The Evolving Business of Healthcare: Key Issues in Healthcare Reform for Infection Prevention Professionals

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Introduction – Key Components of Healthcare Reform

Due to healthcare reform and the debt crisis of the US government, our healthcare system has recently seen and will continue to see significant changes. Healthcare costs are increasing, the payment model is changing, and new provider structures are developing. Additionally, coverage is expanding due to mandates. Healthcare reform was designed to achieve the “triple aim” of reduction of total population cost, improvements in quality, and improvements in patient experience. These “volume-to-value” changes are influencing the way hospital systems operate, as they must adapt and find ways to develop the infrastructure to support such change. Progress-based incentives, new models of care, system and physician consolidation, and improved operational performance are necessary and inevitable in the future of US healthcare.

US healthcare and hospital expenditures have nearly doubled in the last decade. Spending on healthcare is currently 17.9% of our gross domestic product (GDP), and this is expected to grow to 19.6% by 2021. The national unfunded liability for Medicare is $85 trillion, which equals approximately $750,000 per US tax payer. According to Urban Institute, the average couple receiving Medicare pays $109,000 into the program and receives $343,000 in benefits from it. These increases in healthcare spending are not limited to Medicare; commercial insurance premiums are projected to reach 40% of the median household income for a family of four by the year 2015 (1).

Recent acts such as the American Recovery and Reinvestment Act (ARRA) of 2009 and the Patient Protection and Affordable Care Act (PPACA) of 2010 are driving these changes. A greater percentage of Americans will have healthcare coverage, coverage will be regulated, and the majority of industry growth is expected to be from Medicare patients. However, it is estimated that Medicare payments will be reduced by $146 billion over the next six years, which will likely have a significant impact on healthcare systems (1).

Another important component of reform is the Health Information Technology for Economic and Clinical Health (HITECH) Act, which is part of the ARRA. It was designed to promote the adoption and meaningful use of health information technology (2). Electronic Health Record (EHR) use is required to manage population health. Currently, incentives for implementation are available if meaningful use is demonstrated, but penalties will begin in 2015 for violations of this act. Implementation is occurring in both physician offices and hospitals and is consuming a considerable part of budgets nationwide (3).

Adapting To the New Payment Model

While costs continue to increase, payment and delivery systems are also changing. The Hospital Value-Based Purchasing Program (VBP) was designed by the Centers for Medicare and Medicaid Services (CMS) to reward acute-care hospitals with incentive payments for the quality of care they provide to people with Medicare. It aims to improve quality, patient satisfaction, and reduce readmissions and hospital-acquired conditions (4). The program adjusts payment to hospitals based on their Total Performance Score (TPS), which is comprised of Clinical Process of Care domain score and the Patient Experience of Care domain score. These scores are then weighted, 70% and 30%, respectively (5). It should be noted that these scores will be made public. Comprising the TPS are nine measures of Patient Experience and twelve Clinical Process of Care measures (6), which are listed below. This number is expected to increase in the future.
Clinical Process of Care measures:
- Acute myocardial infarction (AMI) (2 measures)
- Heart failure (1 measure) and Pneumonia (2 measures)
- Healthcare-associated infections (4 measures)
- Surgery (3 measures)

In fiscal year 2014, three mortality outcomes measures will be included and scored similarly to the Clinical Process of Care measures: acute myocardial infarction, heart failure, and pneumonia (5). Additionally, the rate of hospital-acquired conditions are penalized (1% penalty top quartile), as are readmissions. There is a 30 day readmission rate for pneumonia, acute myocardial infarction, and heart failure, which are subject to an up to 1% penalty in 2013 and increasing to an up to 3% penalty by 2015 (7). For an average 300 bed hospital, $6-7 million could be at risk for performance across these measures.

The VBP program became effective for Medicare inpatient prospective payment system (IPPS) discharges on Oct. 1, 2012 and will be funded in fiscal year 2013 by reducing the base operating diagnosis-related group (DRG) payment for each IPPS discharge by 1 percent (6). According to CMS, the VBP program will be funded by a 1.5% reduction from participating hospitals’ DRG payments in 2015 (8).

From Volume to Value – The Impact on Integrated Healthcare Delivery Systems

The aforementioned changes result in a transition from volume-driven, fragmented care to value-driven continuum of care and from a fee-for-service payment model to a global payment model. To quote Richard Umbdenstock, President and CEO of the American Hospital Association (AHA), “The fee for service reimbursement model as we know it today is dying quickly; we just don’t know the date of the funeral yet” (1).

One industry response in an attempt to deal with these changes is the development of Accountable Care Organizations (ACOs). An ACO is a group of doctors, hospitals, and other health care providers, who come together voluntarily to give coordinated high-quality care; these parties work together to achieve the “triple aim.” Goals of ACOs include coordinating care for the patients they serve; delivering seamless, high-quality care; creating patient-centered organizations where the patient and providers are true partners in care decisions; and aligning financial incentives. Current estimates place the number of ACOs in the US at more than 450, and commercial payers are quickly moving in this direction (9). ACOs commonly utilize measured outcomes to improve the individual experience of care, improve population health, and reduce the overall cost of healthcare. Utilization of process-level care management to oversee the provision of clinical care, coordination of provision of care across the continuum of health services, and investment in and utilization of appropriate IT to manage population health are common goals. Lastly, ACOs aim to align financial incentives to encourage the production of high-quality outcomes and bear financial risk for the measured health of a population (10).

Already established Integrated Delivery Networks (IDNs) in the healthcare system will also be impacted in a positive way. According to a Mark Dixon, consultant and former healthcare executive, these will see improved operational performance, reduced costs, and improved operating margins. He estimates that IDNs can make money on Medicare by cutting costs by 15 – 20%. Dixon also predicts that ACOs and healthcare reform will affect decision-making at IDNs, with less local decision-making and more system level decision-making. There is also potential for more physician consolidation and development of clinically integrated physician networks (11).

As the “volume to value” shift occurs, IDNs are spending a considerable amount for Electronic Health Records (EHRs), physician network creation and practice acquisitions, and infrastructure to support the shift. It is estimated that the cost of implementing such a shift can often exceed $30 million (1). In addition to the cost, this transition requires improvements in clinical outcomes and patient experience to be delivered at a lower cost. This has led to new innovations such as patient-centered medical home (a new way of designing primary care practices), clinically integrated networks of physicians, partnerships between organizations and specialists, care bundles and pathways, and capabilities to provide care coordination across the provider network (11).

At the same time, the downward pressure on operating margins will create a challenge for IDNs. Medicare is the fastest growing segment of the healthcare market, and the average margin on Medicare is negative 6% (12). Historically, commercial payments would offset the Medicare losses, but commercial payments are approaching Medicare rates (13). State implemented provider taxes (which are designed to help pay for healthcare reform) are reflected as surcharges to the hospitals. IDNs are forced to focus on opportunities to reduce cost and improve operating margin to ultimately make money.
on Medicare. Many are considering ways to standardize care because it allows for leveraging of volume and commitment, reduces cost, and improves the patient experience. Systems are utilizing physician input and supporting evidence in their purchasing decisions and approaches to cost reduction. The role of group purchasing organizations (GPOs) is also expanding, as they have a wealth of data that can support the value analysis process.

The focus on patient experience will also aim to increase consumer engagement. This may involve virtual care, patient activation, and shared decision making. Accountable care has also created the incentive for healthcare systems to work more effectively across the continuum of care and provide effective care transitions, particularly in long-term care and post-acute care settings. Various care transitions initiatives have been developed and implemented in large systems with success. For example, some organizations provide non-optional home visits to patients after hospital discharge to assess clinical and social circumstances that drive readmission rates, while others place resources and additional staff at long-term facilities for support, monitoring, and family education.

**Understanding the Role of Infection Prevention**

In keeping with the goals of better outcomes, better patient experience, and reduced cost, infection prevention is one way healthcare systems can have a positive impact. Healthcare-associated infections (HAIs) are associated with prolonged length of stay and increased patient costs. Therefore, reducing HAIs can reduce cost, decrease legal liability and improve public image, as the public demand for safety accountability has increased. Going forward, Total Performance Scores in the VBP system will be made public (5).

The VBP program was designed to reward acute-care hospitals for quality care, and one of the goals is to reduce the incidence of HAIs. Therefore, implementation of strategies to reduce HAIs is a critical component to a healthcare system’s delivery of care. If an infection prevention and control program is not already in place, implementation of such a program is likely to help a healthcare system achieve the “triple aim.” Implementation involves identifying areas of needed improvement and focusing on ways to incorporate change that will improve outcomes. Because physicians still hold considerable decision making power in the healthcare system, it may be beneficial for a physician to champion the implementation of such a program. As an Infection Prevention champion, it is important to quantify what is best practice (including cost, quality, and experience) for the healthcare system and, in addition to effects on patient outcomes and experience, it is important to show how an infection prevention and control program affects the budget. Administrators will be interested in cost versus savings for the healthcare system. Measureable value of the program should be easily demonstrated.

Coordination and involvement with the system’s coding and billing department may also be essential due to collection of information for scoring in the VBP. Currently, there is controversy regarding how information on HAIs is collected. The Association for Professionals in Infection Control and Epidemiology (APIC) maintains that administrative data should not be used exclusively to identify HAIs because it is “not a precise measure.” Research shows that there is a wide disparity in the number of HAIs identified when using administrative codes compared with validated infection surveillance systems. EHR in combination with electronic surveillance technology may change the approach in the future, but the challenge of identifying accurate data retrieval methodologies remains (14).

In summary, there are a multitude of factors contributing to the transformation of delivery of care in the US, including healthcare reform that increases coverage and requires EHR implementation, changes in payment models, development of ACOs, and rewards for quality and outcomes, or progress-based incentives. Healthcare systems have already seen quite a bit of change, and this is expected to continue. It is assumed that relentless focus in all areas of the IDN to reduce cost will become the new normal. Improvements across the board are expected; IDNs will have an efficient cost model with significant reduction in variation, elimination of readmissions and unnecessary surgeries and care. Systems will be able to manage risk and integrate clinical and financial data across populations of patients. Physicians and employees will be engaged. The creation of value will position IDNs to be successful under multiple payment models and each healthcare system should strive to achieve the “triple aim” in order to remain competitive in today’s market.
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