



# Advancing Excellence in Patient Care

## Improving Quality and Patient Safety

### Background

Putting patients first – ensuring their care is centered on the individual, rooted in best practices and utilizes the latest evidence-based medicine – is a priority for America’s hospitals. It’s what guides the actions and decisions of nurses, physicians and other caregivers every day.

Following the Institute of Medicine’s landmark report, *To Err Is Human*, hospitals have renewed their commitment to improving and aggressively addressing many quality and patient safety concerns. Hospitals are engaged in a variety of initiatives, all of which lead to better, safer care.

### AHA View

Public policies including regulations, measurement activities and oversight activities must be crafted to support improved care. The AHA’s efforts to foster such public policies are focused on the following:

#### COMMUNICATING QUALITY

**Hospital Quality Alliance.** As a partner in the Hospital Quality Alliance (HQA), the AHA works with a broad group of stakeholders to drive forward a national set of standardized quality measures. The HQA believes that the availability and use of information – from treatments for heart attack, heart failure, pneumonia and surgical patients to patients’ view of their hospital care – will spur positive changes in health care delivery. A key goal of the group is to collect and report data on a robust set of standardized and easy-to-understand hospital quality measures.

In 2009, the HQA added several new measures to its consumer-friendly *Hospital Compare* Web site, [www.HospitalCompare.hhs.gov](http://www.HospitalCompare.hhs.gov). Three hospital readmission measures share information on how often a Medicare patient with a heart attack, heart failure or pneumonia returns to a hospital within 30 days of being discharged. The HQA also added another measure of surgical care, continuing to round out the picture of hospital quality for surgical services.

The recently signed *Patient Protection and Affordable Care Act* (PPACA) takes advantage of this strong public reporting effort. These data will be used to support value based purchasing and other policies where payment is more tightly linked to performance than it has been in the past. The law also includes language that brings greater structure to quality improvement efforts, providing the opportunity for physician, nursing home and hospital quality measures to be in closer alignment.

#### REDUCING MISSTEPS IN CARE

**Hospital Readmissions.** Federal policy initiatives increasingly seek to address the issue of hospital readmissions and several propose penalties for readmissions deemed “avoidable.” In fact, the PPACA includes a readmission provision that imposes financial penalties on hospitals for so-called “excess” readmissions when compared to “expected” levels of readmissions based on the 30-day readmission

measures for heart attack, heart failure and pneumonia that are currently part of the Medicare pay-for-reporting program. The AHA believes that the goal of all efforts to reduce hospital readmissions should be to improve patient care. Readmission policies should separate planned readmissions – which occur to provide patients needed care – from unplanned readmissions. Otherwise, policies may penalize hospitals and physicians for providing appropriate services. The readmissions provision in the PPACA fails to make this important distinction. Readmission policies should not be used as a blunt cost-cutting tool. Policies should recognize differences among hospitals, their communities and the patients they serve. The limited availability of important, post-acute and ambulatory health care services in some communities, the level of poverty of hospitals' patients and the availability of community services could affect a hospital's performance on readmission measures and should be addressed in any measurement process. The AHA will continue to advocate on behalf of hospitals, working with Congress and the Administration on this issue, including seeking changes to the readmissions policy.

**Hospital Acquired Infections.** Hospitals are aggressively working to address hospital acquired infections and the AHA supports these efforts, working with the Agency for Healthcare Research and Quality (AHRQ) on programs that prevent infections in Michigan and 10 other states. Recent stimulus funding will roll out these programs nationwide. The PPACA includes provisions that require reporting on hospital acquired infections to the Centers for Disease Control and Prevention (CDC) as well as reporting on hospital acquired conditions - which include several infections - to the Centers for Medicare & Medicaid Services (CMS). The PPACA also directs CMS to penalize hospitals with the highest rates of infections and continues the payment penalties on hospital acquired conditions, potentially doubly penalizing some hospitals. The AHA opposed these provision that result in duplicate reporting and advocate for policies that reward improvement rather than those which double count or unfairly penalize hospitals working to advance patient safety.

**Geographic Variations.** Data produced for many years by researchers in the *Dartmouth Atlas of Health Care* depicts substantial variation in the use of health care services and in health care spending across the country. This variation has received a great deal of attention from public policy makers during the health reform discussions for two reasons:

- Such variation suggests an opportunity for cost savings through the elimination of extra services that don't improve outcomes; and,
- Greater standardization in care processes has been shown to lead to better outcomes.

The HHS Secretary has asked the Institute of Medicine for advice on how to create appropriate public policies leading to reductions in the variations across geographic areas.

Policy proposals that fail to account for the complex array of factors that influence geographic variations in health care spending could create unintended consequences for health care providers, patients and communities. The AHA has convened a task force to examine key contributors to geographic variation in health care spending.

Many variables impact geographic variations from regional practice patterns to local health behaviors and risk factors. From exploring the relationship between quality and cost to assessing value-based purchasing, bundling and efficiency criteria, the task force is working to develop a set of principles to evaluate potential policies to reduce unwarranted variation in health care services while respecting differences among populations that lead to justifiable patterns of geographic variation.

Related, the PPACA directs the HHS Secretary to pay hospitals in the lowest quartile of counties (determined by cost per Medicare beneficiary adjusted for age, sex and race) a bonus payment for the next two years. The payments will total \$200 million for FY 2011 and \$200 million for FY 2012.

## **PURSUING EXCELLENCE**

**Hospitals in Pursuit of Excellence.** Last year marked the launch of Hospitals in Pursuit of Excellence (HPOE), a new strategic platform to accelerate performance improvement in the nation's hospitals. Through HPOE, the AHA provides field-tested practices, tools, education and other networking resources that support hospital efforts to meet the Institute of Medicine's Six Aims for Improvement – care that is safe, timely, effective, efficient, equitable and patient-centered. Led by the AHA Quality Center, HPOE draws upon the resources of the entire association, including the American Organization of Nurse Executives, AHA Solutions, the Center for Healthcare Governance, Health Research & Educational Trust, Institute for Diversity in Health Management and the AHA's Personal Membership Groups.

HPOE is driven by three goals:

- To facilitate performance improvement efforts that assist hospitals in providing high quality, affordable care;
- To further the sharing of best practices among hospitals; and,
- To demonstrate the commitment of the hospital field to improve performance in several areas of operation.

Last year, HOPE focused on eight specific improvement objectives – from reducing surgical infections and complications to reducing MRSA and pressure ulcers – all of which help hospitals improve quality and reduce cost. In 2010, HPOE continues to advance patient safety and quality improvement activities in hospitals working specifically on the issues of care coordination, eliminating avoidable readmissions and improving medication administration as well as patient flow.

## REWARDING IMPROVEMENT

The AHA supports better alignment between payment and quality improvement such as value based purchasing, bundled payments and accountable care organizations. However, it's essential these initiatives be implemented in a manner that allows both high-performing and improving organizations to receive bonus payments as reward for their achievements.

**Value-based Purchasing.** Through the HQA, hospitals share reliable, credible and useful information on hospital quality with the public. The reporting of this information is tied to hospital payments. Hospitals are required to submit the quality data to Medicare in order to receive a full market-basket update for their hospital inpatient payments. Today, 4,900 hospitals voluntarily report their quality data on the *Hospital Compare* Web site.

The AHA supports pay-for-performance programs that reward providers with payment incentives for demonstrating excellence in patient safety and effective care. The AHA worked with Congress to establish a hospital value-based purchasing program in the PPACA which was budget neutral, resulting in no aggregate reduction in payments, as had been proposed by the Administration. The program is also consistent with the AHA's principles which include:

- Aligning hospital and physician incentives to encourage collaborative, effective and appropriate care;
- Involving all stakeholders in the program's development;
- Focusing on improving quality rather than acting as a cost cutting mechanism;
- Providing rewards that will motivate change;
- Implementing elements of the program incrementally;
- Recognizing and rewarding both high levels of performance and substantial improvements;
- Using measures that are developed in an open and consensus-based process and selected to streamline performance measurement and reporting;
- Using measures that are evidence-based, tested, feasible, statistically valid and recognize differences in patient populations; and,
- Designing the program carefully so as not to perpetuate disparities in care.

**Bundled Payments.** Bundling payments to cover a set of clinical best practices has the potential to create consistent, high quality care that is efficient. Congress accepted an incremental approach in the PPACA that tests different models of bundling to determine what works and what doesn't before broad adoption and rejected using bundled payments broadly as a cost cutting mechanism, an approach proposed by the Administration. While the concept is appealing, no one has yet identified the practical model that works best for Medicare patients. By allowing different organizational entities to receive the bundled payments, such as health systems, hospitals that employ physicians, physician-hospital organizations, and multi-specialty group practices or designated "medical homes," Congress has enabled the field to move forward.

The AHA believes that CMS should establish a reliable evaluation system to assess bundling's impact and report back to Congress on the approaches that warrant broader consideration. Bundling payments should not be automatically implemented by law or regulation. A variety of demonstration projects with proper evaluation can determine what best serves patient needs. Approaches that create greater integration across the health care system should be eligible for greater rewards.

**Accountable Care Organizations.** Accountable Care Organizations (ACOs) offer an opportunity to improve integration of inpatient and outpatient care and promote joint accountability for care delivery. The AHA supports this concept of care and strongly supported health reform provisions that enabled hospitals to join with doctors and other providers experiment in the design and operation of ACOs. Conceptually, ACOs will incent providers to deliver all the services needed to produce good outcomes for patients. The AHA worked to ensure an opportunity for hospitals with different structures and in different communities to take a leadership role in pilot testing the organizational structures and processes that will make an ACO a thriving part of the health care delivery system, delivering more fully integrated care.

### **ACHIEVING EQUITABLE CARE**

Responding to the Institute of Medicine's landmark report, *Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care*, the AHA convened a Special Advisory Group tasked with a simple question: how can hospitals improve the care we provide to minorities? Led by Kevin Lofton, past AHA chairman and CEO of Catholic Health Initiatives, one of the group's initial activities provided recommendations to hospital leaders of specific activities to eliminate disparities.

The PPACA includes several AHA supported provisions that will help address disparities in care. From the start of health reform discussions, the AHA advocated for equal access to care for all individuals. The AHA joined 20 national health and advocacy organizations calling for key elements to be included in health reform. Those included:

- Support improvements in health care delivery through incentives, resources and better data collection designed to eliminate disparities in health care for minority populations;
- Develop and expand the health care workforce to improve the availability of nurses, doctors and other caregivers in minority and underserved communities; and,
- Eliminate other barriers to access for minorities by providing coverage and access to care for all, resources to address the factors that contribute to the disparities gap and training to help health care providers deliver culturally competent care.

The AHA also is bringing together tangible resources to help hospitals navigate the path toward disparities elimination. Through the AHA's Center for Health Care Governance and Institute for Diversity in Health Management, a trustee training program was developed that helps hospitals expand the racial and ethnic diversity of their governing boards.

To help hospitals measure and thereby effectively address disparities, the AHA's Health Research and Educational Trust created and made available online the Disparities Toolkit. The Web-based toolkit helps hospitals collect race, ethnicity and primary language data in a uniform way and is endorsed by the National Quality Forum.

As hospitals and health systems across the country work to align quality improvement goals with disparities solutions, the AHA's web-based resource shares proven solutions via hospital case examples from a range of hospitals addressing disparities in care as well as informative articles and tools.