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A Message from the President...

It seems like every day we hear about another new initiative to improve patient safety, efficiency or cost. Healthcare is evolving before our eyes and these are truly exciting times to practice medicine. It's also overwhelming. How do we coordinate and execute all of this change?

One of the cornerstones of the Iowa Healthcare Collaborative (IHC) is to "Align and Equip Providers for continuous improvement." Through our collaborative efforts, we aim to promote better execution and care coordination and to speed the spread of best practice. A key to our strategy is to constantly work to align with national strategies.

The Affordable Care Act passed in 2010 seeks to increase access to high-quality and affordable healthcare for all Americans. This law requires the Secretary of the Department of Health and Human Services (HHS) to establish a **National Strategy for Quality Improvement in Health Care** (the National Quality Strategy) that sets priorities to guide this effort and includes a strategic plan for how to achieve it. The initial report was recently released and is the first effort to create national aims and priorities to guide local, State, and national efforts to improve the quality of health care in the United States.

The National Quality Strategy promotes quality health care that is focused on the needs of patients, families, and communities. At the same time, the Strategy is designed to move the system to work better for doctors and other health care providers – reducing their administrative burdens and helping them collaborate to improve care. The Strategy presents three aims:

- **Better Care:** Improve the overall quality, by making health care more patient-centered, reliable, accessible, and safe
- **Healthy People & Communities:** Improve the health of the U.S. population by supporting proven interventions to address behavioral, social, and environmental determinants of health in addition to delivering higher-quality care
- **Affordable Care:** Reduce the cost of quality health care for individuals, families, employers, and government

To help achieve these aims, the Strategy also establishes six priorities to help focus efforts by public and private partners. These priorities are:

- Making care safer by reducing harm caused in the delivery of care.
- Ensuring that each person and family is engaged as partners in their care.
- Promoting effective communication and coordination of care.
- Promoting the most effective prevention and treatment practices for the leading causes of mortality, starting with cardiovascular disease.
- Working with communities to promote wide use of best practices to enable healthy living.
- Making quality care more affordable for individuals, families, employers, and governments by developing and spreading new health care delivery models.

This National Quality Strategy is designed to be an evolving guide for the nation. I hope that you will take some time to review it at: <http://www.healthcare.gov/center/reports/quality03212011a.html>. (Supporting documents are available at <http://www.ahrq.gov/workingforquality/>.)

We look forward to our continued collaboration with you to make the National Quality Strategy a reality.



Patient-Centered Medical Home Learning Community

Healthcare is constantly changing and so is the Medical Home. How we pay for it – document it – coordinate it - measure it – report it and yes, transform it. The Iowa Healthcare Collaborative spring Medical Home conference, *Coordinating Care in the Community*, includes a dynamic presentation by Harold Miller, CEO for the Network for Regional Healthcare Improvement, Pittsburg, Pa. He will address alternative ways to pay for health care, including bundled payments, warranties, comprehensive care payments to enable health care providers to reduce health care costs without rationing.

Other topics include:

Medical Home and Health Reform, Dr. David Swieskowski

HIT and Meaningful Use, Dr. Tim Gutshall

Care Coordination and Transitions, Dr. Don Klitgaard

Lean and Medical Homes, Dr. Tim Quinn

Medical Home Recognition, Myra Ricceri and Dr. Lewis Eirinberg

Register today for the March 30th, 2011 at the IHC website at www.ihconline.org

One Week Left of Registration for the Lean Application Series

IHC is offering a follow up program to build upon that new knowledge called the ***Application of Lean Series***. The series of three sessions is designed help you apply lean principles and techniques to real time problems you're dealing with in your institution. Participants will choose to focus on one of four problems common in health care today. [Click here for registration.](#)

Our areas of focus will be:

- Wait times in the Emergency Department
- Patient Flow
- Transitions of Care
- Medication Reconciliation

Lean Application

Series Dates:

Session 1: March 29th

Session 2: May 10th

Session 3: June 28th

Together, participants will build a strategy to address the issue at their institution using a lean tool over the 12 weeks of the program. They will select their project and develop a plan in session 1, review progress, receive coaching, and revise the plan in session 2, and report progress and share lessons learned in session 3. The series will be convened at the Foxboro Convention Center in Johnston, IA.

Contact [Ryan Meyer](#) for questions.

CDC Presenters Address HAI Reduction at March Conferences

Paul Malpiedi, Maggie Dudeck, and Dr. Carolyn Gould, all CDC staff members, were featured presenters at the IHC Patient Safety and Hospital Learning Community meetings in March in Ames.

Paul Malpiedi, an epidemiologist with CDC, addressed conference attendees at the March 9 Patient Safety event. He reviewed the National Healthcare Safety Network (NHSN) and its growing use among healthcare providers in the US. He indicated that 88 Iowa healthcare facilities, mostly hospitals, are currently enrolled to use the system.

Maggie Dudeck, also an epidemiologist with CDC, reviewed NHSN system details, definitional protocols and their use. She also presented a series of case studies focusing on the use of NHSN to capture central line-associated bloodstream infections (CLABSI). CLABSI entry into NHSN has been a recent topic of interest among many US hospitals resulting from the introduction of payment incentives from the Centers for Medicare and Medicaid Services.

Dr. Carolyn Gould, an HAI expert also with CDC, made two presentations for hospital staff participating in the Iowa Department of Public Health's HAI statewide reduction effort. Dr. Gould reviewed the CDC's catheter-associated urinary tract infection (CAUTI) toolkit on March 9 and their *Clostridium difficile* infection (CDI) toolkit on March 10. Each of the presentations were made by webinar, recorded, and will be posted later in March on the IHC website.

IHC thanks these CDC staff members for their time in Iowa providing the benefits of their insight on the use of NHSN and in reviewing strategies to reduce these important infections in Iowa hospitals.



Attendees at the Hospital Learning Community on March 10th in Ames.

March 9th, 2011 Patient Safety Conference. From left to right: Steve Berkowitz, M.D., Brian Dieter, Tom Evans, M.D., and Eric Lothe.



Patient Safety Conference and Hospital Learning Community Recap

Participants who attended this month's Patient Safety and the Hospital Learning Community conferences were treated to presentations from our local communities and national experts. Dr. Berkowitz described how we must get back to the basics of patient care to meet healthcare reform expectations. Dr. Evans reiterated how we must to use our healthcare resources wisely to meet the triple aim. That is (1) to improve health of lowans, (2) to improve the safety and care of individuals, and (3) reduce the overall cost. During the Patient Safety conference, speakers described safety challenges such as medication management, preventing patient injuries and infection. Speakers discussed how standard care guidelines and evidence-based practice principles were used to improve care. The next day's Hospital Learning Community conferences allowed participants to network while learning about patient care programs from peer organizations from across the state.

Join us for Iowa Healthcare Collaborative Annual conference on August 31st and the next Hospital Learning Community conference on September 1st for essential information which will help your hospital meet the ongoing challenges of patient safety and quality improvement.

Feature Article: National Healthcare Spending– Are we Buying Value?

Researchers from the Office of the Actuary, Centers for Medicare and Medicaid Services (CMS), and the National Health Expenditures Account Team recently released an annual update on national healthcare spending. I try to follow these reports from year to year to get a sense of how much, and where, we are collectively spending our income. It's an important issue that is tied to many aspects of national well-being. *Good news* – in 2009 the rate of increase in national health spending declined to a historically low rate (4%)¹. *Bad news* – the authors point out that despite the most recent and longest economic recession since World War II, which dampened demand for healthcare services and products, national levels of healthcare spending exceeded our ability to pay for these goods and services. In other words, spending in the healthcare sector still outpaced the growth of the overall economy.

As a nation we spent 2.3, 2.4, and 2.5 trillion dollars on healthcare from 2007-2009 respectively¹. In 2009, the amount spent on healthcare per person per year surpassed the \$8,000 level for the first time, reaching \$8,086. An oft-referenced metric of national spending levels is the percentage of our national gross domestic product (GDP = the total market value of all goods and services produced within a country in a given period of time) that is spent as a nation on healthcare. Healthcare spending as a proportion of our national GDP continues to rise – 16.2%, 16.6%, and most recently a large 1% jump to 17.6% - from 2007-2009 respectively.

Higher levels of spending may be driven by a combination of many factors – price/cost, quality, volume, supply, demand – but, what one would deem to be appropriate spending is highly context specific. After all, spending more for a pricier product or service in the short run may yield value in the long run – essentially an “investment” whose real value is realized at a later time. Moreover, purchasing more of a particular item might not be bad for us – if we can afford it and the extra volume doesn't lead to other problems related to overuse. Both contextual examples are tenable up to a point. That point being the level at which additional units of expenditure don't yield an acceptable return in marginal value. Determining that level is tricky, and highly contentious especially when the individual receiving the benefits of a particular good or service is not the party that is paying most of the bill.

Certainly, in the context of certain domains within healthcare – for example, in many areas of preventative care – there is ample evidence that certain amounts of spending on healthcare good and services is highly valuable over the long run. Consider for example that many immunizations are valuable in that the costs of vaccines and treatment processes are low, while the benefits realized by the avoidance of debilitating conditions, illnesses, and death are high. In contrast, there are numerous other healthcare “treatments”, that are currently being sold and consumed, that warrant further research in order to more accurately determine the true worth of these products and services. Complicating matters is the fact that most healthcare is not purchased by the individuals receiving care – at least in most cases not directly with out-of-pocket funds at or just after the point of service. The purchasing and payment infrastructure that has evolved in the U.S. over the last century is a complex web of individuals, employers, philanthropists, insurers, and myriad government entities. In healthcare, the purchasing and payment context is both complex and technical.

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As the authors point out in their analysis of healthcare spending, the predominant payers of healthcare services and products are federal/state/local governments¹. And, on the heels of a revenue-depleting recession these payers' ability to afford and sustain a certain level of spending is severely stressed. The authors note that just "like households, the federal government faced declining revenues in 2009." Furthermore, "health spending as a share of total revenue increased from 38% in 2008 to 54% in 2009".

Are we Buying Value? Continued...

Not surprisingly, over the past decade there has been heightened interest in increasing the value of the healthcare products and services purchased – especially by governmental entities. Given the current economic context, federal/state/local government stakeholders have increasingly had to make difficult decisions regarding how to best manage revenue streams, assess value, and appropriately reimburse providers for high-value services and products.

Most governmental policy makers understand that a one-dimensional cost-cutting approach to solving budgetary shortfalls will not suffice. Rather an approach that best balances the relationship between cost and quality, within budgetary constraints, will likely yield the best value over the long run. At the federal level some work has been completed that essentially provides a foundation for purchasing and payment policies that focus on reducing the waste associated to overuse, misuse, and underuse of goods and services. Now, details for some of the more aggressive policies are being unveiled for the first time.

This January CMS published a proposed rule for reimbursement of hospital-based services based on assessments of hospitals' overall quality of care. This is a significant redirection of federal reimbursement policies that have been in place since the early-1980's. The proposed "value-based purchasing" (VBP) policy places the federal government increasingly in the role of a discerning payer, one that pays for quality and ultimate value, instead of paying full dollar for the amount of services provided without regard to the quality of services rendered. A special point should be noted here that safety is a subset of quality. Therefore, new reimbursement policies are planned to also target the delivery of consistently safe care, or care that is "defect-free", that does not further harm the patient and incur additional cost.

This (VBP) rule contains features that are initially aimed at establishing a clearer business case for the achievement and maintenance of higher levels of quality/safety performance. *Good news* – the proposed policy is designed to be budget neutral from the outset – paying more to those hospitals that make great leaps in quality/safety improvement over time or those that have attained "high" absolute levels of quality/safety performance; and conversely paying less for services rendered at low performing hospitals. Although the policy is budget neutral and may not substantially affect costs or spending levels in the short term, it is designed to continually improve the quality and safety of healthcare goods and services which hopefully would help reduce expenditures associated to misuse, underuse, and/or overuse over the long term.

Although many of the rule details will be worked out and finalized this coming year the essence of this rule has been anticipated by healthcare stakeholders for several years. The overarching Affordable Care Act (ACA) legislation requires that the performance measures used in the VBP program be derived from those measures that have been posted on the public CMS Hospital Compare internet website for at least 1 year. Thus, the current VBP proposal initially includes 17 process measures that are currently reported on Hospital Compare and span the heart attack (AMI), heart failure (HF), infection prevention (SCIP), and patient experience (HCAHPS patient experience survey) domains. Later, the program proposes to include outcome and hospital-acquired condition (HAC) metrics. [NEXT PAGE.](#)

Currently, the rule also proposes to assess hospital performance using two types of scores. An “achievement” score would be calculated to examine how well the hospital performs relative to a benchmarked threshold performance level for all U.S. hospitals’ performance. And, an “improvement” score would be used to assess how much the hospital has improved over time relative to its own performance from a baseline period. Although only the best of these two scores would be used in a final determination of a hospital’s reimbursement incentive, the inclusion of the improvement score may allow relatively “low” performing hospitals to earn an incentive. As proposed, the total incentive amounts to be redistributed between low and high performing hospitals starts at 1% for fiscal year 2013 and increases monotonically to 2% in 2017.

Healthcare value isn’t derived from just hospital services. The ACA legislation includes the development of plans for VBP programs in the home health, skilled nursing facilities, and ambulatory surgery center settings; and includes a value-based payment modifier for physicians. As information regarding value is released to the public from these VBP programs it is likely that many consumers will use this information to guide purchasing decisions and payment policies. Certainly employers, insurers, and governmental entities will use this information. However, we must not forget that there is only so much our employers, insurers, and the government can do for us in attempting to optimize both physical and economic health – at both the individual and national levels. To a high degree we are all individually responsible for engaging in those behaviors that promote good physical and economic health.

In a complex and technical environment the increased availability of better information will assist us in making better health-related decisions. It will be important for all of us to use the growing amount of publicly-available information on the cost, quality, and value of healthcare services to identify, select, and pay for high-value goods and services. In the current economic environment our budgets need all the help they can get.

Here in Iowa the Iowa Healthcare Collaborative continues to monitor and act on important federal policies in ways that are supportive of our vision – an Iowa healthcare culture of continuous improvement in quality, safety, and value that provides the most efficient and effective care in the nation.

Martin A, Lassman D, Whittle L, Catlin A; National Health Expenditure Accounts Team. Recession Contributes to Slowest Annual Rate of Increase in Health Spending in Five Decades. Health Affairs (Millwood). 2011 Jan;30(1):11-22.

Upcoming Meetings:

May 4th—Data Committee & Patient Safety Committee (10 a.m.);
Provider Advisory Council (1:00 p.m.) @ Iowa Medical Society, Des Moines

May 19th— IHC Board of Directors (10:00 a.m.)
@ Iowa Medical Society in Des Moines