

Improving Hospital Performance

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 (IOM) 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. In particular, provisions from the *Patient Protection and Affordable Care Act* (ACA) must be implemented in a way that is fair and equitable for hospitals while seeking to avoid adverse unintended consequences. To foster such public policies, the AHA’s efforts are focused on the following:

Public Reporting of Quality Data. As a partner in the Hospital Quality Alliance (HQA), the AHA works with a broad group of stakeholders to drive consensus on 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 for surgical patients to patients’ assessments 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 2010, the HQA added several new measures to its consumer-friendly *Hospital Compare* website, www.HospitalCompare.hhs.gov, including an additional measure of inpatient surgical care and measures of care for outpatient surgery patients and heart attack patients transferred to other facilities.

Several provisions in the ACA build on this strong public reporting effort. The HQA 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 included language that brings greater structure to quality improvement efforts, providing the opportunity for physician, nursing home, long-term care and hospital quality measures to be in closer alignment.

Health Care Use Variation. In 2009, the AHA convened a task force to examine key contributors to geographic variation in health care spending. The task force found that variation goes beyond just measures of spending and arises from many interrelated factors, some within and some beyond the control of the health care system. Not all variation is undesirable or inappropriate. Variation can be appropriate when it is due to the characteristics of the population served

(e.g., age or gender) or the varying circumstances of providers (e.g., special missions, costs of doing business, rural/urban location).

Distinguishing among the types of variation is critical to arriving at a reasonable set of recommendations for action and a fair set of policies for holding providers and other stakeholders accountable for their results. Many aspects of health care reform are pushing the field to address variation, and pressures will accelerate as the drive to bend the cost curve intensifies. Hospitals, in conjunction with physicians, other clinicians and other care partners, must be aggressive and start to reduce the variation that is within their control; collaborate with other parts of the health care system, insurers and employers to address inappropriate variation across the care continuum; and provide leadership in bringing together other stakeholders to deal with broader societal issues that affect health behavior and health status.

ACA IMPLEMENTATION

The ACA seeks to help hospitals improve performance by providing assistance and through a new legislative framework.

National Quality Strategy. The ACA called for the establishment of a national quality improvement strategy, which includes priorities that have the greatest potential to improve patient outcomes, patient-centeredness and efficiency. The selected priorities will become the basis for further work to develop and implement measures to foster improvement and public reporting, including public reporting on hospital quality on *Hospital Compare*. The AHA supported the inclusion of this provision in the ACA. In late 2010, the Agency for Healthcare Research and Quality released a proposed national strategy, upon which the AHA offered comments. In March 2011, a final version of the national strategy was released.

Patient-Centered Outcomes Research Institute. The ACA created an independent Patient-Centered Outcomes Research Institute to conduct comparative effectiveness research. This research will focus on health care interventions, protocols for treatment and pharmaceutical use. The Institute will assist patients, clinicians, purchasers and policymakers in making informed health decisions by advancing evidence-based knowledge of how diseases and other health conditions can effectively and appropriately be prevented, diagnosed, treated and managed. The AHA successfully nominated two individuals to serve on the Institute's 19-member board; they were chosen to serve as chair and vice-chair.

Value-based Purchasing (VBP). 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 VBP program in the ACA that was budget neutral,

resulting in no aggregate reduction in hospital payments. The program also is consistent with many of the AHA's principles on pay-for-performance. The Centers for Medicare & Medicaid Services (CMS) released a proposed rule in early January to implement the VBP program. The AHA supports the general direction of CMS' proposed rule but expressed serious concerns about the following specific proposals: the inclusion of hospital-acquired conditions (HAC) in the VBP program when a separate HAC provision in the ACA will also impose financial penalties on a segment of hospitals in fiscal year (FY) 2015, the weighting of the patient experiences of care survey data, and the required minimum number of patient cases to participate in the program. The AHA has encouraged CMS to address these concerns in the VBP final rule, which is expected later this spring.

Post-acute VBP. In 2011, the AHA will contribute to CMS processes required under the ACA to develop quality measures for inpatient rehabilitation facilities and long-term acute care hospitals. In addition, the AHA will provide input to CMS' efforts to advance the current home health and skilled nursing facility pay-for-reporting programs toward pay-for-performance, as mandated by the ACA.

Readmissions. The ACA included a readmissions 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. As AHA advocated, the law stipulated that readmissions that are planned or unrelated to the initial admission should be excluded from the calculations of the measures. This distinction is important to recognize differences among hospitals, communities and the patients served. We expect CMS to propose the implementation guidelines for the readmissions provision in the FY 2012 inpatient prospective payment system (PPS) rule. In light of these expectations, the AHA has been sharing with CMS ideas for how the agency may account for planned and unrelated readmissions in the readmissions calculations in a manner that does not increase the reporting burden on hospitals. We will continue to work with CMS on this issue and provide comments when the proposed rule is released.

Hospital-Acquired Conditions (HAC). The provision applies a financial penalty to hospitals with high risk-adjusted rates of the HACs identified by CMS for use in the inpatient PPS hospital-acquired conditions policy, or any other condition selected by the Health and Human Services Secretary. Beginning in FY 2015, hospitals in the top quartile of national HAC rates will receive 99 percent of their otherwise applicable Medicare payments for all discharges. The Secretary is required to develop and use a risk-adjustment methodology when calculating the HAC rates. The AHA strongly opposes this provision as some hospitals will always see financial penalties each year, despite any overall progress made by the field in reducing the occurrence of these events. As mentioned above, we currently oppose CMS' plans to include these same conditions in the VBP program, because both policies together could result in double penalties for certain hospitals.

PURSUING EXCELLENCE

Hospitals in Pursuit of Excellence. Through the AHA's strategic platform to accelerate performance improvement in the nation's hospitals, *Hospitals in Pursuit of Excellence* (HPOE), the AHA provides field-tested practices, tools, education and other networking resources that support hospital efforts to meet the IOM's Six Aims for Improvement – care that is safe, timely, effective, efficient, equitable and patient-centered. 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.

In 2011, HPOE will continue to advance performance improvement and delivery system transformation by providing:

- Best practices through www.hpoe.org in the areas of patient safety, flow, wellness, care coordination, health information technology and other topics;
- Action guides on a variety of topics, including disparities, population health, variation and payment innovations;
- Fellowship programs in patient safety and health care system reform; and
- National clinical improvement projects to reduce central line-associated bloodstream infections (CLABSI) and catheter-associated urinary tract infections (CAUTI).

Achieving Equitable Care. Responding to the IOM'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 made recommendations to hospital leaders on specific activities to eliminate disparities.

The ACA 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 in calling for key elements to be included in health reform. They called for the legislation to:

- 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 brought together tangible resources to help hospitals navigate the path toward disparities elimination. Through the AHA's Center for Healthcare 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 & Educational Trust created and made available online the Disparities Toolkit. This web-based toolkit helps hospitals collect race, ethnicity and primary language data in a uniform way and is endorsed by the National Quality Forum.

Prescription Drug Shortages. In 2010, the Food and Drug Administration (FDA) reported a record number of drug shortages, nearly 200, including critical drugs used in surgery/anesthesia, emergency care and oncology. Drug shortages make delivering patient care more difficult and dangerous by causing delays in treatment and forcing the use of alternative drugs that are less familiar to the provider. The AHA supports the *Preserving Access to Life-Saving Medications Act* (S. 296) introduced by Sens. Amy Klobuchar (D-MN), Robert Casey (D-PA) and Richard Blumenthal (D-CT). The bill would help address issues leading to shortages and give the FDA additional authority and information that will assist in preventing further drug shortages in the future.