPS to reduce MRSA
- Hospital data de-identified
 - QIO data not subject to Freedom of Information Act Requests
- QIOs must report to CMS on their progress mid-cycle (18 months)

Outpatient Prospective Payment System (OPPS)

- Object left in during surgery;
- Air embolism;
- Blood incompatibility; and
- Falls and trauma fractures, dislocations, intracranial injuries, crushing injuries, and burns.
- Adverse drug events-CMS Asked for commentary

OPPS CONCERNS

- POA not applicable to outpatient setting
- Care episodic- which episode counts?
- Suggest gain further experience with IPPS, unintended consequences before trying to apply to less structured setting

OPPS CONCERNS

- HAIs better suited to risk adjusted, rate based approach as they are not completely preventable with today's evidence based knowledge
- Better to incorporate into Value-Based Purchasing Program than “NEVER EVENT” category

Federal activity

- Current Government Accounting Office (GAO) inquiry
 - Series of interviews with stakeholders in 2007
 - Purpose is to discuss federal requirements and guidelines related to infection control prevention in hospitals.
 - Ultimately will make recommendations to Congress

Federal legislation introduced

- HR 1174 Healthy Hospitals Act of 2007
Summary: To amend the Social Security Act to require public reporting of health care-associated infections data by hospitals and ambulatory surgical centers, establish a pilot program to provide incentives to hospitals and ambulatory surgical centers to eliminate the rate of occurrence of such infections.
- Sponsor: Rep. Tim Murphy (R,PA-18)

Federal legislation introduced

- S 692 VA Hospital Quality Report Card Act of 2007
- Summary: establish a Hospital Quality Report Card Initiative to report on health care quality in Veterans Affairs hospitals including rates of nosocomial infections
- Sponsor: Sen. Barack Obama