The Affordable Health Care Act: Any Progress?
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It has been over one year since the passage of the Affordable Health Care Act. Many skeptics did not believe that the proposed law would make any progress towards transforming our health care system. Contrary to this projection, a number of initiatives have been implemented.

As Lori Finkelstein-Blonde, R.N., M.A., C.I.C., reported in our March Quality Quarterly, value based purchasing is one example of an initiative under the new health reform law to improve the overall quality of care. Other proposals are underway. In April, the Department of Health and Human Services announced a new national partnership, the Partnership for Patients. Under this public/private initiative, members (including hospitals, physicians, employers, and administrators) vow to improve the quality of care, reduce health care costs, and create safer patient care. Several major entities, including the American College of Surgeons, have joined forces to promote the two major goals set forth by the partnership: 1) reducing hospital readmissions and 2) preventing hospital-acquired infections and injuries. The program’s intent is to reduce hospital-acquired infections and injuries by 40% compared to 2010 levels. Additionally, the prevention of hospital readmissions by 20% compared to 2010 rates is a major aim and will be achieved by preventing complications during transitions from one health care setting to another. Federal funds have contributed nearly $1 billion in investment for the cause.

Another controversial proposal under the health reform law is the creation of new models for Accountable Care Organizations (ACOs). ACOs are the mechanism by which doctors, hospitals, and other health care providers collaborate in order to provide more coordinated care which ultimately leads to improving the overall delivery of health care. The Centers for Medicare and Medicaid Services (CMS) hopes to accelerate the process by working more closely with physicians to expand the number of ACOs. Under CMS’s Shared Savings Program, released in March, ACOs that lower Medicare costs and fulfill performance standards will be recognized.

The Pioneer ACO model, which will be available this summer, is expected to save up to $430 million within the next three years. This model is for established ACOs that want to gain momentum with the overall coordination process. The ACOs will work closely with private payers to promote their goals.

Will ACOs be effective? Robert Laszewski, a health policy strategist, believes that they “are a tool in a big tool box of care and cost management tools but, like all of the other tools over the years like HMOs and IPAs, they won’t be used as they were intended because everybody—providers and insurers—can make more money in the existing so far limitless fee-for-service system.” Regardless of what the skeptics say, the aim is to reduce the fragmentation of care.

References:


“Partnership for Patients to Improve Care and Lower Costs for Americans.” April 12, 2011. HHS Office of Public Affairs.

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Why pay attention to SCIP?

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There are approximately 30 million major operations each year in the United States.

In 2003, the Journal of the American Medical Association published a study which showed that postoperative complications accounted for up to 22 percent of preventable deaths among patients, depending on the complication.

The Centers for Disease Control (CDC) has reported that 2.5% of all patients undergoing surgery develop a surgical site infection and 17% of all hospital acquired infections (HAI) occur in surgical patients. This accounts for 300,000 surgical site infections (SSIs) per year and 17% of all HAIs; second only to urinary tract infections.

The rate of mortality among patients who have developed an SSI is 3%. Moreover, 75% of deaths among patients with SSIs are directly attributable to the SSI. The cost of a surgical complication can range from $3,000-$29,000 per case, up to 10 billion dollars annually and increase length of stay by 7-10 days.

The Surgical Care and Infection Prevention project (SCIP) was developed as a multi-year national quality campaign and partnership aimed at reducing surgical complications by 25 percent by the year 2010. SCIP is sponsored by the Centers for Medicare and Medicaid Services (CMS) in collaboration with a number of other national partners serving on the steering committee, including the American Hospital Association (AHA), CDC and Institute for Healthcare Improvement (IHI), Joint Commission on Accreditation of Healthcare Organizations (JC) and others.

SCIP measures are evidenced based and are intended to close the gap between theory and practice with the goal of fewer SSI infections, blood clots and fewer cases of post operative pneumonias and other complications.

Studies have also demonstrated improved performance is associated with improved outcomes at the discharge level when all SCIP measures are adhered to as a composite and not when compliance is measured by individual SCIP measures alone.

Dr. Arthur Aufses, chairman emeritus for the Department of Surgery, has been actively engaged with Quality and Performance Improvement and has been leading efforts to promote adherence to the SCIP process measures at Mount Sinai since 2006. Dr. Edward Chin has also been an active participant in the SCIP process as our Surgeon Champion for the Department.

Presently there are 10 publicly reported SCIP measures, 6 of which focus on postoperative infection prevention. Beginning with July 2011 discharges CMS is requiring 100% compliance on 7 out of the 10 (highlighted below) SCIP measures highlighted below.

**SCIP INF 1:** Prophylactic antibiotic received within one hour prior to surgical incision

**SCIP INF 2:** Prophylactic antibiotic selection for surgical patients

**SCIP INF 3:** Prophylactic antibiotics discontinued within 24 hours after surgery

**SCIP INF 4:** Cardiac surgery patients with controlled 6 a.m. postoperative blood glucose

**SCIP INF 6:** Surgery patients with appropriate hair removal

**SCIP INF 9:** Urinary catheter removal on post operative day 1 or 2

**SCIP INF 10:** Surgical patients with perioperative temperature management

**SCIP CARD 2:** Surgery patients on beta-blocker therapy prior to arrival who received a beta-blocker during the perioperative period

**SCIP VTE 1:** Surgery patients with recommended venous thromboembolism prophylaxis ordered

**SCIP VTE 2:** Surgery patients who received appropriate venous thromboembolism prophylaxis within 24 hours prior to surgery to 24 hours after surgery

References:
Stulberg, Jonah J, MD, PhD, MPH et al; Adherence to Surgical Care Improvement Project Measures and the Association with Postoperative Infections, JAMA 2010; 303 (24):2477