

Reform Speeds Up an Already Accelerating Transformation: The Effect on Health Care Quality

Stephen Wallenhaupt, MD

Is health care the last major industry that proves value can be delivered at a lower price and with improved service? The answer may be “yes.” And it is my belief that everyone who cares for patients and supports the delivery of health care must embrace this value proposition because our industry has forever changed and will never return to the not-so olden days of reimbursing health care services based on price alone.

As a not-for-profit, integrated health care system, Novant Health believes the safety and quality of care delivered to our patients should be our top priority. I know few health care providers who prioritize anything else.

The recently passed Patient Protection and Affordable Care Act will dramatically change the health care industry. What remains to be seen is how it will change our nation’s delivery system—for the better or the worse? The new law contains a number of quality provisions that flew under the public’s radar as national attention focused on insurance reforms, decreasing the number of the nation’s uninsured, and a host of very emotional issues that often engulfed the debate.

Signed into law by President Barack Obama, the new law contains a number of pilot projects, demonstrations, and other programs that call for providers to be paid based on the quality, rather than the quantity, of services. This emphasis on quality and accountability is long overdue and these inclusions

throughout the reform package comprise an important step in the right direction. A strong national focus on quality of services will result in better outcomes for the individuals who entrust their care to us during the most vulnerable times of their lives. Our consumers increasingly expect higher quality, better service, more affordability and, it should go without saying, an expectation that we do not harm them.

First though, let’s acknowledge exactly how health care providers will be rewarded for achievements in providing quality care: low performers will pay penalties and high performing organizations will avoid those penalties. In other words, health care organizations who do not meet national quality standards will be penalized by government payers and those fines will help pay for federal health coverage expansion. For example, two quality provisions in the new law will remove approximately \$8.5 billion from Medicare reimbursements to providers over a 10-year period. That’s in addition to the \$147 billion in further reductions to hospital Medicare and Medicaid payments over 10 years that will also help fund expanded coverage. Government leaders who designed the legislation expect these payment reductions to be offset by helping 32 million uninsured people acquire health insurance and consequently reduce health care providers’ charity care and bad debt expenses. We hope this *quid pro quo* occurs, but early estimates predict additional payment losses for providers rather than a neutral impact.

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In a nutshell, quality will be perversely rewarded by fining health care providers with poor performance and allowing high performing organizations to escape with a neutral impact to their Medicare reimbursement rates, which in most cases do not currently cover the actual cost of providing care to our nation's seniors.

With that being said, there's a tremendous amount of work ahead in hammering out details for the overall concept of pay-for-quality (also known as pay-for-performance or P4P). As with other large, complicated pieces of legislation, the majority of provisions will need to go through the rule-making process where the particulars of each of these new programs and reforms will be decided and, therefore, where these programs' chance of success or failure will be determined. If done thoughtfully and with input from the individuals who provide patient care everyday, the significant changes that health care needs could be on a horizon that we see in our lifetimes. However, if developed and implemented incorrectly, then rural and metropolitan communities and their health care safety nets could be adversely altered for decades to come.

All health care providers own the responsibility to make their opinions and experiences known during this regulatory process. The individuals on the government frontlines who are creating the details and policies for these new programs may not possess the knowledge needed to make the most appropriate decisions.

I was particularly pleased to see an aggressive emphasis on public reporting and transparency included in the final legislation. Our health system supports public reporting and our motivation for transparency is simple: the patient deserves as much information as possible for making an informed decision. We welcome the movement in this direction and believe that holding hospitals and other health care providers more accountable will undoubtedly move all of us to improved performance.

Some hospitals and health systems have already begun efforts to publish more quality indicators than are required by Medicare. Novant Health is preparing to publish a panel of additional quality indicators on our websites, including our hospitals' serious safety event rates, employee hand hygiene compliance, health care acquired MRSA rate, ICU central line associated bloodstream infection rate, and other key measures. We believe this additional level of transparency will, by itself, accelerate change and improve quality. Consumers will be able to access this data and, even more importantly, our own staff in all 12 hospitals and 360 physician practice locations will be able to compare their performance with others throughout our health system.

A few organizations have even attempted publishing pricing information for consumers, but this challenge continues to be mired in differences between health plan deductibles, co-pays, discounts off charges, and other complex factors.

Another component of the Patient Protection and Affordable Care Act includes a Value Based Purchasing (VBP) program for hospitals. This program is scheduled to begin in fiscal year 2013 and will use 2012 data to hold hospitals accountable for measures that are part of the hospital quality reporting program. Although the VBP program has been described as improving quality by incentivizing hospitals, the program will be completely financed by withholding reimbursements from hospitals. These withheld funds will be returned to hospitals in the form of incentives. While Novant certainly supports the concept of holding hospitals accountable for quality measures, we also think this objective should be accomplished with actual incentives, not by simply holding back part of a hospital's existing Medicare reimbursement.

The new law also contains an initiative to penalize organizations with high rates of hospital acquired conditions (HACs). While we were pleased to see reform directly address the issue of hospital acquired conditions, we have concerns about how the penalties will be implemented. The legislation calls for hospitals in the low performing quartile for frequency of HACs to be financially penalized. This policy will eventually need to transition away from identifying the poorest performing quartile to instead having more absolute benchmarks in which all systems are held accountable to a best practice standard. By using a national comparative database in which hospitals should rapidly improve over time, even high performing facilities with low infection rates could eventually fall into the poorest performing quartile.

Novant Health and its hospitals have worked relentlessly to reduce our incidence of HACs over the past five years. We have significantly decreased MRSA infections from 2005 to the present, due in part to hard-hitting hand hygiene education and internal staff monitoring. Our current MRSA rate is 0.16 per 1,000 patient days, which is extremely low based upon other organizations who voluntarily report this data. This type of national target, rather than a quartile ranking, which does not establish best practices for preventing hospital acquired conditions such as MRSA, should be established to truly reward hospitals for quality.

For Novant's efforts, The Joint Commission honored our staff with the prestigious national Ernest A. Codman award for patient quality and safety. We established a website (<http://www.WashingHandsSavesLives.org>) where any hospital or health care organization can access our hand hygiene campaign materials and use them free of charge. Several thousand organizations from the United States and approximately 70 countries have accessed materials from the website. We believe it's an obligation to share success and best practices among health care providers. National efforts to improve quality must encourage this type of clinical exchange. We fear that competitive databases, instead of the establishment of best practice standards, won't foster the sharing of ideas.

Health reform also attempts to address the problem of excessive readmissions to hospitals. Again, most health care providers believe this should be a priority that needs aggressive action in order to minimize the incidence of inappropriate patient readmissions to the hospital setting. We wholeheartedly support the concept; however, as with the other reform provisions, it contains a draconian flaw. The legislation calls for steep penalties for excessive readmissions in the areas of heart attack, heart failure, and pneumonia. Unfortunately, no consideration is given to whether the readmission is related to the original admission. In addition, if a hospital experiences even one more readmission than the "expected" number, all Medicare reimbursements will be reduced for that facility.

We accept our responsibility to provide the best possible care to our patients and to discharge them back to their normal lives. However, if a hospital and physician appropriately readmit a patient for a condition that is completely unrelated to his or her initial hospitalization, and

that readmission puts the facility one case over the expected rate, all of the hospital's Medicare reimbursements will be penalized. It's difficult to understand why legislators thought this process would be fair. Fortunately, this provision as well as others will be subject to rule-making, and therefore health care providers hope to influence the final outcome before a flawed policy is implemented.

Our individual hospitals, outpatient centers, and physician practices continue to improve medical care and services for our patients. We hold ourselves accountable for improving the quality and safety of patient care during every encounter. We believe strongly in sharing knowledge and best practices among health care systems and providers. The new reform law has permanently changed health care, especially with the components that focus on linking quality with payment. This emphasis can positively affect our industry if science and fairness intersect during the development process. Our patients and communities depend upon this success. **NCMJ**



Odds of a child becoming a top fashion designer: 1 in 7,000

Odds of a child being diagnosed with autism: 1 in 110

Some signs to look for:

No big smiles or other joyful expressions by 6 months.	No babbling by 12 months.	No words by 16 months.
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To learn more of the signs of autism, visit autismspeaks.org

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