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The Affordable Care Act, Healthcare Reform and Economic Risk

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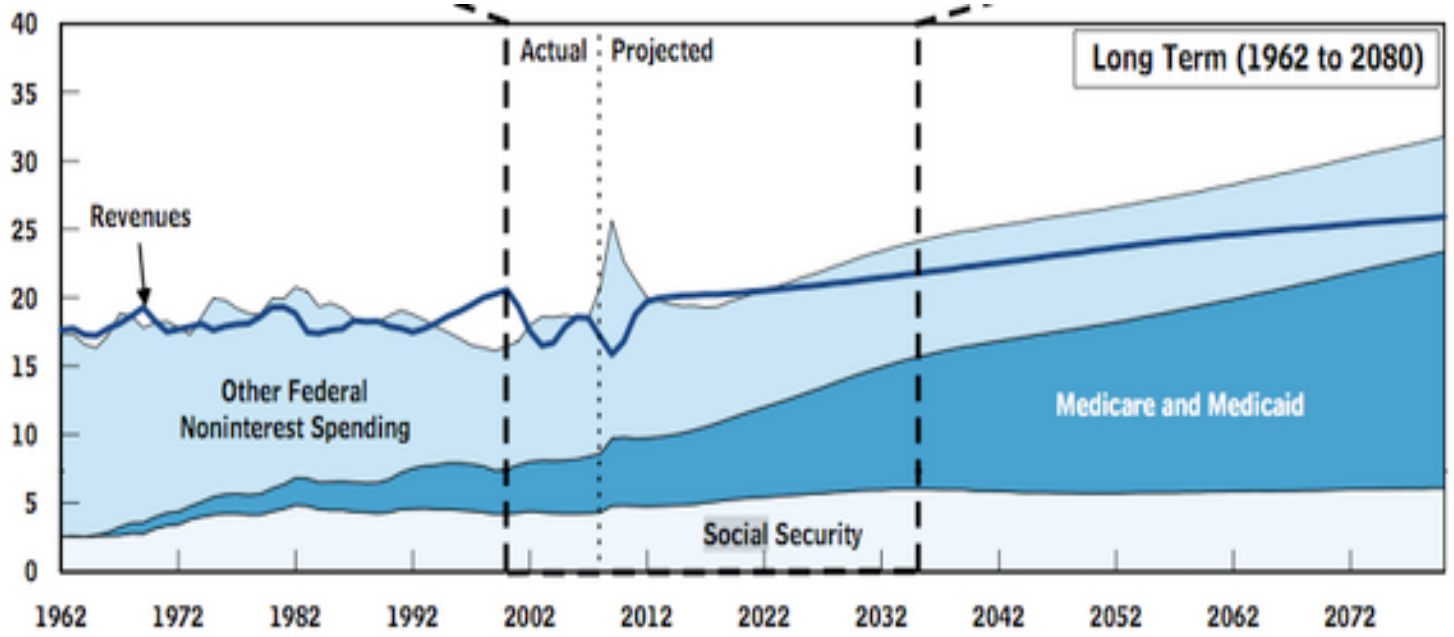
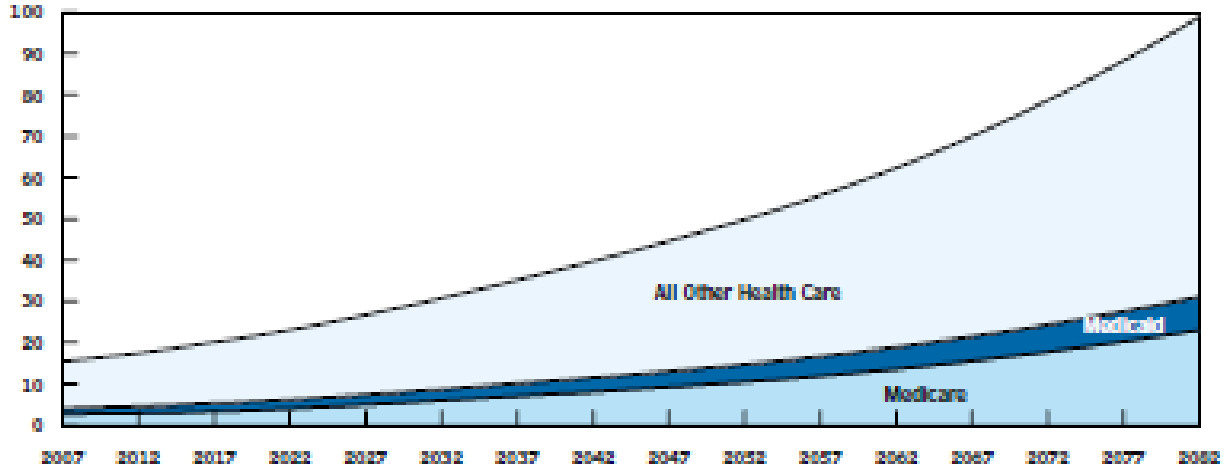
THE LONG-TERM MEDICARE/MEDICAID CRISIS



The Long Term Outlook For Healthcare Spending

Projected Spending on Health Care Under an Assumption That Excess Cost Growth Continues at Historical Averages

(Percentage of gross domestic product)



Source: Congressional Budget Office.

Notes: Excess cost growth refers to the number of percentage points by which the growth of spending on Medicare, Medicaid, or health care generally (per beneficiary or per capita) is assumed to exceed the growth of nominal gross domestic product (per capita).

Amounts for Medicare are net of beneficiaries' premiums. Amounts for Medicaid are federal spending only.

Utilization vs Outcomes

Utilization Based Payment

- **Disease Care**
- **Promotes > Utilization**
- **Utilization > Costs**
- **Procedure Based**

Outcome Based Payment

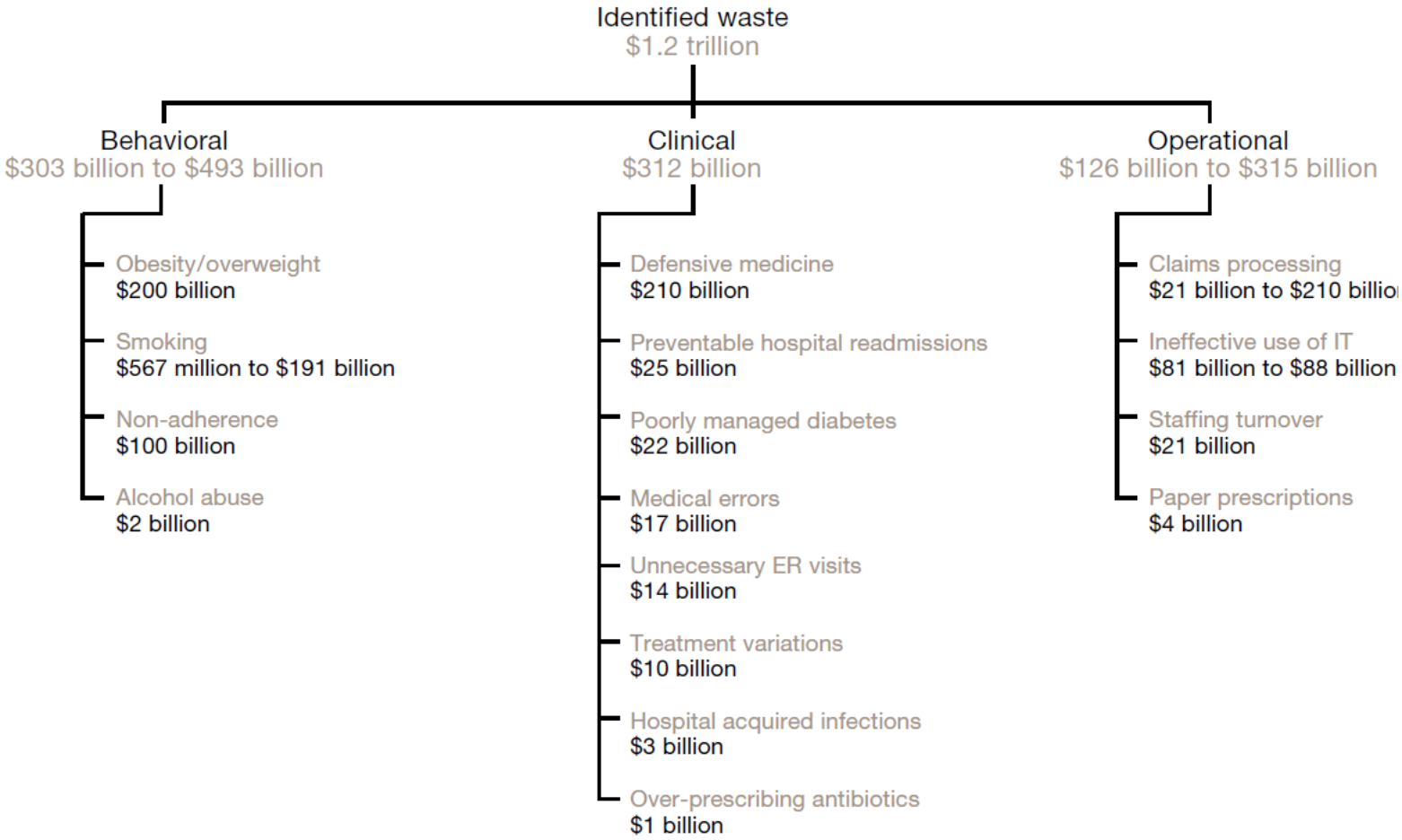
- **Health Care**
- **Promotes > Wellness**
- **Wellness < Costs**
- **Episode Based**

The Unintended Consequences of Utilization Based Reimbursement

Prominent experts have estimated that 30% of US healthcare spending represents waste or pays for poor-quality care that doesn’t benefit patients.

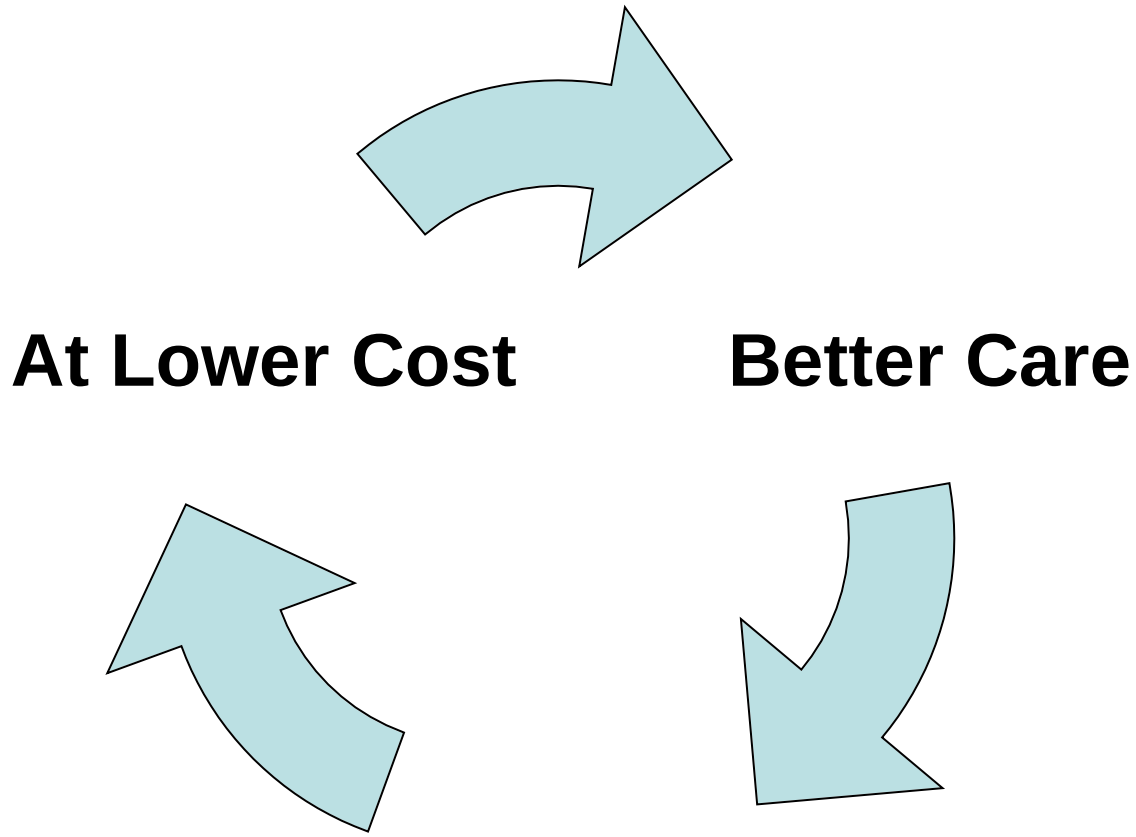
Reid PP, Compton WD, Grossman JH, Fanjiang G, eds. Building a better delivery system: a new engineering/health care partnership. Washington, DC: National Academies Press, 2005

Wasteful spending in the health system has been calculated at up to $1.2 trillion of the $2.2 trillion spent nationally.



Source: Analysis by PricewaterhouseCoopers' Health Research Institute

CMS's "Triple Aim" Solution



Financial Solution

Utilization ($)

Outcomes ($/$)

Hospital Payment Reform Incentives

Pay for Reporting

- Hospital Inpatient Quality Reporting
  - 2% Penalty to Annual Percentage Update (APU) for not reporting ($)
- Hospital Outpatient Quality Reporting
  - 2% penalty to Annual Percentage Update (APU) for not reporting ($)

Quality Reporting - Metrics

www.Quality Net.Org

- Hospital – Inpatient
- Hospital – Outpatient
- Physicians Offices
- Nursing Homes
- ESRD
- Quality Improvement

Quality Reporting - Facilities

http://www.medicare.gov/quality-care-finder/

- Hospital Compare
- Nursing Home Compare
- Home Health Compare
- Dialysis Facility Compare
- Physician Compare
- Medicare Plan Finder

Robert Wood Johnson Foundation Launches Online Directory to Compare Local Hospitals, Physicians

June 28, 2011

An online directory launched by the Robert Wood Johnson Foundation will give patients a new avenue to find comprehensive, comparative and quality healthcare information provided on physicians and hospitals in their communities, according to a RWJF news release.

Comparing Health Care Quality: **A National Directory links to 197 free and publicly available reports in 46 states**. There are no reports for Alabama, Alaska, Hawaii and Idaho, the release said.

The directory also has 27 reports with information on the performance of hospitals and physicians nationally.

Public Reporting of Quality Data

Most Americans say they would look for a hospital rating, although less than half are "very likely" to do so. ***But if their hospital receives a bad rating, nearly 75% say they would change hospitals rather than stay put.*** *If specialty care is needed, slightly more than half would seek out the best-rated facility rather than go to their community hospital.* ***If a serious illness is involved, nearly 60% would rely on ratings rather than community location in seeking care.***

The *Thomson Reuters 2010 PULSE™ Healthcare Survey November 14, 2011*

Achievement Thresholds and Benchmarks that apply to the FY 2013 Hospital VBP Measures – Clinical Process of Care Measures

Measure ID	Measure Description	Achievement Threshold	Benchmark
AMI-7a	Fibrinolytic Therapy Received Within 30 Minutes of Hospital Arrival	0.6548	0.9191
AMI-8a	Primary PCI Received Within 90 Minutes of Hospital Arrival	0.9186	1.0
HF-1	Discharge Instructions	0.9077	1.0
PN-3b	Blood Cultures Performed in the Emergency Department Prior to Initial Antibiotic Received in Hospital	0.9643	1.0
PN-6	Initial Antibiotic Selection for CAP in Immunocompetent Patient	0.9277	0.9958
SCIP-Inf-1	Prophylactic Antibiotic Received Within One Hour Prior to Surgical Incision	0.9735	0.9998
SCIP-Inf-2	Prophylactic Antibiotic Selection for Surgical Patients	0.9766	1.0
SCIP-Inf-3	Prophylactic Antibiotics Discontinued Within 24 Hours After Surgery End Time	0.9507	0.9968
SCIP-Inf-4	Cardiac Surgery Patients with Controlled 6AM Postoperative Serum Glucose	0.9428	0.9963
SCIP-VTE-1	Surgery Patients with Recommended Venous Thromboembolism Prophylaxis Ordered	0.9500	1.0
SCIP-VTE-2	Surgery Patients Who Received Appropriate Venous Thromboembolism Prophylaxis Within 24 Hours Prior to Surgery to 24 Hours After Surgery	0.9307	0.9985
SCIP–Card-2	Surgery Patients on a Beta Blocker Prior to Arrival That Received a Beta Blocker During the Perioperative Period	0.9399	1.0

Hospital Payment Reform Incentives

Pay for Performance

- Hospital Value-Based Purchasing ($/$)
  - 1%(+/-) FY2013 to 2% (+/-) FY2017
- Readmissions Program ($)
  - Minus up to 1% FY2013 to minus up to 3% FY2015
- Hospital Acquired Conditions Low Quartile ($)
  - Minus 1% FY2015

Affordable Care Act
Economic Risk

Worst Case Scenario

"For the typical hospital, being on the bottom quartile in terms of quality could mean millions of dollars lost annually. For instance, for a 300 bed community hospital with $50 million in Medicare inpatient net revenue, failure to improve on hospital Readmissions (a loss of about $96,780), failure with HVBP (a loss of $750,000), and ending up in the lowest quartile for HAC ($500,000), ***would create a drop of $1.35 million in income."***

PriceWaterhouseCoopers' Health Research Institute
Health Reform- Prospering in a post-reform world
May 2010

VBP Economic Risk

Catholic Health Services of Long Island

Medicare Value-Based Purchasing (VBP) Financial Assessment Tool

Provider #: '330286'
Hospital: GOOD SAMARITAN HOSPITAL MEDICAL CENTER
Address: 1000 MONTAUK HIGHWAY
City: WEST ISLIP
State: NY
ZIP Code: 11795
Phone: (631) 376-3000
Type: Acute Care Hospitals

PROCESS OF CARE MEASURES

MEASURE	%	Threshold	Bench	Best Score	MEASURE	%	Threshold	Bench	Best Score
MI Fibrin Rx:		76.5	100		Antibiotic On Time:	98	98	100	3
PCI w/in 90 min:	100	93	100	10	Correct Antibiotic:	98	98	100	1
D/C Instruct:	100	93	100	10	Stop Antibiotic:	94	97	100	0
Blood Culture:	99	97	100	7	Glucose Ctrl:		95	99.4	
Proper Antibiotic:	100	94	99.65	10	Anti-clot Rx:	97	97	100	2
Beta Blockers:	99	96	100	7	Anti-clot Rx Timing:	95	95	100	2

HCAHPS MEASURE

MEASURE	%ile	Threshold	Bench	Best Score
Nurse Communication:	29%	50%	95%	0
Doctor Communication:	17%	50%	95%	0
Quick Help from Staff:	13%	50%	95%	0
Pain Controlled:	43%	50%	95%	0
Staff Explain Meds:	29%	50%	95%	1
Home Instruct:	55%	50%	95%	1
Overall Rating:	21%	50%	95%	0
Quiet and Clean:	25%	50%	95%	1
Consistency Points:				5

POC Measure Total Score(%): 55.6%

HCAHPS Measure Total Score(%): 8.0%

Total Blended Hospital VBP Score(%): 41.3%

Hospital's FY 2013 Estimated "Par" Amount (1%): $750,936.19

Hospital's FY 2013 Estimated Earned Amount: $1,142,068.92

Hospital's Overall Payment Impact for FY 2013: $391,132.73 GAIN

VBP Economic Risk

Catholic Health Services of Long Island

Medicare Value-Based Purchasing (VBP) Financial Assessment Too

BD

Provider #: '330259'
Hospital: MERCY MEDICAL CENTER
Address: 1000 NORTH VILLAGE AVENUE
City: ROCKVILLE CENTRE
State: NY
ZIP Code: 11570
Phone: (516) 705-2525
Type: Acute Care Hospitals

PROCESS OF CARE MEASURES

MEASURE	%	Threshold	Bench	Best Score	MEASURE	%	Threshold	Bench	Best Score
MI Fibrin Rx:		76.5	100		Antibiotic On Time:	98	98	100	1
PCI w/in 90 min:		93	100		Correct Antibiotic:	98	98	100	1
D/C Instruct:	78	93	100	0	Stop Antibiotic:	98	97	100	7
Blood Culture:	99	97	100	8	Glucose Ctrl:		95	99.4	
Proper Antibiotic:	95	94	99.65	2	Anti-clot Rx:	96	97	100	0
Beta Blockers:	96	96	100	1	Anti-clot Rx Timing:	93	95	100	2

HCAHPS MEASURE

MEASURE	%ile	Threshold	Bench	Best Score
Nurse Communication:	22%	50%	95%	0
Doctor Communication:	30%	50%	95%	0
Quick Help from Staff:	10%	50%	95%	0
Pain Controlled:	20%	50%	95%	0
Staff Explain Meds:	17%	50%	95%	0
Home Instruct:	37%	50%	95%	0
Overall Rating:	21%	50%	95%	0
Quiet and Clean:	27%	50%	95%	0
Consistency Points:				4

POC Measure Total Score(%): 25.0%

HCAHPS Measure Total Score(%): 4.0%

Total Blended Hospital VBP Score(%): 18.7%

Hospital's FY 2013 Estimated "Par" Amount (1%): $329,687.97

Hospital's FY 2013 Estimated Earned Amount: $227,091.45

Hospital's Overall Payment Impact for FY 2013: ($102,596.52) LOSS

Economic Risk

Catholic Health Services of Long Island

VBP Impact per FY13 Final Rule

Provider	Hospital Name	VBP Impact	Natl Rank (out of 3,404)	Percentile
330182	"ST FRANCIS HOSPITAL, ROSLYN"	$141,981.99	53	98.40%
330246	ST CHARLES HOSPITAL	$46,606.41	387	88.60%
330259	MERCY MEDICAL CENTER	($73,109.47)	3189	6.30%
330286	GOOD SAMARITAN HOSPITAL MEDICAL CENTER	$71,690.67	216	93.60%
330332	ST JOSEPH HOSPITAL	$0.00	1449	41.30%
330401	ST CATHERINE OF SIENA HOSPITAL	$60,153.14	284	91.60%

Readmissions Impact per FY13 Final Rule

Provider	Hospital Name	Readmit Impact	Natl Rank (out of 3,404)	Percentile
330182	"ST FRANCIS HOSPITAL, ROSLYN"	($58,083.54)	2559	24.80%
330246	ST CHARLES HOSPITAL	($38,381.75)	2341	31.20%
330259	MERCY MEDICAL CENTER	($155,357.63)	3059	10.10%
330286	GOOD SAMARITAN HOSPITAL MEDICAL CENTER	($168,985.14)	3106	8.70%
330332	ST JOSEPH HOSPITAL	($46,598.75)	2444	28.20%
330401	ST CATHERINE OF SIENA HOSPITAL	($375,957.10)	3325	2.30%

Economic Risk

Catholic Health Services of Long Island

CLABSI Status

Provider	Hospital Name	Qual Measure	Score	Percentile	Natl Rank (out of 1,988)
330182	ST FRANCIS HOSPITAL ROSLYN	HAI_1_SIR	0.24	0.345	735
330246	ST CHARLES HOSPITAL	HAI_1_SIR	0	0.00%	1524
330259	MERCY MEDICAL CENTER	HAI_1_SIR	0.31	38.50%	1208
330286	GOOD SAMARITAN HOSPITAL MEDICAL CENTER	HAI_1_SIR	0.74	70.50%	575
330332	ST JOSEPH HOSPITAL	HAI_1_SIR	0.33	40.20%	1165
330401	ST CATHERINE OF SIENA HOSPITAL	HAI_1_SIR	1.12	86.80%	255

Higher Rank and Lower Percentile is Better; Rank 1,524 = No Infections during reporting period

CAUTI HAC Status

Provider	Hospital Name	Qual Measure	Score	Percentile	Natl Rank (out of 3,329)
330182	ST FRANCIS HOSPITAL ROSLYN	HAC_7	0.341	72.20%	922
330246	ST CHARLES HOSPITAL	HAC_7	2.479	98.70%	43
330259	MERCY MEDICAL CENTER	HAC_7	0.251	35.10%	24
330286	GOOD SAMARITAN HOSPITAL MEDICAL CENTER	HAC_7	0.05	48.00%	1730
330332	ST JOSEPH HOSPITAL	HAC_7	0.348	72.60%	910
330401	ST CATHERINE OF SIENA HOSPITAL	HAC_7	0.083	49.50%	1679

Higher Rank and Lower Percentile is Better; Rank 1,744 = No Infections during reporting period ~1600 hospitals reported 0 CAUTIs during reporting period

And now for something truly different…..

Accountable Care Organizations

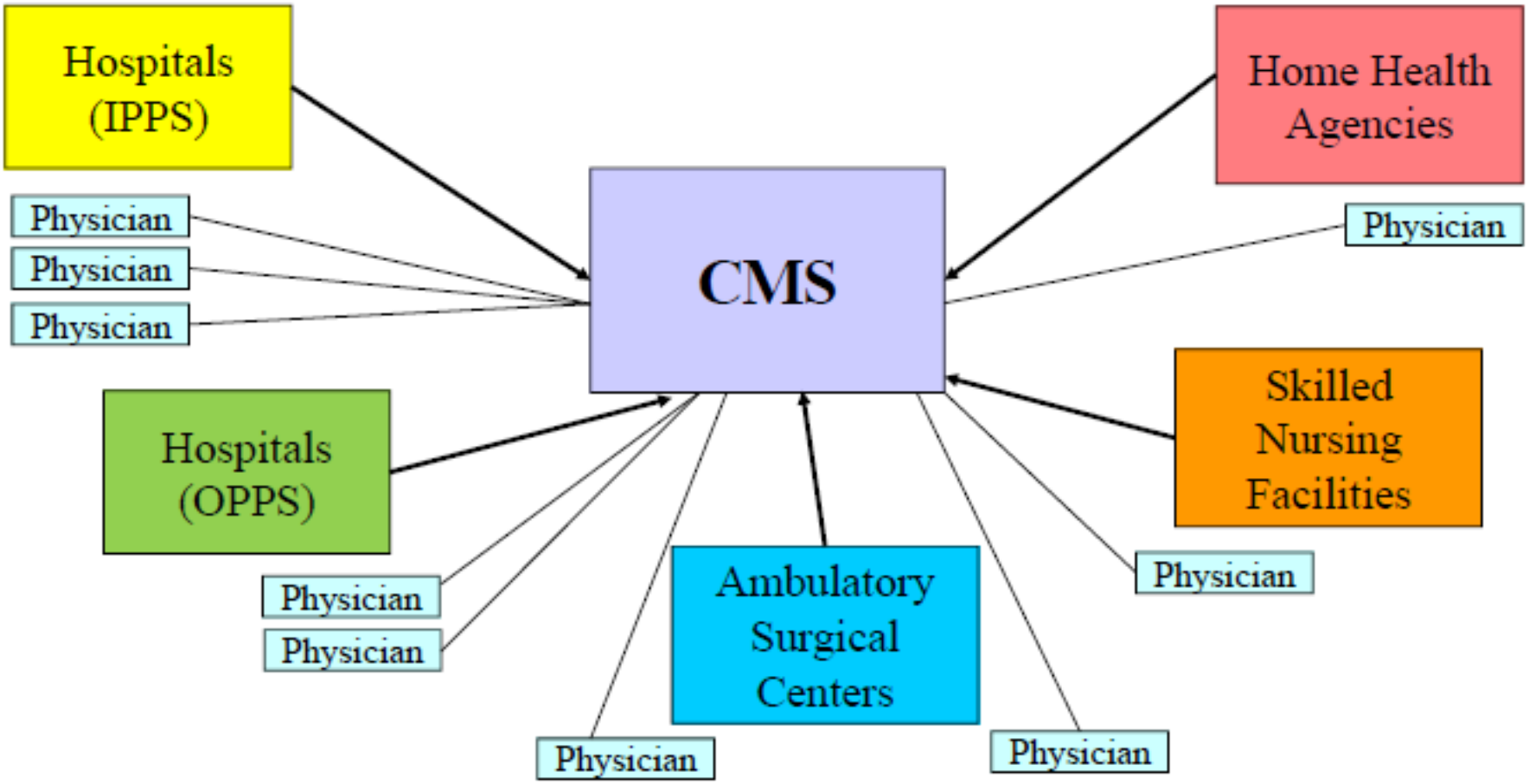
Bundled Payments

Accountable Care Organizations

What makes ACOs different?

- We've been focused on a hospitals performance relative to specific metrics. This is still important to an ACO but…….
- The primary focus of an ACO is lowering the total cost of care for a population. This includes all costs including inpatient, outpatient, office visits, ASCs, SNF, etc.

Fragmented Health Care System

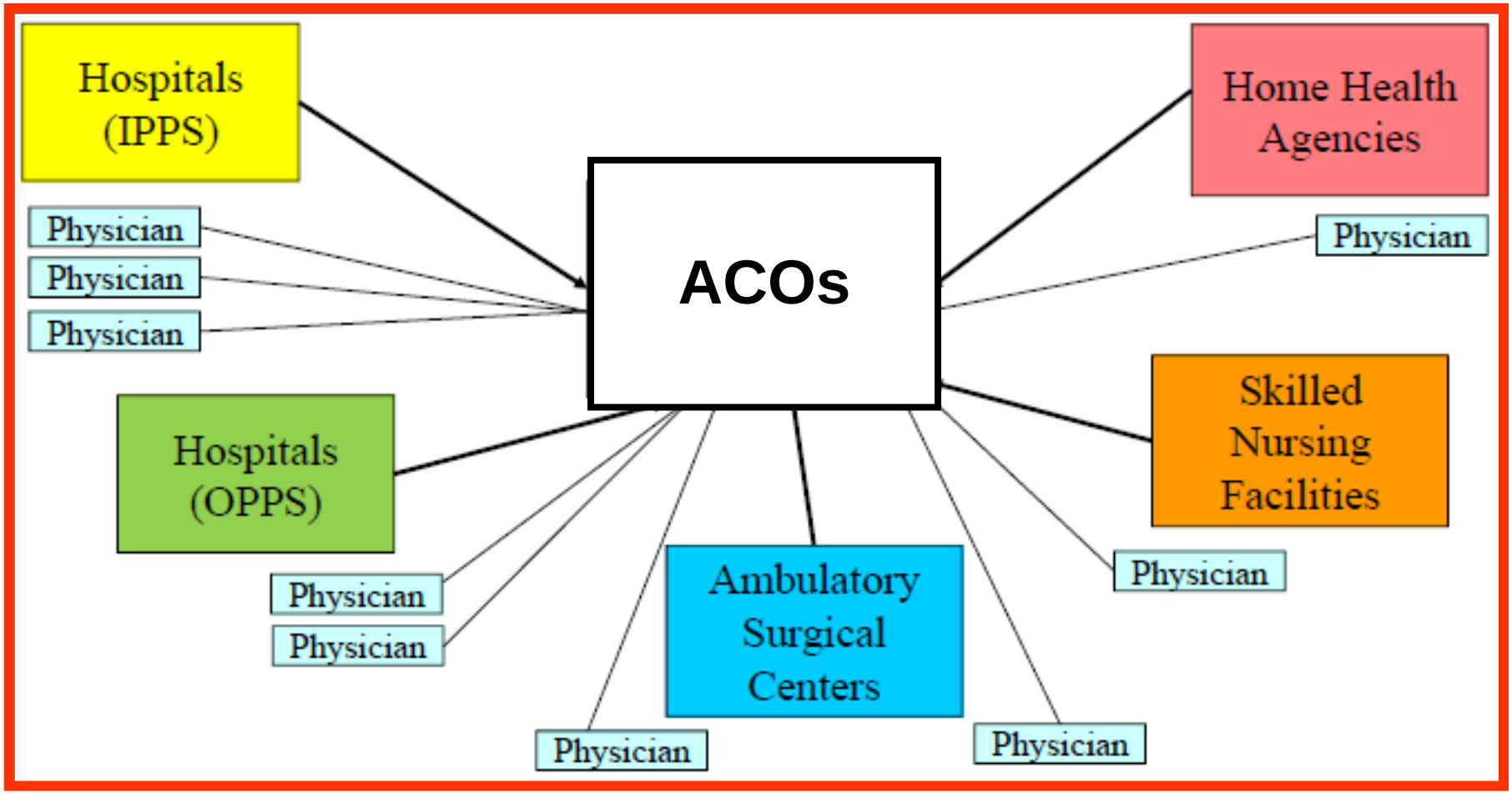


ACO Financial Solution

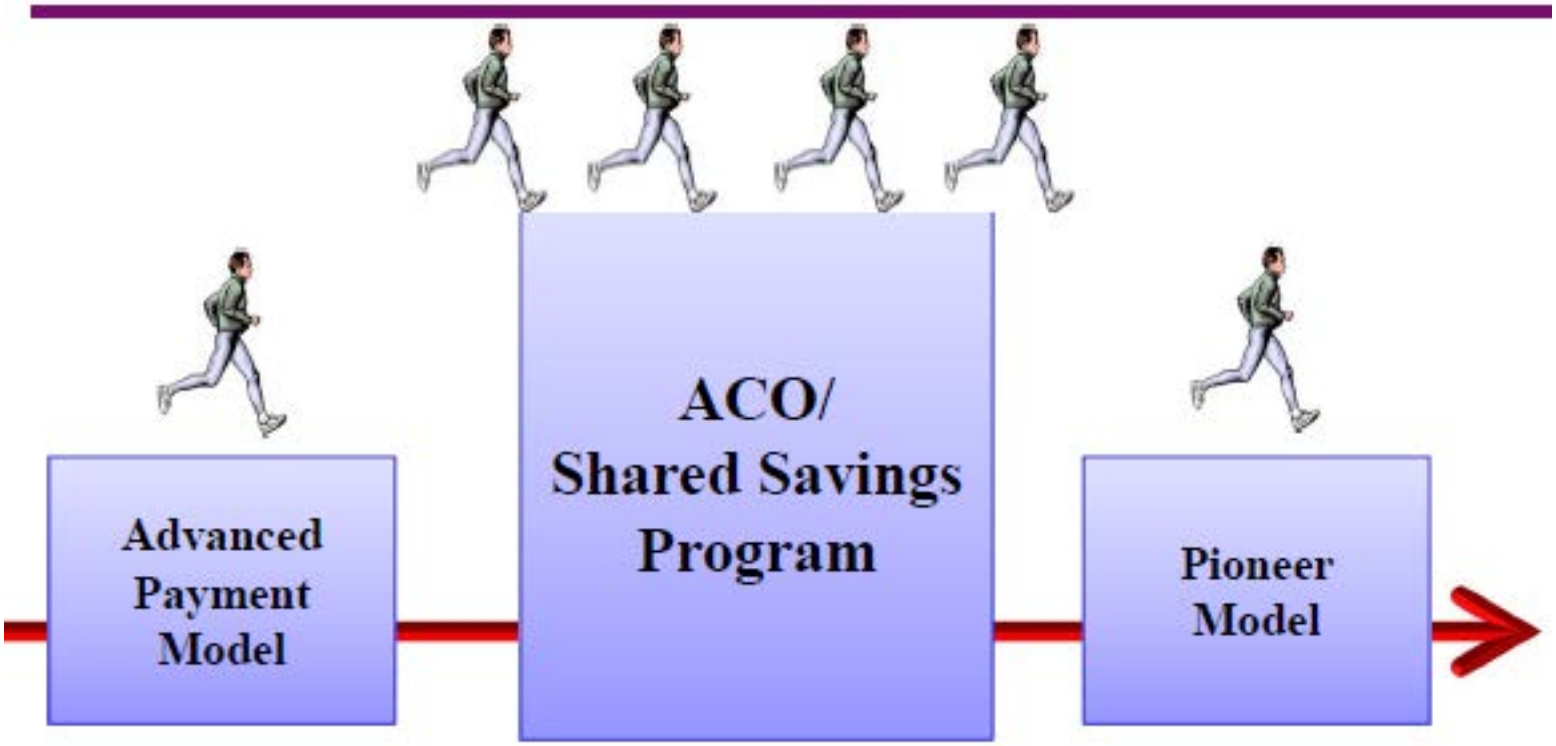
Utilization ($)

Shared Savings for a population($/$)

ACOs Coordinate Care Throughout the Healthcare Sectors



Three ACO Models



One Sided Model

Assume ACO Medicare enrollment	10,000 Medicare patients
Assume “Benchmark”	$8,000 per patient
Assume actual spending	$7,500
Savings	$500.00 per patient (0.0625%)
Gross Savings (10,000 X $500)	$5,000,000
2% Threshold	$1,600,000
Savings above threshold	$3,400,000
Uncapped Shared Savings	**$1,785,000**

(Up to 52.5% of savings above min. threshold)

Quality Performance Measure Scoring

As required by the Affordable Care Act, before an ACO can share in any savings created, it must demonstrate that it met the quality performance standard for that year. CMS will measure quality of care using nationally recognized measures in four key domains:▪

- Patient/caregiver experience (7 measures)
- Care coordination/patient safety (6 measures)
- Preventive health (8 measures)
- At-risk population:
  - Diabetes (6 measures)
  - Hypertension (1 measure)
  - Ischemic Vascular Disease (2 measures)
  - Heart Failure (1 measure)
  - Coronary Artery Disease (2 measures)

ACO Financial Incentive

“Shared Savings”-- if below cost targets **and meet quality standards** they financially share in the savings with CMS

- Controlling Cost Growth
- Improving Quality/Outcomes
- Changing Incentives
- Coordinating Care

ACO Financial Incentive

Market Share

Increased market share allows for better management of assigned risk

Better Data from CMS

“Can’t manage what you don’t measure”

Shared Savings

Pays for infrastructure

Decreases over time

Top 25 Diagnoses for Pioneer ACOs

1. Supplementary classifications — 2,150,629
2. Disease of the circulatory system — 1,271,469
3. Females with deliveries — 947,421
4. Heart disease — 816,933
5. Disease of the digestive system — 811,833
6. Diseases of the respiratory system — 797,652
7. Injury and poisoning — 689,136
8. Disease of the musculoskeletal system and connective tissue — 510,330
9. Disease of the genitourinary system — 457,144
10. Mental disorders — 454,974

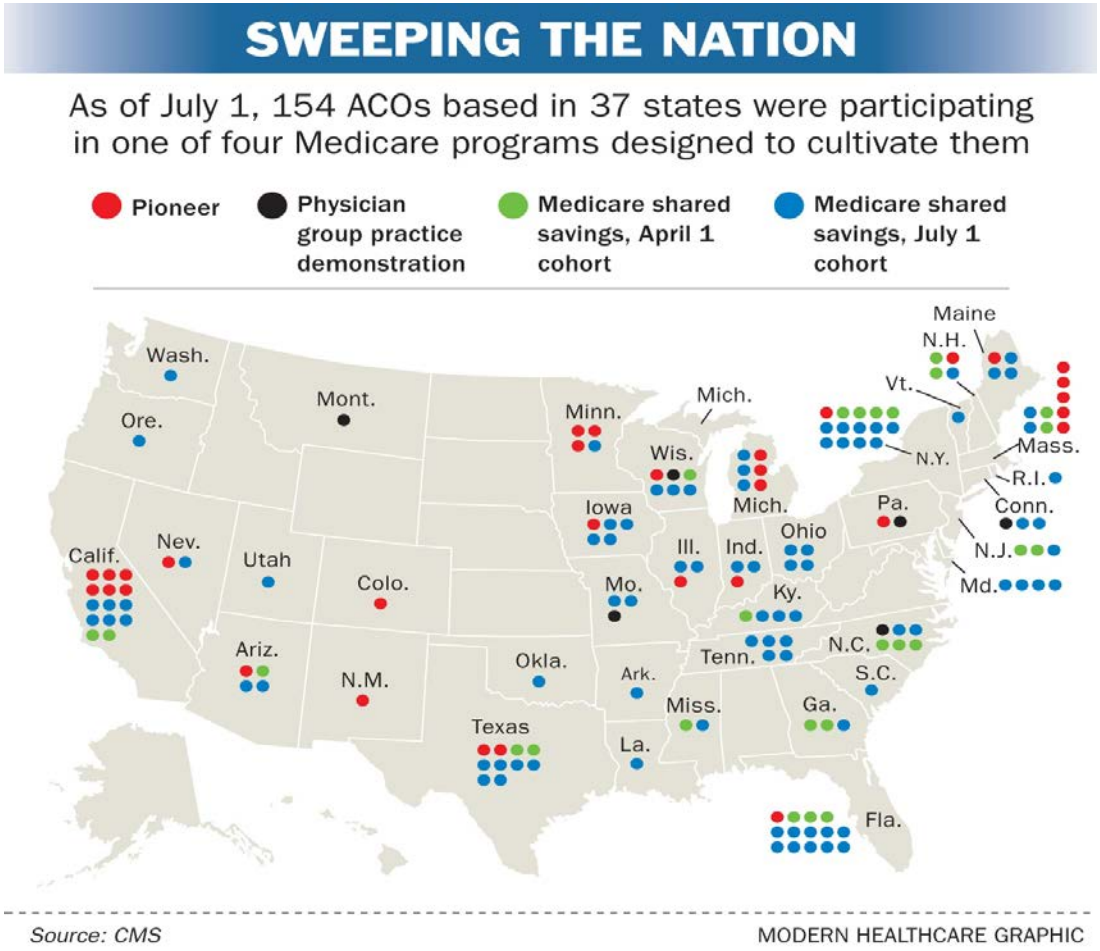
The following information pertains to the first 32 CMS Pioneer Accountable Care Organizations in 2011. Data was provided by Stratasan and published in a Jarrard Phillips Cate & Hancock blog post.

Top 25 Diagnoses for Pioneer ACOs

11. Endocrine, nutritional and metabolic disease and immunity disorders — 421,046
12. Neoplasms — 391,270
13. Psychoses — 323,919
14. Malignant neoplasms — 301,355
15. Infectious and parasitic diseases — 262,760
16. Pneumonia — 253,413
17. Fractures, all site — 244, 254
18. Disease of the nervous system and sense organs — 228,021
19. Congestive heart failure — 223,144
20. Certain complications of surgical and medical care — 216,035

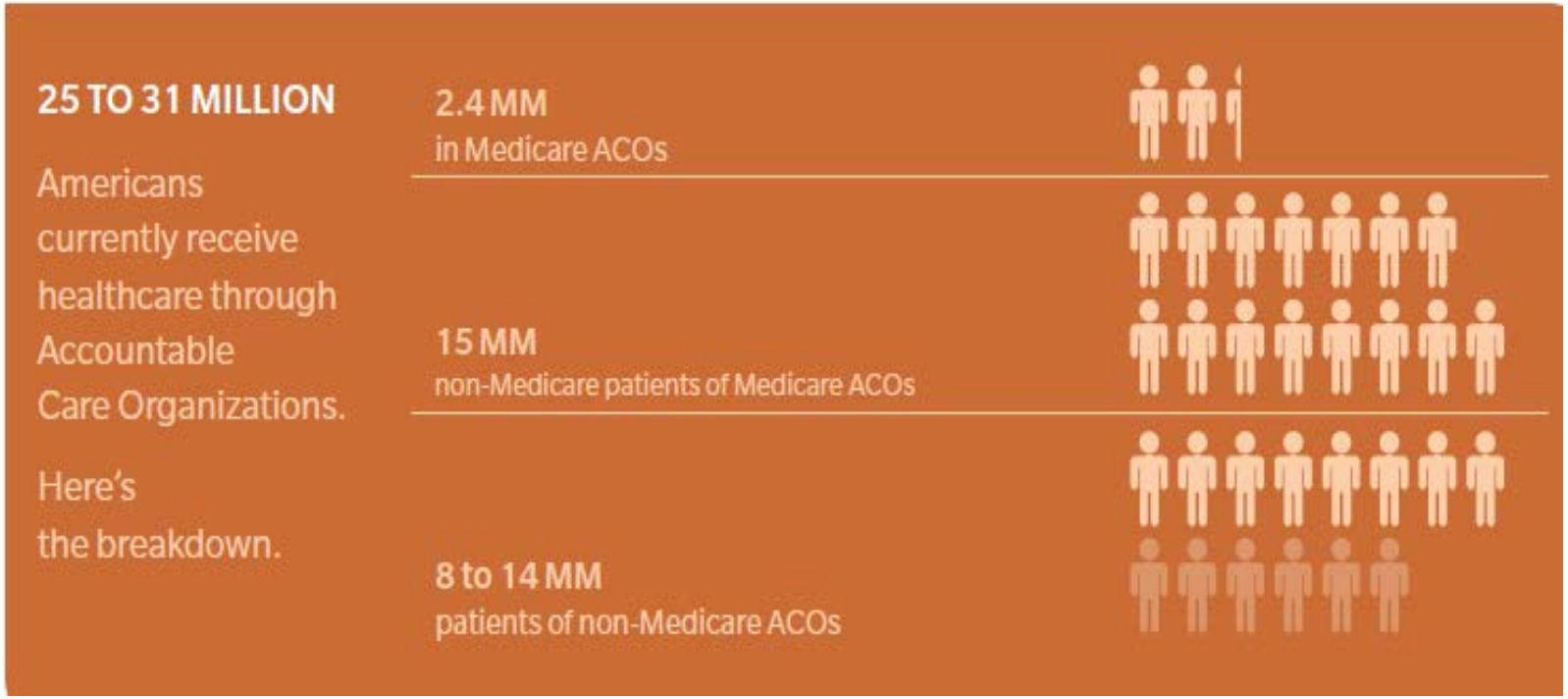
The following information pertains to the first 32 CMS Pioneer Accountable Care Organizations in 2011. Data was provided by Stratasan and published in a Jarrard Phillips Cate & Hancock blog post.

ACO Distribution



The 150 Million Patient Question

"How many ACO are there and……
how many patients do they serve?"



The ACO Surprise, Oliver Wyman, 2012

Bundled Payments

Under episode-based bundled payment systems, a provider contacting organization is paid a fixed amount for all care required by patients who meets the definition of the episode. Since no definition of episodes results in a totally homogeneous group of patients, cost of individual patients vary, and therefore the contacting organization is subject to random variations in its average per-patient cost depending on which patients are included in its episodes.

Bundled Payments

As bundled payment models evolve, two different methods of managing these types of variations appear to have emerged:

- Under the **Medicare** Bundled Payment for Care Improvement episodes were based on DRGs, all variations of a base DRG were required to be included (without complications, with complications, etc.). Because Medicare patients comprise a large portion of most hospitals' patient populations, this definition resulted in a relatively large number of patients be included in the episodes. Therefore, the risk mitigation strategy was based on large population sizes.

Bundled Payments

As bundled payment models evolve, two different methods of managing these types of variations appear to have emerged:

•Under many **commercia**l bundled payment contracts, however, the strategy appears to be different. In these contracts, episodes are defined using ICD-9 diagnosis and procedure codes, rather than DRGs. Since diagnosis codes are more granular, this results in a smaller number of patients in each episode. Therefore, the risk mitigation strategies employed in these contracts appear to be to tightly define the episodes, and to exclude patients with unrelated conditions, expecting that this will compensate for the smaller population sizes.

Show me the money!

Utilization Payment ($)

Value-Based Purchasing ($/$)

Readmissions ($)

Pay for Reporting ($)
- Inpatient QRP
- Outpatient QRP

HAC Low-Quartile ($)

Published Metrics/Performance ($/$)

Bundled Payments

Accountable Care Organization

October 1 – January 1, 2013

Here is what we know about the financial impact of October 1, 2012:

- Value-Based Purchasing (VBP)
  - CMS has predicted that $850 million will change hands among inpatient acute care hospitals.
- Readmissions
  - Hospitals will be assessed a penalty of up to 1% to the extent they exceed expected readmissions for pneumonia, heart failure and acute myocardial infarct. BD's Reimbursement team has calculated a net loss, in aggregate, of $330.8 million. Once again, fortunately for BD, we can model how each hospital in the US will fare under the readmission program. CMS states $280 million in savings
- Hospital Acquired Conditions / Present On Admission (HAC/POA)
  - CMS has predicted a net savings of $24 million under the HAC program for FY13.
- Payment Reform (Accountable Care Organizations, Bundled Payments, etc.)
  - Most facilities appreciate there will be an intermittent loss in revenue as they transition from a fee-for-service model to payment models that encourage better coordinated care, resulting in reduced utilization.

Here is what we know about the financial impact of January 1, 2013

- Sequestration (The Budget Control Act 2011) To make matters even worse, at the end of the first quarter of FY13, hospitals <u>may</u> lose an additional 2% of their revenue on January 1, 2013 under Sequestration. What is Sequestration? This is the program that was ultimately adopted when Congress could not resolve the budget deficient issue.

4 Pressing Financial Issues Facing Hospital C-Suites

1. Cost Containment: *Negotiate more aggressively with vendors and suppliers*

2. Improving Patient Quality: *Hospitals are willing to pay a premium for those products that reduce stays and errors. If suppliers can prove they have an immediate impact on patient outcomes, that'll resonate with the C-Suite of the hospital.*

3. Maintaining Reimbursement: *The level of reimbursement from commercial payors is likely to be impacted more and more*

4. Data Connectivity: *Its not just data, but meaningful information that can be used across the spectrum of care.*

Hospital's Rethink MedTech Purchasing Strategies as Budgets Grow, Bob Lavoie, VP LEK Global

Process Improvements Vital to Cost Containment

Health Leaders Magazine

In our annual Industry Survey, healthcare leaders place cost control and ***process improvement*** *as their third-highest priority for the next three years (behind patient experience and satisfaction, and clinical quality and safety).*

John Commins, for HealthLeaders Media , June 11, 2012

Drill Down Benchmarking

Process improvement methodology must include meaningful measures of performance that can be easily reported to employees and staff.

For example, for years we told nurses to shorten length of stay, but what does that mean to them? Once we drilled down to the specific ways they could impact LOS, we started seeing improvement.

How can nurses impact LOS? They can make sure orders are inputted in a timely manner; they can make sure test results are delivered to physicians quickly; the list goes on*.*

A Culture of Continuous Improvement is Necessary for Success Under Value-Based Care, Imran Andrabi, Sr VP and CPO Mercy

Unintended Consequences of Reducing Labor Costs

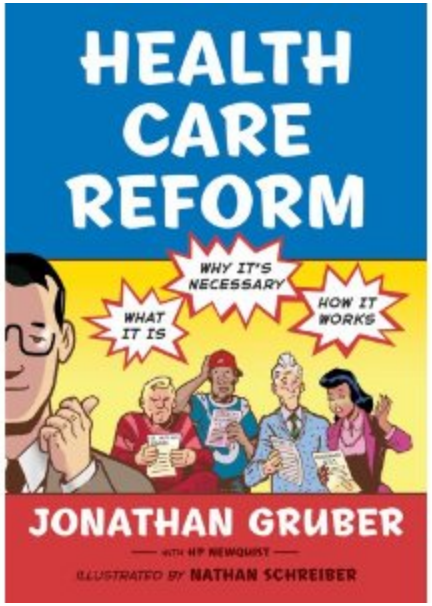
- The transition to ACOs and the fiscal impact of the Affordable Care Act (ACA) provisions will result in reduced revenues for hospitals over the next three to five years.
- As a result, hospitals are striving to reduce costs by 5% for every 1% reduction in revenue
- About two-thirds of every dollar spent by hospitals goes to wages and benefits for qualified, **trained nurses**, physicians, caregivers and other staff. Growth in labor cost accounts for about 35% of overall growth and more than half of the growth in the costs of purchased goods and services.
- If the rate of mass layoffs in hospitals remains steady, the industry is slated to have a similar number of mass layoffs in 2012 as it did in 2011, according to an *American Medical News* report. The first nine months of 2012 brought 93 layoff incidents that left 6,529 people claiming unemployment benefits. A total of 124 mass layoffs are projected for the year, if this rate continues, affecting roughly 8,700 people. The year 2011 brought 121 mass layoffs in hospitals, resulting in job loss for 8,098 people.

Unintended Consequences of Reducing Labor Costs

- Burned-out nurses linked to more infections in patients. For every extra patient added to a nurse's workload, there was roughly one additional hospital-acquired infection logged per 1,000 patients, according to researchers from the Center for Health Outcomes and Policy Research at the University of Pennsylvania School of Nursing. For each 10 percent jump in the proportion of nurses who logged high levels of burnout, there was roughly one additional catheter-associated urinary tract infection per 1,000 patients and almost extra two surgical site infection per 1,000 patients according to a study published in the American Journal of Infection Control.
- Medical Errors with the largest measurable costs: #2 Post-Operative Infection Total Cost of Error; $3,676 million
- Healthcare-associated positive clinical culture results may be associated with a significantly shorter time to hospital readmission. The researchers identified 4,737 patients with positive clinical cultures for MRSA, VRE or C. difficile after more than 48 hours following hospital admission. These patients were 40 percent more likely to readmitted to the hospital within a year and **60 percent more likely to be readmitted within 30 days** than patients with negative or no clinical cultures.
- 2,211 hospitals stand to forfeit an estimated $280 million in Medicare funds beginning October 1, as year one of Medicare readmissions penalties take effect in October 1st.

Health Care Reform

What It Is…Why It's Necessary… How It Works



Jonathon Gruber

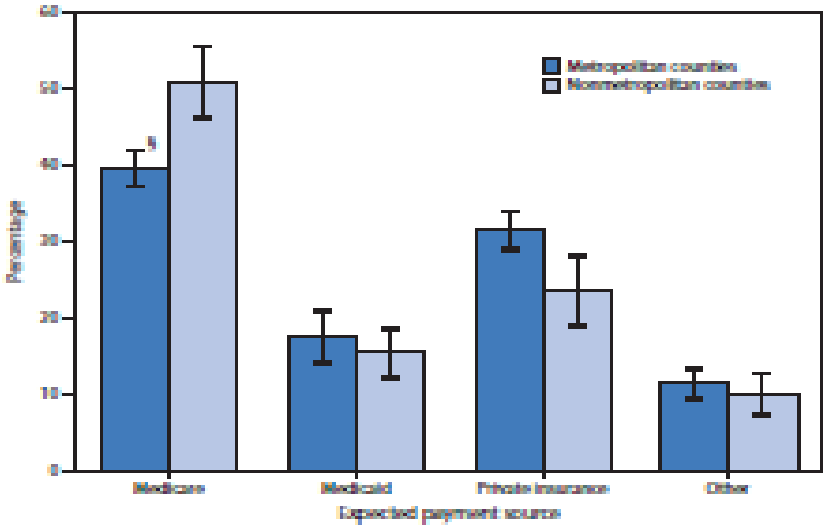
Amazon.com $7.50

Thank You!

Percentage of Hospitalizations, by Expected Payment Source*

FROM THE NATIONAL CENTER FOR HEALTH STATISTICS

Percentage of Hospitalizations, by Expected Payment Source* and Hospital Locality† — National Hospital Discharge Survey, United States, 2009



* Expected payment source is the type of program or insurance that, on admission to the hospital, was expected to be the principal payer for the hospital stay.
† Counties where hospitals are located were classified as metropolitan or nonmetropolitan using June 2003 U.S. Office of Management and Budget standards based on the 2000 Census.
§ 95% confidence interval.

In 2009, Medicare was expected to pay for 51% of U.S. hospitalizations in nonmetropolitan counties and 40% of hospitalizations in metropolitan counties. Private insurance was the expected source of payment for 32% of hospitalizations in metropolitan counties, compared with 24% of hospitalizations in nonmetropolitan counties.

Source: National Hospital Discharge Survey data (2009). Available at http://www.cdc.gov/nchs/nhds.htm.

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Three ACO Models

- Mandated ACO/Shared Savings Program
  - One-sided Model: Share in savings, no penalty for loses
  - Two-sided Model; Share in savings AND losses

- Related Initiatives thru ‘Innovation” Center (CMMI)
  - Pioneer Model
    - Faster pathway for “mature” ACOs
    - Exisiting organizations structured to provide coordination, integrated care
  - Advanced payment Model
    - For organizations that need additional access to captial to become an ACO
    - Funding based on expected future savings

Final IPPS Rule Has Three New Value-Based Purchasing Measures, Finalizes Readmissions Factors

- **The new measures that will be included for the 2015 value-based purchasing program include two new outcomes measures** –
  - a central line-associated blood stream infection
  - a patient safety indicator composite measure –
  - plus a Medicare spending per beneficiary efficiency measure.

- **The final rule also finalizes the methodology and payment adjustment factors to account for excess hospital readmissions** for three conditions:
  - heart attack,
  - heart failure
  - and pneumonia.

CMS estimates that the readmissions program will result in an approximately $280 million decrease -- .3 percent -- in overall hospital payments.

Healthcare Facility HAI Reporting to CMS via NHSN – Current and Proposed Requirements

HAI Event	Facility Type	Reporting Start Date
CLABSI	Acute Care Hospitals Adult, Pediatric, and Neonatal ICUs	January 2011
CAUTI	Acute Care Hospitals Adult and Pediatric ICUs	January 2012
SSI	Acute Care Hospitals Colon and abdominal hysterectomy	January 2012
I.V. antimicrobial start	Dialysis Facilities	January 2012
Positive blood culture	Dialysis Facilities	January 2012
Signs of vascular access infection	Dialysis Facilities	January 2012
CLABSI	Long Term Care Hospitals *	October 2012
CAUTI	Long Term Care Hospitals *	October 2012
CAUTI	Inpatient Rehabilitation Facilities	October 2012
MRSA Bacteremia LabID Event	Acute Care Hospitals	January 2013
C. difficile LabID Event	Acute Care Hospitals	January 2013
HCW Influenza Vaccination	Acute Care Hospitals	January 2013
HCW Influenza Vaccination	ASCs	October 2014
SSI *(future proposal)*	Outpatient Surgery/ASCs	TBD

* Long Term Care Hospitals are called **Long Term Acute Care Hospitals** in NHSN

Burned-out nurses linked to more infections in patients

- **For every extra patient added to a nurse's workload, there was roughly one additional hospital-acquired infection logged per 1,000 patients**

- **For each 10 percent jump in the proportion of nurses who logged high levels of burnout, there was roughly one additional catheter-associated urinary tract infection per 1,000 patients and almost extra two surgical site infections per 1,000 patients**

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Cimiotti, J.P., Aiken, L.H., Sloane, D.M. (IN PRESS). Nurse staffing, burnout, and healthcare-associated infection. *American Journal of Infection Control*.