

In Pursuit of Excellence: The Hospital Commitment



This action plan outlines the Maine Hospital Association Board of Directors' vision of what hospitals could and should do to lead health care reform. The Board made a conscious decision to develop an initiative that was hospital focused. In other words, instead of developing the traditional health care reform proposal regarding universal coverage, payment system changes and other global reforms that others should undertake, we focused our efforts on what hospitals should do to reform the health care delivery system. It is a clear statement of the hospital commitment to a concrete substantive action plan around defined measurable goals that will, when achieved, make genuine progress toward better health and consistently providing evidence-based affordable care.

Our targets are designed to be reached over five years and organized around the pillars of wellness, quality, access, and cost. The specific priorities and the associated measures are in alignment with each other, as well as with ongoing work across the state and across the nation by other stakeholders to leverage efforts.

While hospitals alone cannot solve all of the problems in health care, we will demonstrate leadership and accountability by publicly taking responsibility for our pursuit of excellence in health and health care.

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MAINE HOSPITAL ASSOCIATION

Wellness: Attaining and maintaining health by reducing impact of chronic disease

According to the Maine Centers for Disease Prevention and Control (CDC), Maine has the fourth highest mortality rate of chronic disease in the country. Seventy percent of Maine people die from four diseases that are often preventable: cardiovascular disease (heart disease and stroke), cancer, chronic lung disease and diabetes.

In addition to contributing to human suffering, chronic disease is expensive. These often preventable diseases account for \$2.5 billion in health care costs each year in Maine.¹ In fact, nearly 37% or \$1.2 billion of Maine's *increase* in health spending from 1998 to 2005 was attributable to the four leading chronic illnesses.²

Complications of chronic disease account for a large portion of hospital admissions and emergency room use. Many of the episodes causing these services are felt to be avoidable; that is, they could have been prevented with more adequate primary care.³

There is a clear link between chronic disease and obesity. Adults with diabetes are one-and-a-half times more likely to be obese and more than three times as likely to be extremely obese. Adults with diabetes were one-and-a-half times more likely than those without diabetes to have asthma, nearly three times more likely to have hypertension, more than three times more likely to have heart disease, and more than four times more likely to have a stroke.⁴ In addition, obesity raises an individual's health care costs by 36% and medication costs by 77% as compared to the general population.⁵ And, according to the Maine CDC, Maine's obesity rates have risen over 100% in just 17 years.

Goals:

- Reduce admissions for the Agency for Healthcare Research and Quality's (AHRQ) ambulatory care sensitive conditions by 10% over five years.
 - In 2003, Maine ranked 23rd in Medicare hospital admissions for ambulatory care sensitive conditions.⁶ According to that report, if Maine performed as well as the top ranked state, there would be \$21,626,000 in savings through reduced hospitalizations.
- Exceed the 2010 Maine CDC goals of reaching and maintaining healthy weights by 2014:
 - Decrease proportion of the adult population who are overweight from 37% to 30%;
 - Decrease proportion of the adult population who are obese from 17% to 15%; and
 - Decrease proportion of high school youth who are overweight from 10.4% to 5%.

¹ Dora Mills, MD, Maine CDC. "Prevention Emerges as a Tool to Control Health Care Costs." The Community Leader, 2004.

² Maine State Health Plan 2008-2009, page 21.

³ Maine State Health Plan 2008-2009, page 39.

⁴ Agency for Healthcare Research and Quality's Medical Expenditure Panel Survey, 2004.

⁵ Maine CDC. "Obesity in Maine." May 2007.

⁶ Commonwealth Fund. "Aiming Higher: Results from a State Scorecard on Health System Performance." June 2007.



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Quality: Hospitals provide the right care at the right time in the right place, every time

Maine hospitals have long been committed to quality improvement and public reporting of quality data. In fact, MHA’s hospital-specific report card preceded both Centers for Medicare and Medicaid Services (CMS) and the Maine Quality Forum’s reporting initiatives. In 2002, MHA developed principles to guide the publication of actionable hospital-specific quality measures. The data must be:

- Valid, relevant, reliable and simple;
- Well defined, consistently measured and verifiable;
- Easily understood by the public;
- Accurate;
- Uniform;
- Risk or population adjusted when appropriate;
- Reflect statistically significant differences in performance;
- Comparable;
- Current to the extent possible;
- Protective of patient privacy and confidentiality;
- Accepted by practitioners as measures of quality; and
- Cost-effective.

The abstracted clinical data hospitals submit to CMS meets these criteria.

Goal:

- Improve statewide performance in the CMS heart failure “appropriateness of care” composite measure from 78% to 100% by 2014.
- Improve statewide performance in the CMS heart attack “appropriateness of care” composite measure from 96% to 100% by 2014.
- Improve statewide performance in the CMS pneumonia “appropriateness of care” composite measure from 71% to 100% by 2014.
- Improve statewide performance in the CMS Surgical Care Improvement Project “appropriateness of care” composite measure from 86% to 100% by 2014.



According to the federal Centers for Disease Control and Prevention, infections that patients acquire while receiving treatment for other conditions are estimated to be one of the top 10 causes of death in the nation.⁷ To prevent and improve the management of health care-associated infections, Maine

⁷ U.S. Government Accountability Office. GAO-08-673T. “Health Care Associated Infections in Hospitals.” April 16, 2008.



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hospitals, in collaboration with the Maine Hospital Association, Maine Quality Forum, Northeast Health Care Quality Foundation, and the Maine CDC, formed the statewide Maine Infection Prevention Collaborative. The Collaborative members collectively determine the priority work and how to most efficiently use limited resources.

Goal: Beginning in 2009, 100% of Maine hospitals will be active members of the statewide Maine Infection Prevention Collaborative, fully supporting and participating in its work.



Central line associated bloodstream infections are health care-associated infections that are costly and potentially lethal. An evidence-based initiative (“bundle” compliance) in 103 Michigan hospitals decreased the mean rate per 1000 catheter-days from 7.7 to 1.4 at 18 months.⁸

MHA’s Board of Directors endorsed the Institute for Health Care Improvement’s 100,000 Lives Campaign when it began in January 2005, as well as the 5 Million Lives Campaign in June 2007. Both campaigns include reducing central line associated blood stream infection rates as targeted interventions.

Goal: Over five years, Maine hospitals will improve statewide performance for compliance with the central line bundle to 100% and decrease the statewide overall mean rate of central line associated blood stream infections from 2.31 per 1,000 central line catheter days to 1.4 or fewer.



The CMS/AHRQ HCAHPS (Hospital Consumer Assessment of Healthcare Providers and Systems) survey was designed to produce nationally comparable data on patients' perspectives of care. Information about other patients’ experience is widely requested and understandable by patients.

The HCAHPS survey is composed of 27 questions that CMS has rolled up into 10 composite measures for public reporting:

- Six summary measures: how well nurses and doctors in the hospitals communicate with patients, how responsive the hospital staff are to patient needs, how well the hospital staff help the patient manage pain, how well the staff communicate with the patient about medicines, and whether pertinent information was provided when the patient was discharged.
- Two individual items address the cleanliness and quietness of the patient’s room.
- Two global ratings are the overall rating of the hospital and whether the patient would recommend the hospital to others.

Goal: Hospitals will score at least the national 90th percentile on all HCAHPS composite measures within 5 years.

⁸ Pronovost P, Needham D, Berenholtz S, et al. “An intervention to decrease catheter-related bloodstream infections in the ICU.” *N Engl J Med.* 2006;355(26):2725–2732.



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Access: Improve appropriate access to evidence-based care in the right setting

Lack of access to primary care physicians fuels increased health care costs as patients delay care or seek service in emergency departments (EDs). According to a recent state analysis, Maine's ED use in 2006 was about 30% higher than the national average. The age groups where Maine's experience was most disproportionate to the national average was among those ages 5 to 25. Use of emergency department care for outpatient care by MaineCare members is more than three times as high as rates of use by privately insured residents. The uninsured are responsible for 9% of emergency department visits, concentrated among young adults. A review of diagnoses frequently seen in EDs suggests that a substantial number of visits are made for conditions that could be more appropriately treated in doctors' offices.

One out of every five physicians is at or nearing typical retirement age. Physician recruitment for rural areas is challenged by lower earning potential, longer hours, and isolation from medical colleagues, coupled with heavy debt loads from over ten years of training, including college, medical school, internship and residency. In November 2008, the Maine Recruitment Center, the Maine Hospital Association's physician recruitment service, had 60 openings for family practice physicians, 36 internal medicine openings, 14 pediatrician vacancies and 10 OB/GYN openings.

In addition to physical health, Mainers lack access to mental health services. Interest in the management of major depression by primary care practitioners has increased since the release of guidelines for the treatment of depression by the Agency for Health Care Policy and Research. With fewer mental health specialists to whom they can refer patients, rural practitioners may treat more cases of depression on their own than their urban counterparts. Primary care practitioners provide a substantial portion of mental health care in rural America.⁹

Addressing these issues not only will improve the quality of care patients receive but also reduce inappropriate utilization, thereby reducing cost growth.

Goals:

- Reduce the vacancy rate for primary care physicians in Maine by 50% over five years.
- Increase prevalence of depression management programs in hospital-owned physician practices by 10% over five years.
- Hospitals, in partnership with the state and other stakeholders, will work together to bring Emergency Department use rates in line with the national average within five years.

⁹ David Hartley, PhD; Neil Korsen, MD; Donna Bird, MS, MA; Marc Agger, MPH. "Management of Patients With Depression by Rural Primary Care Practitioners ." Arch Fam Med. 1998;7:139-145.



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Cost: Maine hospitals provide efficient and affordable care

Perhaps the biggest challenge to the health care system is cost. Hospital and total health care costs have historically been higher in New England than in the rest of the country. Each year the American Hospital Association calculates a cost per adjusted discharge, CPAD, to accurately compare hospital costs between states and to adjust for patient acuity. The Dirigo Health Agency also uses a very similar measurement when calculating aggregate measurable cost savings associated with Dirigo. Using this well accepted measure, Maine's hospital costs are below the New England average and consistent with the United States average. This trend has been in place and consistent for many years.

Nonetheless, in 2003 as part of the Dirigo Health Reform package, Maine hospitals agreed to voluntarily limit cost increases and consolidated operating margins. These voluntary efforts have proven quite successful and the Superintendent of Insurance has certified that these hospital savings initiatives have saved a total of at least \$114 million in health care costs in the first four Dirigo years. Maine hospitals support the continuation of this successful effort into the future.

Goals:

- Hospitals will limit aggregate cost increases to a level of the Medicare market basket increase plus 10%, consistent with the Dirigo Health law.
- Hospitals will limit annual consolidated operating margins to 3%. This will be measured by a rolling average over the most recent four years.



According to the state's Advisory Council on Health System Development's Cost Driver Report of April 2009, two-thirds of health care spending is driven by how much we use, while one-third is driven by the price of each service. Given that Maine's per unit hospital costs are not out of line with where we would expect them to be, hospitals will work on driving down unnecessary hospital utilization, especially for services that are potentially avoidable and for which clinicians can choose less costly interventions. Maine hospitals will be working in partnership with state government and other stakeholders to reduce avoidable hospitalizations for ambulatory sensitive care conditions and decrease inappropriate Emergency Department use.

Goals:

- Hospitals will reduce avoidable hospitalizations for ambulatory sensitive care conditions by 10% within five years.
- Hospitals, in partnership with the state and other stakeholders, will work together to bring Emergency Department use rates in line with the national average within five years.

