

## October 2012 Pulmonary Journal Club

**Lee GM, Kleinman K, Soumerai SB, Tse A, Cole D, Fridkin SK, Horan T, Platt R, Gay C, Kassler W, Goldmann DA, Jernigan J, Jha AK. Effect of nonpayment for preventable infections in U.S. hospitals. N Engl J Med 2012;367:1428-37.**

This article looked at the results of a pay for performance program initiated in 2008 by Medicare and Medicaid. The program was designed to reduce the rates of catheter related blood stream infections (CRBSI) and catheter related urinary tract infections (CRUTI) by financial disincentives, meaning reducing payments for diagnosis codes indicating CRBSI and CRUTI. The study looked at the rates of CRBSI, CRUTI before 2008 and after 2008 when the program was initiated. A total of 398 hospitals were included and data from the periods of January 2006 and March 2011 were included.

The results of the study showed no difference in the incidence rates of CRBSI or CRUTI post policy implementation. The authors concluded that the lack of response may be attributed to factors such as change in ICD codes, hospital based quality assurance programs that were initiated prior to financial disincentives, and the possibility that the financial penalties were not severe enough to change practice patterns.

Our discussion of this article confirmed several notions. First, our overall practice patterns have not changed, we still perform procedures when needed regardless of a pay for performance policy. Second, complications may be preventable but sometimes they are inevitable. We must be cautious that in our attempt to be perfect that we do substitute what is most appropriate for patient care for what is more appropriate in coding and reimbursement. I will argue that real advancement and progress in patient care still comes through medical research, and with physicians at the bedside. The more we lean on policy and guidelines to incentivize us the further we drift from the 'ART' of medicine.

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