

Highest Quality Care

Background

The best care is when caregivers and patients work as a team to make the right decisions with the best possible information. We need to invest in the research that will identify the best treatments, technologies and protocols, and then reward providers who use them. We must coordinate the treatment of physical and behavioral health needs; reward care outcomes, not the number of patients seen; and make palliative care more available and better understood. And we have to ensure that our workforce is able to deliver the care we need today and into the future.

AHA View

As part of the *Health for Life* initiative, the AHA determined that an essential element of reforming our health care system is to focus on how to deliver the highest quality care. It is one of the five pillars of the AHA's framework for change.

Delivering the right care at the right time in the right setting is the core mission of hospitals across the country. The AHA and its Board of Trustees are committed to helping members improve the quality of care they deliver every day. The AHA pursues this mission by:

- **assisting with performance improvement** by sharing strategies and tools that will ensure the reliable delivery of top quality, efficient care and prepare hospital leaders and governing bodies to drive quality and safety improvement in their organizations;
- **envisioning system reform** through research and strategic discussions with field leaders; and
- **advocating for improved government oversight and Private Sector Accreditation** that creates an environment in which high-quality, safe care can flourish.

The AHA Quality Center, launched in 2006, helps hospital leaders stay abreast of effective methods for improving quality and safety. The Center helps hospital leaders sort through the dizzying array of strategies, tools and projects to determine those methods that best fit their organizations and their goals.

The Quality Center recently sent hospitals a new guide titled "Hospitals in Pursuit of Excellence" to engage, support and further enable hospital leaders' continuing efforts to improve the patient experience and outcomes and accelerate progress in achieving clinical, operational and financial excellence. The guide is the first in a series of quality resources that are designed to help hospitals achieve performance excellence.

Greater Transparency – the Hospital Quality Alliance. Since 2002, the Hospital Quality Alliance (HQA) has enabled hospitals to share reliable, credible and useful information on hospital quality with the public. The HQA was created when the AHA, the Association of American Medical Colleges and the Federation of American Hospitals invited government agencies, professional organizations,

purchaser alliances, consumer organizations and others to forge a shared national strategy for accurate quality measurement and public accountability. The alliance includes the Centers for Medicare & Medicaid Services (CMS), Agency for Healthcare Research and Quality (AHRQ); professional organizations such as the American Medical Association, the American Nurses Association, The Joint Commission and the National Quality Forum; insurers such as Blue Cross Blue Shield Association; and consumer, labor and employer organizations such as AARP, AFL-CIO, Consumer-Purchaser Disclosure Project and the U.S. Chamber of Commerce.

Initially, HQA began as a voluntary effort to share data with the public. Soon, Congress, recognizing the importance of this initiative, began requiring hospitals to submit the quality data requested by the HQA in order to receive a full Medicare market basket update for hospital inpatient payment. The HQA's Web site, www.hospitalcompare.hhs.gov, helps the public better understand how care is provided by their hospitals. More than 4,900 hospitals now display data. The quality improvement effort has expanded to include new measures each year. For fiscal year (FY) 2009, there are 41 measures, including patients' experience of care, 30-day mortality rates for heart attack and heart failure, surgical care and seven measures of outpatient care quality.

The HQA continues to identify other key areas of quality to be measured and reported, such as information on infection prevention, surgical care and care of individuals with chronic conditions. It also is looking to identify methods and measures for effectively examining efficiency. The HQA provides a firm foundation for further transparency and for what may be the next step in the national quality movement – pay-for-performance programs that reward providers with payment incentives for demonstrating excellence in patient safety and effective care.

Hospitals currently face multiple requests for quality data from insurers, employer groups, accreditors and government agencies. Rather than helping to illuminate key aspects of quality, these myriad demands create confusion and frustration for hospitals and the public alike. **Hospitals strongly urge that quality data should be reported in just one way to just one place, and that is to the Hospital Quality Alliance.**

Moreover, HQA's work depends on scientifically sound and meaningful measures, and a strong federal commitment to a public-private partnership that provides a vital public service. The nation will need to build on this partnership as it moves to revamp America's health care system. That is why the AHA has been working with a coalition of other interested stakeholders, known as Stand for Quality, to bolster federal support for the nation's performance measurement, reporting and improvement enterprise.

Payment Incentives for Quality. A number of public and private payers are considering and testing "incentive payments" to reward provider performance, sometimes referred to as "pay-for-performance" or "value-based purchasing." In late 2007, CMS issued a report to Congress outlining options for a value-based purchasing incentive program that would reward hospitals for meeting certain performance thresholds.

The hospital field supports the concept of aligning payment incentives with the provision of high-quality care, but recommends moving forward thoughtfully and deliberately as the development of incentive-based programs are proving complex.

To be successful, incentive approaches should:

- align hospital and physician incentives to encourage all to work towards effective and appropriate care;
- be developed collaboratively with all stakeholders;
- focus on improving quality, not act as a cost cutting mechanism;
- provide rewards that will motivate change;
- be implemented incrementally;
- recognize and reward both high levels of performance and substantial improvements;
- use measures that are developed in an open and consensus-based process and selected to streamline performance measurement and reporting;
- use measures that are evidence-based, tested, feasible, statistically valid and recognize differences in patient populations;
- be designed carefully so as not to perpetuate disparities in care; and
- be implemented in a budget-neutral manner.

Readmissions. Other proposals that link hospital performance and payment are also under consideration. For example, building on work done by the Medicare Payment Advisory Commission (MedPAC) and the Congressional Budget Office, the Obama Administration has put forward a proposal to decrease payments to hospitals with high 30-day rates of readmission. Readmissions account for a significant amount of Medicare and other payer spending. For example, MedPAC estimates that 18 percent of Medicare patients discharged from hospitals in 2005 were readmitted within 30 days, costing the Medicare program approximately \$15 billion.

Preventing readmissions is a complex, system-wide problem that involves hospitals, physicians and other providers who manage patients' care, as well as patients and their families. Arbitrary policies that assume many hospital readmissions are not appropriate raise concerns. Planned readmissions likely represent good care, and access to these services should not be reduced. Unplanned readmissions that are unrelated to the reason for the initial hospitalization are unlikely to be preventable. **Public policy efforts aimed at reducing readmissions should identify and focus on the subset of unplanned, related readmissions for which the greatest opportunity exists for hospitals to take actions that may prevent their occurrence. The AHA strongly urges that a careful and well planned approach be taken to adjust payment policy in ways that encourage the right care is delivered to patients.**

Improving Health Care Safety. Hospitals have a long track record of working to prevent complications, such as infections and medical errors. Hospitals and clinicians understand action is needed to minimize the risk of unintended consequences. While hospitals are taking many precautionary steps, such as using specialized ventilation

systems for patients whose immune systems are very weak, they acknowledge that more must be done.

Healthcare-associated Infections. The Surgical Care Improvement Project (SCIP), a national quality partnership of the AHA, American College of Surgeons, Centers for Disease Control and Prevention, The Joint Commission, CMS and many others, aims to reduce the most common surgical complications, including surgical wound infections and pneumonia, by 25 percent by 2010. The project promotes clinically-proven prevention steps that every hospital can adopt to improve the care of surgical patients, such as maintaining normal body temperature and glucose levels, as well as clipping, not shaving, the incision skin area. SCIP is one of many hospital initiatives to reduce and prevent healthcare-associated infections (HAIs) and other adverse complications from surgery. The AHA also joined with other groups in promoting the implementation of a surgical checklist that would serve as a reminder to the surgical team of the steps they need to take to prevent many of the potential complications to surgical patients. The AHA will work with hospitals during the year to adapt and adopt this checklist.

The AHA supports sharing meaningful information about HAIs with the public. That information must:

- be based on solid data and good measures;
- target infections that have the highest potential for greatest harm; and
- focus on areas where clinically proven prevention efforts exist.

Specifically, the AHA supports voluntary reporting through the HQA of surgical infection prevention measures, surgical wound infection rates and central-line blood stream infection rates.

In addition, the AHA is working with 10 state hospital associations to expand the success achieved by Michigan hospitals in reducing central-line associated blood stream infections. Through the Michigan Health & Hospital Association's Keystone Intensive Care Unit (ICU) Project, Michigan hospitals succeeded in eliminating virtually all ICU central-line infections. The project has received considerable attention. The Keystone project's work has extended to other states, with the support of the AHA's Health Research & Educational Trust (HRET) and funding from AHRQ. The AHA is looking for other opportunities to expand the project to more hospitals and eventually build an infrastructure for sustaining these types of patient safety improvement innovations.

Comparable Standards for Comparable Services. As complex procedures move into multiple settings, patients – especially Medicare beneficiaries – incorrectly assume that they will be equally protected by patient safety standards and quality monitoring. However, ambulatory surgical centers are subject to less demanding federal standards than hospital outpatient departments, and physician offices are not subject to any federal standards. Standards and oversight must be comparable for comparable services

to protect patients and communities. All providers of surgical services should meet comparable quality monitoring, operating room equipment, staffing, infection control, anesthesiology and other relevant standards.

Similarly, all imaging service providers should meet comparable requirements for patient and staff radiation safety protocols, equipment calibration, staff training and image analysis proficiency, regardless of whether the services are provided in hospital outpatient departments, ambulatory surgical centers, imaging centers or physician offices.

Comparable standards and oversight should apply to providers of comparable services. Achieving comparability should be driven by what is reasonably needed, regardless of setting, to ensure patient safety and quality. Similarly, all Medicare providers should be subject to a comparable level of accountability and transparency with respect to cost and quality data reporting.

Self-referral to Physician-owned Hospitals. Although a congressional moratorium and subsequent Department of Health and Human Services administrative action from late 2003 to mid-2006 generally held physician-owned hospitals in check, their growth is once again on the rise. Many public and private studies conducted since the first moratorium found that physician-owned, limited-service hospitals:

- Reduce patient access to specialty and trauma care at community hospitals;
- Damage the financial health of full-service hospitals and lead to cutbacks in services;
- Reduce efficiency of full-service hospitals that must maintain stand-by capacity for emergencies, even as they lose elective cases;
- Are not more efficient and do not provide better quality;
- Provide limited or no emergency services;
- Raise patient safety concerns regarding the ability to respond to the emergency needs of patients that may arise during the routine course of care;
- Cherry-pick the most profitable patients by:
 - Avoiding low-income populations, both uninsured and Medicaid;
 - Offering the most profitable services; and
 - Serving less sick patients within case types.

Moreover, many physicians are opening ambulatory surgical and diagnostic centers that compete with the hospitals at which they have medical staff privileges and on whose boards they sit. The proliferation of physician ownership in both the inpatient and ambulatory settings is stimulated by opportunities to earn additional income and gain greater control over their operating environment. However, the effect on health care delivery and costs in communities can be devastating, especially when self-referral is involved.

The AHA supports a ban on physician self-referral to hospitals in which they have an ownership interest, with limited exceptions for existing facilities that meet strict investment and disclosure rules.

Incentives for Improving Hospital and Physician Collaboration. Hospital care depends on the ability of hospital leaders and physicians to work together to improve the quality and efficiency of patient care and to get patients the right care at the right time and in the right setting. Yet, many forces today drive hospitals and physicians apart. Federal laws and regulations that prohibit or limit interactions between hospitals and physicians make the situation worse. For example, the Civil Money Penalties law prohibits hospitals from providing any inducement for physicians to limit care to a Medicare beneficiary, regardless of medical necessity. While these laws are meant to avoid conflicts of interest, they need to be modernized to improve the ability of hospitals and physicians to work together to improve the efficiency of hospital care, improve the quality and safety of care, and better serve patients and communities.

Federal laws also need to be simpler and more consistent. The complexity, inconsistency and sometimes-conflicting interpretations of federal laws and regulations regarding hospital-physician arrangements are a significant barrier to physician and hospital collaboration. Clinical integration is one way that hospitals and physicians can tackle fragmentation of the health care delivery system and improve care for patients. However, integration can be burdensome and expensive, and uncertainties about how federal antitrust agencies will apply the laws to clinical integration programs are having a chilling effect. Clinical integration programs involve independent providers working together to pool infrastructure and resources and to develop, implement and monitor clinical protocols and “best practices” in order to achieve a higher quality of care than they could achieve working independently. Clinical integration programs can provide a vehicle for hospitals to work more closely with their medical staffs and improve quality and efficiency, among other benefits.

The AHA believes that federal public policy changes are needed. In some instances, complex areas of the law need to be clarified while in other instances the laws that govern relationships between hospitals and physicians need to be changed or modernized.

The AHA wants additional guidance from the antitrust agencies and proposed specific guidance that would assist hospitals in developing clinical integration programs. In recent letters to CMS and the Office of Inspector General (OIG), we called for coordination and companion guidance that would enable hospitals and physicians to share financial incentives in quality incentive-payment and shared-savings programs. Specifically, the AHA urged CMS to establish two new exceptions under the physician self-referral law and made recommendations for the structure and substance of the exceptions. The AHA also called on the OIG to create a new safe harbor under the anti-kickback law modeled on AHA's recommendations to CMS. Additionally, the AHA urged the OIG to withdraw its 1999 Special Bulletin on Gainsharing that prohibits the use of incentives to improve quality and reduce inefficiencies without adversely affecting the quality of care. All of these initiatives are intended to facilitate hospitals and physicians working together, to not only reduce costs, but also improve access to hospital care, as well as efficiency, quality and safety.

Information Technology. Electronic health records (EHRs) and other forms of health information technology (IT) provide clinicians with important patient information and clinical decision support tools they need to provide safe, high-quality care. The most recent AHA survey on hospital use of health IT shows that hospitals are making progress toward IT adoption, but the field still faces many hurdles to achieving the national goal of an EHR for every patient. *The American Recovery and Reinvestment Act* provides \$19 billion in IT funding, including more than \$17 billion in incentive payments to encourage hospitals and doctors to adopt EHRs. But the measure also carries penalties in the form of Medicare payment reductions if providers fail to adopt EHRs by target dates. For more information, see AHA's issue paper, "Best Information."

Patient Safety Organizations (PSO). Important insights into new opportunities to improve care can be gained by collecting and analyzing reports of errors and "near misses" in patient care. *The 2005 Patient Safety and Quality Improvement Act* allows hospitals, physicians and other health care providers to voluntarily report medical errors as well as other events that did not – but could have – resulted in a medical error in a manner that is legally privileged and confidential. This will help hospitals and clinicians learn to prevent errors while working to develop a "culture of safety," thereby encouraging everyone to openly report errors or near errors.

The Department of Health and Human Services (HHS) last November issued the final regulations to implement the PSO law. Since then, more than 50 organizations have been designated as qualified PSOs. Hospitals are strongly encouraged to enroll in one of these PSOs and take advantage of its data-collection and reporting measures to make care safer.

Racial and Ethnic Disparities. The AHA is working with hospitals to better understand both the patient-related and health-system-related factors that contribute to racial and ethnic disparities in health care, and to marshal the talent and commitment of hospitals to work with others to eliminate health care disparities in the United States. Through its Special Advisory Group on Improving Hospital Care for Minorities, the AHA seeks to:

- create a forum for the AHA to identify and prioritize key issues of concern to leaders and minority group organizations;
- provide a vehicle for the AHA to receive feedback on its *Health for Life* agenda, a strategy for creating better, safer and more affordable care; and
- build long-term, beneficial relationships to address key issues of mutual concern.

HRET has developed a disparities toolkit to help hospitals collect patients' race, ethnicity and primary language data. The toolkit has been endorsed by the National Quality Forum. By developing a uniform approach to data collection, HRET seeks to help focus efforts to eliminate disparities and improve quality of care.

In addition, the AHA's Institute for Diversity in Health Management seeks to increase the number of racial and ethnic minorities in health care administration. Increasing

the diversity of our health care workforce is one way to help address care disparities. The Institute also partnered with AHA's Center for Healthcare Governance to connect hospital boards with diverse candidates whose skills and interests may be a good match for their organizations. To understand and address disparities effectively, all health care stakeholders – patients, hospitals, physicians, other providers, government, insurers, employers and others – need to work collaboratively and on many fronts.

Access to Capital. Hospitals need to fund upgrades and improvements in order to meet the demand for highest quality care. But in today's market, capital is elusive. **Federal help is needed to revive the hospital tax-exempt bond market and lessen borrowing costs.** The AHA will continue to advocate for changes to the Federal Housing Administration's (FHA) Section 242 program to expand eligibility to cover the full array of facilities and services offered by today's hospitals and health systems; exempt hospitals from the 80 percent real property requirement so that borrowing for expensive new technologies can be insured using Ginnie Mae real estate mortgage investment conduits, significantly reducing financing costs; provide federal matching funds to help hospitals meet Section 242's mortgage reserve requirements; permit hospitals to refinance existing obligations without linkage to a construction or renovation project; and increase funding for the Office of Insured Health Care Facilities and clarify that the office qualifies for FHA Modernization Funds, which are used within the agency to improve operations.

Workforce Challenges. While the recession temporarily has eased workforce vacancies in some areas, once the economy improves, severe shortages will return. The demand for registered nurses (RNs) and other health care personnel will continue to rise as the "baby boomers" begin to retire. Without decisive intervention, workforce shortages threaten hospitals' ability to care for patients and communities.

The AHA urges Congress to increase funding for federal programs that support nursing and health professions education. In addition, the AHA supports the reauthorization of the Nurse Reinvestment Act. The programs authorized under this law, which expires this year, should be modified to increase support for additional faculty to educate more nurses. The AHA also supports immigration laws that allow flexibility to employ foreign-trained nurses, as well as the reauthorization of the Conrad 30 program that permits recruitment of physicians to rural areas. Finally, we recommend Congress increase the number of graduate medical education (GME) slots authorized under Medicare.

The Joint Commission MS 1.2 Accreditation Standard. The AHA will continue to work with The Joint Commission to improve the language of the MS 1.20 accreditation standard. The language proposed last year was problematic and needed further work to promote quality as intended. As written, the standard would have reduced the authority of the medical executive committee and would have had an unintended adverse impact on patient safety.