Satisfying New Demands for Quality Reporting and Improvement

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Overview of Presentation

- Introduce HRET
- New demands for hospital improvement
  - Meaningful use of HIT
  - Payment bundling
  - Accountable Care Organizations (ACOs)
  - Value-based payment
  - Hospital-acquired conditions
  - Penalties for avoidable readmissions
- Support to help rural hospitals prepare

The Health Research and Educational Trust (HRET)

- HRET Mission: Transforming health care through research and education
- Established in 1944
- A 501(c)(3) affiliate of the American Hospital Association
- U.S. Agency for Healthcare Research and Quality (AHRQ) has contracted with HRET to bring free patient safety resources and tools to hospitals, primary care practitioners, and health professions educators, that wish to use them

HRET Partners Include AHRQ, State Hospital Associations, QIOs—more welcome!

- AHRQ funds HRET to provide technical assistance for hospitals and other providers.
- HRET partnerships help providers improve patient safety and quality.
- Technical assistance includes “free” national Web conferences, trainings at local events.
- For most of our AHRQ initiatives, HRET can offer free materials, and funding for our partners to host speakers and trainers.

American Recovery and Reinvestment Act HIT Provisions

- Eligible providers will be paid incentives for "meaningful use" of health IT—for up to 4 years if start using HIT meaningfully by 2011.
- Increasing penalties begin in FY 2015 for those that cannot demonstrate "meaningful use," including Critical Access Hospitals.
- HIT Regional Extension Centers may assist rural providers including Critical Access Hospitals in achieving "meaningful use" of HIT—many will not, but Health Technology Services will.

Health Reform: Hospital Acquired Conditions

- Health reform legislation requires public reporting of Hospital Acquired Conditions, such as hospital associated infections, and cuts 1% from payments to PPS hospitals with high rate of HACs.
- Orders a study of the impact applying this to non-PPS hospitals would have on quality and safety.

Health Reform: Reducing Avoidable Rehospitalizations

- Penalties will be imposed on hospitals with excessive readmission rates (calculated for targeted conditions).
- Sole community hospitals, Medicare dependent small rural hospitals, and low volume conditions are exempt from penalties.

Health Reform: Value-based Payments to Providers

- The new law withholds 1-2% of all PPS hospital payments starting 2013 to create a fund to pay bonuses for high performing hospitals.
- Secretary must consult rural hospitals when implementing this provision.
- Payments for sole community and low volume hospitals are exempted at first, *but* demonstrations with CAHs and other excluded hospitals will begin in 2 years.

Health Reform: Medicare Payment Bundling

- Voluntary 5-year pilot, targeting chronic conditions.
- "Bundles" cover care of targeted conditions, starting 3 days before, ending 30 days after, a hospital stay.
- Inpatient, SNF, HHA, inpatient & ambulatory physician care, inpatient rehab and LTCH services, (and others) are bundled together.
- AHRQ to develop episode of care quality measures.
- Secretary "shall consult with representatives of small rural hospitals, including [CAHs] regarding their participation…[to consider] innovative methods" of bundling, given rural concerns.

Health Reform: Accountable Care Organizations (ACOs)

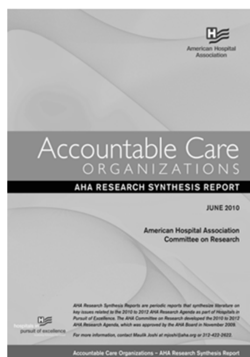
- Permits physicians, hospitals, others to set up ACOs "*accountable for the quality, cost, and overall care of FFS Medicare beneficiaries*"
- Fee for service payments to providers
- Providers share in savings they create
- No penalties if create no savings
- Minimum 5,000 enrollees, 3 yr commitment
- Must have formal legal structure to receive pay
- HHS Secretary may expand to national program without further legislation.

What's the Message in All This?

- Hospitals and ambulatory providers should work together to improve quality, cut costs.
- Reporting quality data is expected; trend is toward reporting more, and reporting clinical performance electronically.
- Payment incentives will reward providers for increasing the value of care, punish them for providing low value care.
- Rural and small providers get some extra help and more time to prepare, but probably will be subject to some form of these incentives.

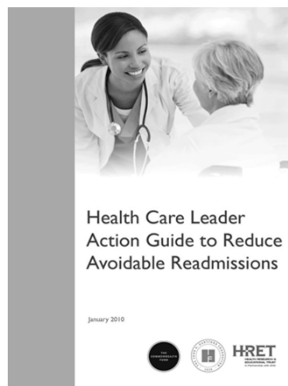
Assistance for Rural Hospitals Responding to New Demands for Higher Performance

New Report on ACOs from AHA



- Community relationships are essential to forming and operating an ACO
- Reaching out to primary care practitioners, nursing homes, home care, AAAs can be a viable strategy for reducing rehospitalizations
- Can improve care, build trust and a mutual understanding of sound operations

HRET Leadership Guide



Provides strategies for you to--

- ✓ **Examine your hospital's current rate of readmissions.**
- ✓ **Assess and prioritize your improvement opportunities.**
- ✓ **Develop an action plan of strategies to implement.**
- ✓ **Monitor your hospital's progress.**

Strategies to Implement Along Care Continuum

To effectively implement these strategies, hospitals may need to involve key stakeholders in the care delivery process: patients, physicians, pharmacists, social services, nutritionists, physical therapists, and the community.

Table 1: During Hospitalization

- Risk screen patients and tailor care
- Establish communication with primary care physician (PCP), family, and home care
- Use "teach-back" to educate patient/caregiver about diagnosis and care
- Use interdisciplinary/multi-disciplinary clinical team
- Coordinate patient care across multidisciplinary care team
- Discuss end-of-life treatment wishes

Table 2: At Discharge

- Implement comprehensive discharge planning
- Educate patient/caregiver using "teach-back"
- Schedule and prepare for follow-up appointment
- Help patient manage medications
- Facilitate discharge to nursing homes with detailed discharge instructions and partnerships with nursing home practitioners

Table 3: Post-Discharge

- Promote patient self management
- Conduct patient home visit
- Follow up with patients via telephone
- Use personal health records to manage patient information
- Establish community networks
- Use telehealth in patient care

Medicare Funded Technical Assistance for Reducing Readmissions

- Health reform legislation budgets $500 Mn for hospital-community organization partnerships to help hospitals to reduce readmissions—priority given to AoA projects and hospitals caring for rural and underserved.
- QIOs *may* be funded in 2011-13 to assist hospitals across the country in reducing readmissions (now active in 14 states).

AHRQ Offers Free Electronic Decision Support to Hospitals/Clinics

- Electronic Preventive Services Selector (ePSS) tool embeds in EMRs, handhelds.
- Helps clinicians understand and use U.S. Preventive Services Task Force (USPSTF) recommendations when seeing patients.
- Provides real-time, patient-specific reminders to offer preventive services.
- HRET will help hospitals/clinics who want to embed AHRQ's free ePSS in their EHR.

AHRQ is Seeking Preventive Services Partnerships with AHECs, Educators

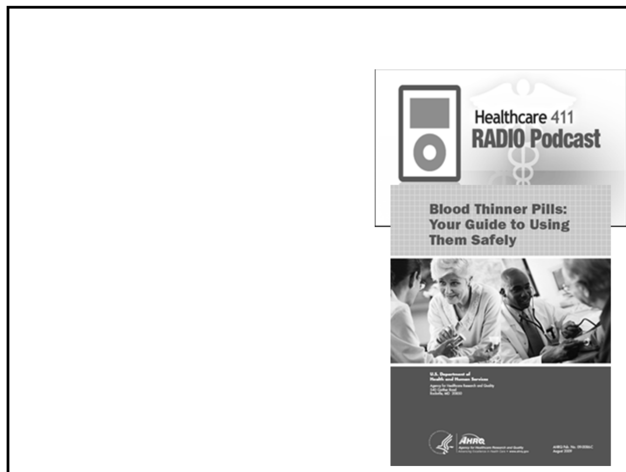
- AHRQ is funding HRET to reach out to health professions educators, offer tools and assistance to teach USPSTF recommendations
- Multidisciplinary approach to educating health professionals: physician, physician assistant, nurse practitioner, pharmacist
- Reaching out to AHECs, classroom educators, preceptors, student organizations
- Showcasing exemplary educators and preceptors to inspire and assist their peers

AHRQ CUSP Initiative to Reduce Hospital-associated Bloodstream Infections: Goals

- Reduce BSI rates nationwide by 80%.
- Include hospitals in 50 states, DC, Puerto Rico.
- Include Critical Access Hospitals.
- Include ICUs *and* other units with BSI risks.
- Improve safety culture so that infection rate reductions are achievable and sustainable.
- Support state hospital association efforts.
- Expand to include Catheter Associated UTIs (CAUTIs) this Fall (in a subset of states).

CUSP Expanding to CAUTI in Fall 2010

- 600,000 patients develop hospital-acquired UTIs per year
- Account for 40% of all hospital-acquired infections
- Catheter-associated infections (CAUTI) comprise 80% of these cases
- Expected Outcomes:
  - Reduction in bacteriuria
  - Reduction in symptomatic UTIs
  - Shorted Length of Stay
  - Decreased Cost per stay



Next Steps

- Contact me (dschulke@aha.org) if you are interested in learning more about any of the tools mentioned.
- Financial help may be available for state efforts to disseminate CUSP, and most AHRQ tools.
- Depending on the specific tool and demand, HRET may be able to support topic specific webinars, onsite trainers for state level events, and follow-up problem solving.
- Tell us which topics and tools most interest you!

Comments and Questions?

Thank you!