

Improving Hospital Performance

Background

Over the past decade, hospitals have worked diligently to improve the safety and quality of the care they provide so that all of our actions lead to the best possible results for patients and for society as a whole. As much as the hospital field has been able to accomplish in this decade – reducing infections, preventing complications in care, improving communication, engaging patients and their families so that care is tailored to meet their needs – hospital leaders are keenly aware that more needs to be done. That is why hospitals are engaged in a variety of initiatives, all of which lead to better, safer, more efficient 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:

Value-Based Purchasing (VBP). In October, Medicare will launch the hospital value-based purchasing program. The AHA fully supports the concept of pay-for-performance programs that provide incentives for demonstrated excellence and noteworthy improvements in patient safety and effective care. The AHA worked with Congress as it established a hospital VBP program that is budget neutral for Medicare. The program is consistent with many of the AHA's principles on pay-for-performance. The Centers for Medicare & Medicaid Services (CMS) released a final rule in August 2011 laying out many aspects of the VBP program; the remaining details will be described in a proposed rule that is expected April 2012.

While the AHA supported the general direction of CMS's July 2011 hospital VBP proposed rule, the AHA expressed serious concerns about the following proposals:

- Inclusion of hospital-acquired conditions (HAC) in the VBP program when a separate HAC provision in the ACA also will impose financial penalties on a segment of hospitals in fiscal year (FY) 2015;
- Inclusion of measures for 2014 that had not yet been displayed on the *Hospital Compare* website as required by law;
- Weighting of the patient experiences of care survey data; and
- Required minimum number of patient cases to participate in the program.

CMS's final rule did not change direction on several of these issues. However, the AHA continued to raise objections with representatives from the Department of Health and Human Services (HHS) and CMS emphasizing how some of CMS's measures and initiatives conflicted with requirements in the ACA. The AHA was

pleased that in the outpatient prospective payment system (PPS) final rule, which was published in November 2011, CMS suspended measures for use in FY 2014.

The AHA expects that CMS will continue to propose additional measures for use in VBP over the next several years, and may retire or suspend some that have already been adopted once performance on those measures has reached a level that suggests further improvement is unlikely. The AHA will continue to work with CMS to ensure that the measures selected for use in hospital VBP are important in improving patient outcomes and efficiency, evidence-based, reliable and valid.

Post-Acute VBP. The AHA is engaged in CMS's processes to implement quality measures for inpatient rehabilitation facilities and long-term care hospitals. These include the ACA-mandated implementation of pay-for-reporting programs for both settings by October 2012, which was initiated through 2011 rulemaking by CMS. The AHA also is participating in the post-acute component of the Measure Applications Partnership, which will recommend to CMS what other measures should be added to the post-acute VBP program in the future. (See "National Quality Strategy" below for details on the Measure Applications Partnership.)

Readmissions. The ACA included a readmissions provision that imposes financial penalties on hospitals for "excess" readmissions when compared to "expected" levels of readmissions. This penalty program will be imposed on hospitals beginning October 1, 2012 (FY 2013). The initial payment penalties are 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 successfully advocated for a provision in the law stipulating that readmissions that are unrelated to the original reasons for admission or are planned should be excluded from the calculations of the measures. This distinction is important because it recognizes differences among the patients served. However, so far CMS has made only modest adjustments to account for readmissions for planned heart surgeries following a heart attack. Further work is needed on all the measures to identify other planned and unrelated reasons for readmissions that should be excluded.

In addition, CMS needs to recognize that readmissions are the result of many factors, some are within a hospital's control, and some are related to the lack of resources elsewhere in the community, such as adequate numbers of primary care clinicians and access to pharmacies. There is compelling evidence that safety net hospitals and others serving large numbers of low-income individuals will have difficulty reducing readmissions due to the lack of some of these resources in the communities they serve. This creates an unfair system that puts these hospitals at greater risk for substantial readmission penalties. Thus far, CMS has refused to account for these community-level factors in the readmission measures.

The AHA continues to share ideas with CMS about how the agency could account for planned and unrelated readmissions in the readmissions calculations in a manner that does not increase the reporting burden on hospitals and account for community-level factors that affect readmissions.

Hospital-Acquired Conditions. The ACA's HAC 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 HHS 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 experience financial penalties each year, despite any overall progress made by the field in reducing the occurrence of these events.** As mentioned above, we oppose CMS's plans to include these same conditions in the VBP program, because both policies together could result in double penalties for certain hospitals.

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 2010, the Secretary asked for input on what the priorities should be in the National Quality Strategy. On behalf of America's hospitals and health systems, the AHA offered ideas drawn from discussions with its regional policy boards and governing councils. The AHA also is part of the National Priority Partnership, a multi-stakeholder group drawn together expressly for the purpose of helping to identify the national priorities and the most promising strategies to achieve results on the identified priorities. The National Priority Partnership also advised the Secretary on the National Quality Strategy.

In March 2011, HHS Secretary Sebelius issued the first national quality strategy calling for better care, healthier people and communities and greater affordability of care. Specifically, it articulated six priorities:

- Reducing unintended harm to patients;
- Spurring more patient and family engagement;
- Improving the effectiveness of communication and care coordination;
- Promoting effective prevention strategies for the leading causes of mortality;

- Promoting healthy living; and
- Making care more affordable by developing and adopting new forms of care delivery.

The ACA also calls for the Secretary to garner advice from a multi-stakeholder group on the measures that should be used in HHS's oversight and payment programs to both encourage improvements in care along the lines envisioned in the National Quality Strategy and enable the nation to track progress toward achievement of the articulated goals. As a founding partner of the Hospital Quality Alliance (HQA), the AHA has spent nearly a decade working with other stakeholders to identify good, reliable measures that could be used to report publicly on hospital care. The measurement work envisioned in the ACA encompassed, but was not limited to hospital care. A new multi-stakeholder group called the Measure Applications Partnership (MAP) was formed to develop a strategy for identifying and recommending measures for a wide variety of applications, including hospital and physician payment programs, so the HQA chose to sunset its operations at the close of 2011. The AHA has refocused its attention on the work of the MAP and participates actively in its Coordinating Committee and the subcommittee that focuses on hospital measures.

The MAP made its first set of recommendations to the Secretary in February and as CMS and other parts of HHS roll out their regulations this spring, the AHA will monitor how closely HHS chooses to follow the recommendations of the MAP.

In the meantime, the National Quality Forum continues to review and endorse additional measures as national standard quality measures. There are now more than 750 endorsed measures.

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 (HRET), Institute for Diversity in Health Management, Physician Leadership Forum and the AHA's Personal Membership Groups.

In late 2011, HRET was awarded the Hospital Engagement Network Contract by CMS to support its Partnership for Patients (PFP) campaign. The project will help hospitals adopt new practices that have the potential to reduce inpatient

harm by 40 percent and readmissions by 20 percent over the contract. As part of the PFP contract and other activities, HRET is providing education and training for the nearly 1,700 hospitals recruited by its 34 state hospital association partners in support of their quality improvement efforts in targeted areas. The PFP focuses on 10 areas for quality improvement:

- Adverse drug events (ADE)
- Catheter-associated urinary tract infections (CAUTI)
- Central line-associated blood stream infections (CLABSI)
- Injuries from falls and immobility
- Obstetrical adverse events
- Pressure ulcers
- Surgical site infections
- Venous thromboembolism (VTE)
- Ventilator-associated pneumonia (VAP)
- Preventable readmissions

In addition, HRET will supplement this work by continuing to support system transformation by providing to the field:

- 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 CLABSI and CAUTI.

Achieving Equitable Care. The AHA has joined four leading health organizations in *Equity of Care*, a national call to action to eliminate health care disparities and improve quality of care for every patient. *The Equity of Care* initiative focuses on three areas:

- Increasing the collection of race, ethnicity, and language preference data and facilitating their use;
- Increasing cultural competency training of clinicians and support staff; and
- Increasing diversity in governance and management.

HRET is supporting the AHA's work, which includes disseminating free resources and sharing best practices on the *Equity of Care* website, www.equityofcare.org. To help hospitals measure and thereby effectively address disparities, HRET developed a Disparities Toolkit that allows hospitals to collect race, ethnicity and primary language data in a uniform way. The toolkit was updated in February to reflect ACA requirements and The Joint Commission standards. In addition, the AHA's Center for Healthcare Governance and Institute for Diversity in Health Management developed a trustee training program to help hospitals expand the racial and ethnic diversity of their governing boards.

Prescription Drug Shortages. In 2011, the Food and Drug Administration (FDA) reported a record number of drug shortages, more than 250, including critical drugs used in surgery/anesthesia, emergency care, parenteral nutrition and oncology. Drug shortages continue in 2012 and 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. Shortages also are costly to hospitals and health systems in terms of staff time and other resources to manage the shortages and the increased cost of buying alternative drugs "off contract." In a 2011 member survey, the AHA found that nearly all hospitals have experienced shortages, across all treatments and that hospitals rarely receive advance notification or information about the causes of shortages.

The AHA has been working closely with FDA and Congress to better understand and seek solutions for this critical public health crisis. The AHA also is working cooperatively with other stakeholder organizations representing pharmacists, physicians, generic drug manufacturers, wholesale distributors and group purchasing organizations to promote policy recommendations to help solve shortages. There are several promising actions that HHS can take using its current statutory authority to help address this public health problem. The AHA has encouraged the department to immediately move forward on those that can be accomplished quickly and commit to moving forward on others that may take a longer time to implement. In addition, the AHA encourages HHS to support those solutions that would require legislative change. Potential solutions fall into four general categories:

- Establishing an expanded "early warning system" to help avert or mitigate drugs shortages.
- Removing obstacles so that FDA is able to keep critical drugs on the market and streamline approval of drugs in shortage.
- Improving communication among stakeholders, including extent and timeliness of information.
- Exploring incentives to encourage drug manufacturers to stay in, re-enter or initially enter the market.

Many of these changes are included in two AHA-supported bills: the *Preserving Access to Life Saving Medications Act* (H.R. 2245/S. 296), sponsored by Reps Diana DeGette (D-CO) and Tom Rooney (R-FL) and Sen. Amy Klobuchar (D-MN), respectively, and the *Drug Shortage Prevention Act* (H.R. 3839) sponsored by Rep. John Carney (D-DE). These bills would help address the issues leading to shortages and provide the FDA with additional authority and information to prevent further drug shortages. In addition, the AHA is working to ensure that the “must-pass” legislation reauthorizing the *Prescription Drug User Fee Act* includes drug shortage provisions supported by the AHA.

Conditions of Participation (CoP). Last fall, CMS proposed changes to the Medicare Conditions of Participation for the first time since 1985. These changes in large measure are intended to permit more effective governance and medical staff involvement in hospital care, reflect the evolving roles of non-physician providers, eliminate record keeping by hand when computers are much more effective, and otherwise modernize the COPs. In issuing the proposed rule, CMS acknowledged that further changes will likely be necessary after these are put in place because so much of hospital practice has evolved since 1985. The AHA saluted the changes CMS proposed, specifically, the move to recognize a single governing body over multiple hospitals within a system, allowing CAHs to provide certain services, such as diagnostic, therapeutic, laboratory, radiology and emergency services under service arrangements and permitting advanced practice practitioners to serve in an expanded role. The final rule is expected in the spring.