

Statement of the St. Luke's Hospital & Health Network

Before the

Senate Public Health and Welfare Committee

Presented by

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Introduction

Chairman Erickson and members of the Senate Public Health & Welfare Committee. My name is Susan York and I am the Director of Accreditations and Standards for St. Luke's Hospital & Health Network. Thank you for the opportunity to be here today and share our views regarding reauthorization of the Pennsylvania Health Care Cost Containment Council.

St. Luke's Health Network is an integrated healthcare network comprised of four acute care not-for-profit hospitals, more than 1,400 physicians and numerous other related health organizations. There are a total of 734 licensed beds among the four hospitals. Annual inpatient admissions for FY 2007 totaled nearly 39,000. St. Luke's Health Network provides direct healthcare services to a population of more than three million people in Lehigh, Northampton, Carbon, Schuylkill, upper Bucks, eastern Berks, upper Montgomery and Monroe counties in Pennsylvania. St. Luke's Health Network currently employs approximately 6,000 people and is the second largest employer in the Lehigh Valley.

Throughout our 130 year history, St. Luke's has remained committed to our vision to be recognized for excellence in clinical outcomes, patient safety, cost-effective care and patient satisfaction. St. Luke's has received 22 national awards for clinical excellence including being named by U.S. News & World Report as one of the nation's best heart hospitals for seven years in a row and twice being named as one of Solucient's 100 top hospitals nationally. St. Luke's has been named as the Lehigh Valley's top hospital and leading birth center by Lehigh Valley Magazine, as well as one of Pennsylvania's Best Places to Work by Best Companies Group and ModernThink for three years. In addition, St. Luke's has also achieved a "better than expected" inpatient mortality rating for nine clinical conditions in the most recent Hospital Performance Report published by PHC4.

We seek to distinguish ourselves as early adopters of innovative national clinical improvement projects. For example, St. Luke's is one of 260 hospitals nationwide participating in a three year Hospital Quality Improvement Demonstration (HQID) project sponsored by the Centers for Medicare and Medicaid Services. The objective of the HQID is to demonstrate the impact of financial incentives on improving quality in five clinical conditions: Heart Attack, Heart Failure, Cardiac Bypass Surgery, Pneumonia and Hip/Knee Replacement Surgery. Results from the first two years of the project demonstrate that there has been a significant improvement in quality, mortality, and cost of care. Findings from the HQID are being utilized to design the future state of national performance-based reimbursement systems. In addition, St. Luke's is participating in a second quality demonstration project called QUEST. Sponsored by Premier this project involves 150 hospitals nationwide. Performance measures and best practices will be developed in 5 domains: clinical quality, mortality, efficiency, patient satisfaction and harm avoidance. This 3 year project started in January, 2008 and will last for 3 years.

Background

Requirements for hospitals to submit performance data have increased considerably over the past five to ten years. Initial requirements were established in the mid 1980's by the Joint Commission (JC), ORYX measures and in Pennsylvania with the authorization of PHC4. PHC4 has been a leader in providing hospital performance data with the publication of its annual Hospital Performance Report and in providing physician performance data with the publication of the Pennsylvania's Guide to Coronary Artery Bypass Graft Surgery Report in 1994.

In 2002, the Hospital Quality Alliance (HQA) was created. The Hospital Quality Alliance (HQA) is a public – private collaborative intended to make accessible to the public critical information about hospital quality performance and to inform and invigorate efforts to improve quality. The Health Quality Alliance (HQA) includes the Centers for Medicare and Medicaid Services (CMS); the Agency for Healthcare Research and Quality (AHRQ); and key national hospital groups, health care quality organizations and consumer groups. The HQA provides data for Hospital Compare, a U.S. Department of Human Services data base. The database is maintained by CMS. Data submission by hospitals for ten clinical measures was voluntary in 2002.

The ensuing Medicare Modernization Act of 2004 created a formal new linkage between the requirement to report data on these ten measures and hospital reimbursement. Hospitals not submitting this data received a 0.4% reduction in their Annual Payment Update (APU). The Deficit Reduction Omnibus Reconciliation Act of 2005, enacted in early 2006, expanded the number of measures hospitals must submit from ten to 21 in order to receive a full Annual Payment Update (APU). The penalty for failure to submit these measures was also increased from 0.4% to 2.0% reduction in the Annual Payment Update (APU). The Deficit Reduction Omnibus Reconciliation Act also calls for the establishment of a new “value-based purchasing” (Pay for Performance – P4P) framework for hospitals to be implemented in 2009. It is clear that the government will increasingly play a major role in determining the performance measurement agenda for hospitals. A plan for the elaboration of ORYX performance measurement requirements (Attachment A) has been proposed by Joint Commission in conjunction with CMS and the Hospital Quality Alliance. The number of measures increased in 2008 to 27. In 2009, outpatient measures will be added for Emergency Department care and outpatient surgery. CMS proposes to add an additional 43 measures by 2010. These measures require extensive resources as they must be manually abstracted from individual patient medical records.

As this national measurement agenda moves forward, CMS has agreed to partner with Joint Commission to create absolute alignment between the measures that both agencies will use for hospital accreditation (JC) and for pay for performance (CMS). The goal is to have the Joint Commission's and CMS's menu of measures become the national standard. “But the problem is that a lot of other people like to invent and add their own measures, and that includes the states – Pennsylvania being a good case in point,” according to Dennis O'Leary, Past President of the Joint Commission (3/23/06).

To actualize the 2009 P4P agenda, a national severity adjustment methodology has been instituted by CMS. The data collection methodology for P4P is MS-DRG which is distinctly different from the severity methodology utilized by PHC4. In addition, the State of Pennsylvania has enacted Act 52 which went into effect in 2008. This requires hospitalwide infection surveillance and implementation of an electronic surveillance system by December, 2008. This has added over \$400,000 in costs for St. Luke's due to the electronic surveillance system and the need to add additional infection control personnel.

Issues

- **Pay for Performance**
 - With the adoption of a national severity adjustment methodology to support the government's value-based purchasing agenda, the importance of PHC4 data to hospitals will decline. Hospitals will be required to focus on data determined by federal reimbursement.
- **Additional Resources**
 - Hospitals will need additional resources such as information technology systems and increased numbers of data abstractors to meet the progressively expanding national measurement and reporting expectations being set

forth. The annual cost to St. Luke's to support current PHC4 data requirements is in excess of \$500,000. Hospitals would be better served by conserving the costs necessary to comply with PHC4's data requirement, so that hospitals can prepare for the national measurement and reporting requirements.

- Impact On Physicians

- Physicians are familiar and comfortable with the data provided by PHC4. Although they may support the continuation of PHC4's current data methodology, this may be due to a lack of understanding and a failure to believe that the national quality agenda will actually take hold and become a reality.

Conclusion

To continue to require Pennsylvania hospitals to support a disparate severity-adjusted data system is simply unreasonable. We respectfully request that you support state legislation which would:

- Remove the mandate requiring Pennsylvania hospitals to contract with a specific vendor to measure quality.
- Require PHC4 to adopt a "nationally recognized" method to measure provider quality.
- Prohibit the Council from requiring additional data elements that are not required by national regulatory bodies such as CMS, Joint Commission and Health Quality Alliance.
- Require a 5-year sunset as a requirement of reauthorization so as to have appropriate review of the Council and its operations.

Again, St. Luke's thanks you for the opportunity today for me to present our hospital and health network's views on reauthorizing PHC4. We appreciate your willingness to engage in public dialogue about this important issue and I will be more than happy to answer any questions that you may have.