

# Mastering the CMS Hospital Infection Control Survey

*The Comprehensive Guide to Compliance with the Final CMS Worksheet*

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# A new regulatory era begins in infection prevention as CMS issues landmark hospital survey

*“It is not just more resources but more empowerment. [Infection control] has to become a priority.”*

By Gary Evans, Executive Editor

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The Centers for Medicare & Medicaid Services (CMS) has finalized an unprecedented infection control survey for hospitals, telling its inspectors the requirements are “effective immediately” and can be used to issue citations in unannounced visits.

Issued Nov. 26, 2014, the 49-page CMS infection control survey is the final iteration of a previous draft version that had been under review and pilot testing for several years. Infection preventionists (IPs), quality managers, employee health professionals, and other hospital leaders and staff can use this book — *Mastering the CMS Hospital Infection Control Survey* — to prepare for the CMS inspections and “teach the test” to their health care colleagues. The CMS is encouraging — though not requiring — hospitals to use the final survey included in this book for infection control risk assessments. (*See appendix, pp. 1-49.*)

The CMS survey was developed in collaboration with the Centers for Disease Control and Prevention, so it essentially codifies a sweeping array of CDC infection prevention guidelines that were heretofore voluntary. In doing so, the CMS continues to raise the profile of infection preventionists, assigning IPs key roles identifying and reducing infection risks to patients and health care workers. (*See related story, p. 12*) The CMS has made significant strides into infection prevention and patient safety in recent years, with the now finalized survey the boldest step yet in a new regulatory era for infection control.

“The [impact] is going to be huge because it refines the points that are important to emphasize in infection prevention and control programs,” said **Ruth Carrico**, PhD, RN, CIC, assistant professor of health promotion and behavioral sciences at the University of Louisville (KY). “Certainly we know that is a constantly moving target, but [the survey shows] us what we need to be able to demonstrate effectively over time. [It brings] clarity to the important aspects of infection prevention.”

Although The Joint Commission uses a different methodology in its surveys, that organization and other accrediting bodies are expected to align their standards with the CMS survey requirements. Responding to a request for comment on the situation by *Hospital Infection Control & Prevention*, The Joint Commission said the CMS survey requirements are in line with its infection control accreditation standards.

“In light of this new Center for Medicare & Medicaid Services’ checklist, The Joint Commission evaluated its hospital infection prevention and control standards and accredita-

tion survey process, and concluded that they address the elements included in the checklist. Therefore, no additional survey activity will be incorporated for hospitals. The Joint Commission's hospital accreditation program has deeming authority recognition from CMS, which means that its standards and survey process meet the federal Medicare requirements."

In any case, CMS can send its federal or designated state surveyors out for unannounced inspections using the survey tool. "Anybody potentially runs the risk of CMS turning up at their doorstep, so it's best to be prepared," said **Sena Blickenstaff**, RN, MBA, BSN, a former Joint Commission surveyor and principal consultant with Compass Clinical Consulting in Cincinnati, OH.

In that regard, *Mastering the CMS Hospital Infection Control Survey* is a preparation guide that features take-home compliance tips from highly regarded experts in infection control and epidemiology as well as substantive background articles and profiles of programs that have developed best practices in the areas under CMS scrutiny. These articles are comprised primarily of recent cutting-edge coverage in *Hospital Infection Control & Prevention* and *Hospital Employee Health*, both of which have been covering their respective fields for decades for AHC Media LLC in Atlanta. In addition to conducting interviews with survey project leaders at both the CMS and the CDC, we talked to frontline clinicians in the field and gleaned their best compliance advice on the various survey sections.

The final version of the survey includes various language changes and revisions from previous drafts, as the CMS has deleted a section on the protective environment (i.e., bone marrow transplants) while expanding a section on antibiotic stewardship. The CMS cannot currently cite hospitals for the lack of antibiotic stewardship programs, but the agency is moving quickly to issue new regulations in this area and may have a draft version out this year. (See Chapter 2 p. 55).

While some have questioned whether the CMS is going beyond the scope of its regulations in some areas, the survey is designed in part to encourage best practices -- such as antibiotic stewardship, prompt removal of catheters, and employee vaccinations. Again, many of these provisions are labeled "no citation" in the final survey, but that is clearly subject to change as CMS expands its oversight of hospitals and other health care facilities. The single largest payer for health care in the United States, the CMS is widely expected to eventually link the infection control survey to its various reimbursement penalties and financial incentives.

"That is the way I read the writing on the wall," said **William Schaffner**, MD, chairman of the department of preventive medicine at Vanderbilt University School of Medicine in Nashville, TN.

For example, with the incentives and penalties currently available to the CMS, hospitals that perform poorly on the survey could suffer the injury of citations and reimbursement penalties followed by the insult of public scrutiny on the CMS Hospital Compare web site. There are no currently announced plans to post survey results or "grades," but the move would be in keeping with the tactics CMS is currently using to reduce health care acquired conditions (HACs) and health care associated infections (HAIs). For example, health care worker flu immunization rates for individual hospitals are now being posted on the CMS hospital compare site. Reducing HAIs has become a national priority, as the CMS, CDC and other agencies within the Department of Health and Human Services (HHS) have been given marching orders to work together and attack this longstanding problem. In the process, the CMS has undergone a significant culture change that suggests high expectations for infection prevention will be the new normal at an agency that has been burned in the past by perceptions of complacency.



## Flashpoints for change

The CMS is facing increasing public pressure about HAIs, a patient outcome whose oversight it has traditionally outsourced to “deemed status” partners like The Joint Commission. CMS and other agencies in the HHS were called on the carpet after a scathing 2008 Inspector General report cited a lack of HHS leadership and coordination to reduce the “needless suffering and death” caused by HAIs.<sup>1</sup> That same year, a hepatitis C virus outbreak at a Las Vegas endoscopy clinic resulted in at least nine HCV infections and more than 100 suspect cases of patients who may have been infected during medical care. As we reported in *Hospital Infection Control & Prevention*, CMS inspectors had actually been to the Las Vegas clinic while the outbreak was ongoing.<sup>2</sup> However, they were apparently insufficiently trained in infection control to recognize the flagrant reuse of syringes and single-dose medication vials on multiple patients in the clinic. That realization became apparent to CDC investigators even as more than 60,000 people — roughly the population of Charleston, WV — were advised to seek testing for HIV, and HCV and HBV. The Las Vegas debacle became the flashpoint for change at the agency. The CMS worked diligently with the CDC to learn more about infection prevention, developing an infection control survey tool for ambulatory care that served as a precursor to the more substantive hospital survey featured in this book.

“I think [the CMS hospital survey] is a very good first step — it’s clear just by its existence that there is a need to be looking more closely at what we are doing,” said **Michael Bell**, MD, deputy director of the CDC Division of Healthcare Quality Promotion (DHQP). “And having trained eyes to do that I think is a necessary addition to the workplace.”

Indeed, while the inertia and entrenched culture of a federal bureaucracy make for a slow change, the CMS and the CDC are forging a powerful partnership with this infection control survey and the upcoming push for an antibiotic stewardship regulation. While antibiotic stewardship efforts are being collected by CMS inspectors “for information only,” the survey lists specific citation “tags” for the vast majority of the infection control measures in other areas. The CMS has charged its inspectors, who typically arrive unannounced, to assess key aspects of infection control, hand hygiene, injection safety, environmental services, and cleaning and reprocessing equipment. The survey includes so-called “patient tracers,” where CMS inspectors assess certain points of care. These are central venous catheters, urinary catheters, ventilators and respiratory therapy, spinal injections, point-of-care devices, surgical procedures and isolation precautions.

“The following is a list of items that must be assessed during the onsite survey, in order to determine compliance with the Infection Control Conditions of Participation (CoP),” the CMS states in instructions to inspectors.<sup>3</sup> “Items are to be assessed by a combination of observation, interviews with hospital staff, patients and their family/support persons, review of medical records, and a review of any necessary infection control program documentation. During the survey, observations or concerns may prompt the surveyor to request and review specific hospital policies and procedures. Surveyors are expected to use their judgment and review only those documents necessary to investigate their concern(s) or to validate their observations. The interviews should be performed with the most appropriate staff person(s) for the items of interest, as well as with patients, family members, and support persons.”

The CMS survey specifically requires “hospital leadership, including the CEO, Medical Staff, and the Director of Nursing Services [to ensure that] the hospital implements successful corrective [infection control] action plans.” That means the CMS survey should

not be perceived as an unfunded mandate, as IPs can use the agency requirements as leverage to sustain and increase program resources to prevent HAIs.

“We need to see if this will motivate the leadership in hospitals — the CEOs — to invest in infection control,” said **Denise Cardo**, MD, director of the CDC DHQP. “[The CMS survey] will empower those programs to do what is needed. It is not just more resources but more empowerment. [Infection control] has to become a priority.”

The CMS also has finalized similar surveys to assess Quality Assessment and Performance Improvement (QAPI) and Discharge Planning. The worksheets will be used by state and federal surveyors on all survey activity in hospitals when assessing compliance with any of these three CoPs, the CMS announced.

“We think this a great hospital self-assessment tool,” said **Daniel Schwartz**, MD, MBA, chief medical officer of the CMS Survey and Certification Group. “I think this survey will be helpful to infection control officers to see the expectations for compliance. So as you go and interact with anybody in the hospital, you have this document. Show them what the expectations are — it doesn’t get much clearer than that. It also will be a very good tool for prepping for surveys, whether it’s a CMS survey or an accrediting organization.”

In addition to risk assessment, the CMS survey could be used for education and training of new IPs on the key aspects of infection prevention, Carrico says. “It’s all part of the risk assessment process,” says Carrico, an IP for many years before going into academia. “What is it that we have to do – standards and regulations – versus what is it that we need to do based on surveillance results? The third thing is what do we want to do -- what are those additional things of personal importance to [our facility]? All of that has been taken into consideration to form an infection control strategy.”

The power of the purse can be formidable. For example, a recent report by the Agency for Healthcare Research and Quality estimated that 50,000 patient deaths due to hospital-acquired conditions (infectious and non-infectious adverse events) were prevented from 2010 to 2013 due in part to “financial incentives created by the CMS and other payers.”<sup>4</sup>

The Affordable Care Act (ACA) has also further empowered the CMS to promote quality improvement and infection reduction in health care. “In the past, hospitals had little financial incentive to improve the quality of their care because Medicare and other purchasers paid hospitals for treating infections or errors even when they could have been prevented,” **Patrick Conway**, MD, director of the Center for Clinical Standards and Quality at the CMS said at a Congressional hearing on HAI prevention. “Now, Medicare, state Medicaid programs, and many private sector health plans and purchasers, are moving rapidly to change payment systems to reward better outcomes instead of volume of services. CMS is working to transform from a passive payer to an active purchaser of higher-value health care services.”

Certainly, the threat of citations and reimbursement cuts will get the attention of hospital administrators, but some studies have found some unintended consequences to CMS incentives. An analysis of CMS policies linked to reimbursement cuts for certain HAIs in 2008 found that only 15% of IPs reported increased funding for infection control as a result of the CMS policy.<sup>5</sup> A few IPs actually had budgets cut, though the majority (77%) reported stable funding levels. Respondents reported faster removal of urinary (71%) and central venous (50%) catheters as a result of the CMS policy, but the study also found some questionable testing policies on admission and “resource shifting” away from HAIs not targeted by the CMS policies.

“The more positive impact has been on hospital leadership and awareness of the importance of infection prevention, which I think really helped a lot of the IPs in terms of

how the ‘C-suite’ feels about the importance of their mission,” said **Grace Lee**, MD, MPH, lead author of the study and associate medical director of infection control at Children’s Hospital in Boston. “That was extremely helpful. It also really enhanced efforts in surveillance education and prevention on the HAIs targeted by CMS policies. They did report improvements as a consequence of a policy such as removing urinary catheters as soon as possible in order to minimize the risk for CAUTIs.”

Although it’s a work in progress, the CMS is clearly aligning its regulations with quality improvement strategies and infection prevention recommendations like those issued by the CDC, she said. “That is the goal — CMS wants to align quality with financial reimbursement,” Lee said.

However, there is also something less tangible that could change hospital infection control in a more powerful and permanent way — the deepening partnerships between HHS agencies that were once separated in their various silos.

“We have been talking to CMS leaders and I think [the survey] is a good opportunity for us to work to improve infection control overall and also to see how the [hospital] programs are working,” Cardo said. “I also know that the Joint Commission is motivated, there are several groups that want to use some tools [like the survey] to do that. We are also working with OSHA in terms of PPE [personal protective equipment]. I think the more we work together as federal agencies — with both OSHA and CMS being the ones that can regulate — the better it will be for everybody. The more that we are aligned and having the goal of protecting workers and patients the better we are going to be.”

Providing a compelling backdrop and potential political momentum is Ebola, with the first American cases in 2014 bringing the most national attention to infection prevention and employee health issues in U.S. hospitals since the emergence of HIV in the 1980s. The CDC is trying to translate the intense reaction to Ebola to other HAIs, but the emotional response will be difficult to generate even for infections like *Clostridium difficile* that kill many more people in the U.S. annually than Ebola ever will.

“The fear is not going to be there, but at least what [Ebola] has revealed is that infection control in U.S. hospitals is not as good as we would like it to be,” Cardo says.

How good is it? The CMS survey with its point-by-point inspection process may provide the data to quantify the answer to this question in the months and years ahead.

*Editor’s note: Questions and comments about the final infection control survey may be submitted to CMS via email to: [hospitalscg@cms.hhs.gov](mailto:hospitalscg@cms.hhs.gov)*

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