

A Radar Report for Hospitals

by Jan Jennings

Hospitals appear to be generally unprepared for healthcare reform. On one level this is understandable. The political winds have changed direction since the November elections and there is considerable chatter about changing H.R.3590 - The Patient Protection and Affordable Care Act to outright repeal. The political rhetoric in Washington is red hot and the differences of opinion are expressed in the most strident terms. Before the tragic shooting spree in Tucson, the House of Representatives was poised to pass a symbolic vote to repeal the healthcare reform bill. That vote will take place this week. Somewhat understandable is the notion that “why change anything until everything has been finalized and the dust settles?” Easily missed, if the Republican Party controlled the White House, the U.S. Senate and the U.S. House of Representatives, there may be less zeal to provide as many millions of additional Americans with health insurance, but healthcare reform will still be a major public policy matter.

What receives little attention is a quiet consensus between the two political parties; the conviction that Medicare and Medicaid costs must be reduced over a ten-year period and the quality of medical and hospital care must be improved. During the early months of debate there was a lot of discussion that a \$500 billion reduction in Medicare and Medicaid costs would come from Medicare and Medicaid fraud and abuse. Most observers doubt there are 500 billion dollars in Medicare and Medicaid fraud and abuse.

Most industry observers see the \$500 billion reduction coming from very different sources (detailed below). There are two reasons that hospital and hospital health system leadership need to be actively engaged in immediate change in order to survive healthcare reform. As a minimum:

- While the current healthcare reform bill will undergo an incalculable number of changes, there will be millions of Americans who will receive health insurance placing demands on hospitals and physicians at a new and higher level than at any time in history. In addition, the income per newly insured patient is likely to be less than previous payments for Medicare and Medicaid payments while Medicare and Medicaid payments are likely to be reduced by over \$500 billion. This is a clarion call to improve operating efficiencies on a level far different than any “cost cutting” activities of the past. An obvious hesitancy exists to make these fundamental changes.

I recently spoke to an executive who installed a system at the Mayo Clinic that automates communication in a manner that remarkably improves efficiencies, physician and nurse satisfaction, patient satisfaction and patient care outcomes. He has not been able to reach one other healthcare executive willing to seriously consider looking at this system. The universal reason offered is this, “If the government does not require the change, I will wait until it is required.”

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Of tremendous concern is a growing sense that hospital and healthcare system boards of directors and executive leadership are deferring to the Federal Government as the *de facto* source for local hospital and health system policy formation with reference to major internal policy change and capital allocations. Here is a clear and present example; some hospital and health systems deployed electronic health records before the term of art, “meaningful use” was forged. Most of the hospital industry is reacting to federal mandates and funding in order to conform to the Federal meaningful use standards. While the leadership of the healthcare industry and the American people are overwhelmingly opposed to “socialized medicine”; whatever that means to you, we seem to increasingly defer our leadership to State and Federal mandates for major internal policy formation.

- Payments to hospitals are proposed to be modified based on quality scoring - this will be detailed below. Monitoring HHS’s Hospital Compare website for patient satisfaction, a surrogate for quality, American hospitals generally score at decidedly average levels of performance. As an industry, it appears that the healthcare industry spends far less money, as a percentage of total operating expenses, to improve quality and now there are well-documented reports (see below) that suggest that we do not provide anything better than good care. Can you imagine a U.S. airline that provided good service with respect to the criteria of successful takeoffs and landings? The budget is for zero defects. There are approximately 45,000 U.S. commercial airline takeoffs and landings on a daily basis and in most years there are zero crashes. This is in sharp contrast to U.S. hospital performance with respect to the quality of patient care.

In summary, there will be more patients with less income per patient and a clear expectation from the United States Congress and the Administration that quality of care paid for from public sources will be remarkably improved.

Independent of healthcare reform, the economy has placed enormous pressure on state budgets leading to unanticipated Medicaid reimbursement cuts. Before moving to quality, here is a summary of Medicare reimbursement cuts from a study paid for by the Kaiser Family Foundation. I would guess that these numbers are subject to remarkable increases and decreases as the political debate unfolds, but it is an accurate reporting of proposed cuts at the present time, proposed Medicare payments cuts of \$533.1 billion:

- Provider payments, including disproportionate share hospital (DSH) payments and home health payments, represent proposed Medicare payment cuts of \$219 billion.
- Medicare Advantage programs are proposed to be cut by \$136 billion.
- Income-related premiums are proposed to yield \$36 billion.
- New Independent Payment Advisory Panel is expected to cut \$16 billion.

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- Delivery system reforms, including hospital readmissions are expected to yield \$12 billion in Medicare payment cuts.

To illustrate why these issues need to be addressed immediately, I will focus on the smallest cut proposed – delivery system reforms.

This is very complex and will take a generation of change in the culture of medical and nursing care. In the 2,400 page Patient Protection and Affordable Act you find the following on page 1,719; the new legislation creates a non-profit, Patient-Centered Outcomes Research Institute within six months, to begin studying patient care outcome variation. Stated alternatively, it is becoming increasingly more clear that we do not need dozens of approaches, procedures and devices to solve the same medical or surgical problem. President Obama's former Budget Director was Peter Orszag, a powerhouse economist; trained at Princeton and the London School of Economics. He asserts, although rarely reported, that the legislation also tests new payment systems for doctors, penalizes hospitals for high readmission rates, and creates an independent commission to evaluate which treatments best serve Medicare and Medicaid recipients. Hospitals, physicians and all care givers are going to be scrutinized under the microscope to determine if what they do makes a positive impact on patients served.

Now becoming ancient history, in 1999 the Institute of Medicine reported that up to 98,000 people die every year as a consequence of medical errors in hospitals. That would be twice the number of people who lose their lives annually due to automobile accidents. Deeply depressing, a new study came out of North Carolina last year that clearly demonstrates that we have made no progress since 1999.

Prior to becoming the Administration's Budget Director, Professor Orszag was a scholar at the Brookings Institute in Washington. Orszag was perplexed that so much attention was being paid to the rising cost of Social Security, even though healthcare represented a far larger share of the nation's economy. Orszag eventually discovered the Dartmouth Atlas of Health Care, a national study on the variations in how medical resources are distributed in the U.S.

Professor Orszag's research suggested that \$700 billion in annual savings could be achieved by eliminating wide disparities in the cost of similar procedures, especially those in which pricier options don't produce better outcomes. "Huge efficiencies could be gained if we change the way we practice medicine," Orszag said in a May 2009 interview, as he lobbied for the creation of a government institute to gather the evidence. That much desired "institute" is now a reality and the healthcare industry will be financially punished for mistakes, readmissions within 30 days, potentially hospital-acquired infection and on and on.

Our concern is the hospital industry, in general, is not prepared for these changes in reimbursement. I attend many state hospital annual meetings and at a recent meeting, the keynote speaker presented these concerns in much more detail and made a clarion call for change. There was not a single question and the audience sat in stone silence. On the other

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hand, there are hospital executives and physician quality champions making a huge difference in the way care is delivered. From the Flexner report, 100 years ago, a reform in medical education unfolded. Between 1910 and 1935, one half of all U.S. medical schools closed. Reform in the healthcare industry is not new. On the contrary, we are always changing healthcare teaching, research and practice. A characteristic of our history is that change creates winners and losers. It is human nature to resist change. Those who overcome this human weakness are destined to win.

If your hospital leadership (Board, Administration and Medical Staff) cannot answer the following questions, your hospital needs help:

- How many patients endured hospital acquired infections by month over the last twelve months? Are we getting better or worse?
- How many blood stream infections have occurred secondary to intravenous lines? Are we improving or not?
- How many patients were readmitted to the hospital within 30 days of discharge? Are we doing better or worse?
- How many patients were returned to surgery in response to a post-operative complication? Are we improving or not?
- Do we simply report the error/complication statistics or do we have a comprehensive plan to resolve these quality problems? Why? How that last question is answered has a huge impact on the success or failure of your hospital.

Two-thirds of American hospitals are losing money at the operating line or just barely breaking even. What would a five or ten percent cut in Federal payments in Medicare and Medicaid do to these hospitals as healthcare reform matures and the economy continues to sputter?

Of equal concern is the possibility of reimbursement cuts to hospitals associated with quality scoring. At the moment, this is hypothetical, but if the Center for Medicare and Medicaid Services cut the reimbursement to your hospital by several million dollars and issued a corresponding press release to your local newspaper inferentially casting doubt on the quality of care of your hospital, you find yourself in a public relations crisis. The Center for Medicare and Medicaid Services, according to *Modern Healthcare*, has proposed regulations that would establish in fiscal year 2013, a new hospital value-based purchasing program for Medicare that would reward hospitals for providing high-quality, safe care for patients.

There is help available. If you need help, you should get it. It is important that you get to this as soon as possible for the following reason: There is a tremendous shortage of advisory services that truly understand how to re-engineer patient care throughput, assure quality outcomes, improve patient satisfaction and assure employee safety. At the moment, as is normally the case at the beginning of a new way of doing things, there are numerous dilettantes holding themselves out as “the answer.”

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You certainly do not have to call us. But, you should call someone for help. These forces of change are immutable and coming faster than most industry leaders believe. Once again there will be winners and losers. Find yourself in the winner's circle; do not stick your head in the sand.

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