Public Reporting of Cardiac Surgery Outcomes in Pennsylvania

A 20 Year Personal Perspective

Raymond L. Singer, MD, MMM, CPE
Chief, Division of Cardiothoracic Surgery
Vice Chair, Quality, Patient Safety & Outreach
Learning Objectives

1. Cite the history of public reporting of cardiac surgery outcomes in Pennsylvania.

2. Describe the national trends of public reporting, pay for performance, and related health care reform measures.

3. Describe both the intended and unintended consequences of public reporting of cardiac surgery outcomes.

4. Compare the consequences of public reporting of cardiac surgery outcomes in Pennsylvania to the growing call for public reporting of all health care outcomes nationwide.
Gibbon’s Magnificent Machine

First successful use of the heart-lung machine at Thomas Jefferson University Hospital on May 6, 1953

John H. Gibbon, Jr.
1903-1973
Bavolek, Miss Cecelia
60 Poland Street
Swoyerville, Pennsylvania

Age: 18

Jefferson Hospital JEG 1779 W
May 6, 1953

Referring Physician:

Donald B. Lewis, M.D.
951 Wyoming Avenue
Forty Fort, Pennsylvania

Preoperative Diagnosis:

(1) Interventricular septal defect
(2) Interatrial septal defect
(3) Mitral stenosis?

Operation:

Closure of interatrial septal defect under direct vision with complete maintenance of cardiorespiratory function with heart-lung machine for 26 minutes

Postoperative Diagnosis:

Large interatrial septal defect

Surgeon:

John H. Gibbon, Jr., M.D.

Assistants:

Frank F. Allbritten, M.D.
Bernard J. Miller, M.D.
Thomas F. Nealon, Jr., M.D.

Anesthesia:

Intravenous sodium pentothal with intratracheal tube and manual assistance to ventilation

Suture Material:

Cotton and catgut

Operative Time:

Approximately 5 hours
InterAct
ACPE Distance Education
American College of Physician Executives
Inspiring physician leaders—Improving health
Three Faces of Quality
Dr. Nash’s Mentoring...
Leaders Create More Leaders

- Structure
- Process
- Outcomes
Master of Medical Management (MMM)

Carnegie Mellon University

H. John Heinz III School of Public Policy & Management
Certified Physician Executive (CPE)

The Certifying Commission In Medical Management

Since January 1997 CCMM has approved 1486 Certified Physician Executives (CPE's).

Board Certification in Medical Management
For the physician executive, board certification in medical management can be the key to success in today's competitive health care environment. CPE certification can be a valuable credential that can help you advance your career, enhance your credibility, and attain the satisfaction of reaching a major achievement.

Achieving CPE Status
Certification is awarded based on a candidate's stature as a physician, educational achievements, medical management experience and completion of a four-day skill building Certification Program administered by the CCMM.

At the Certification Program, you will practice management techniques in front of a video camera and you are evaluated on your ability to:

- make a convincing presentation describing your skills and accomplishments to a panel of health care leaders. You will be evaluated equally on your content and your public speaking skills.
- give feedback in your cohort group.
- complete written 'in-basket' exercises, which are cases developed around the nine core courses.

Why CPE?
CPE is the certification of choice. The American College of Physician Executives is promoting the CPE certification to CEO's and physician recruiters.

Sunday Aug. 22
Next
Certification Program
February 20-24, 2011
Tampa, FL
Lehigh Valley Health Network
<table>
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<tr>
<th>Year Range</th>
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<td>1999-2004</td>
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<td>2010-Present</td>
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Lehigh Valley Hospital gets minus in report on heart bypass surgery

Individual surgeons reviewed

A new report attributes a poor death rate from bypass surgery to Lehigh Valley Hospital by placing the hospital's 13 heart surgeons in a group of coronary surgeons with a poor death rate from bypass surgery that ranges from 8.35% to 12.7%, while the average death rate in the United States is 4.9%.

Hospitals Performing Coronary Artery Bypass Graft Surgery
Treatment Effectiveness & Average Charges in 1990

<table>
<thead>
<tr>
<th>Hospital</th>
<th>Total Patients</th>
<th>Patients who died</th>
<th>Average Charge</th>
<th>Death Rate</th>
<th>Risk Adjusted Death Rate</th>
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<tr>
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<td>9,000</td>
<td>3.7%</td>
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</table>

Lehigh Valley Hospital performs the second largest number of heart bypass operations in Pennsylvania, but its death rate is 12.7%, which is not only higher than the national average of 4.9%, but also higher than the death rate of other hospitals in the region.

The report was compiled by the Pennsylvania Health Care Cost Containment Council, which was established in 1990 to study the cost and quality of health care in the state. The council's findings are based on a study of more than 5,000 heart surgery operations performed in Pennsylvania hospitals in 1990.
Opinions differ on study evaluating heart surgeons

By MARGIE PETERSON
Of The Morning Call

Choosing a heart surgeon is not like picking a home mortgage. You can’t put numbers into a computer and expect to come up with best choice.

So claim cardiologists, family doctors and others, who say a study released last week by a state health-care group did a disservice to patients.

By MARGIE PETERSON
Of The Morning Call

If New York’s experience is any guide, we have a lot of surgeons who have had success here but haven’t used the facility in a long time. That’s not something we want.
Coronary Artery Bypass Surgery

- 400,000 procedures per year in U.S.
- Follow-up data on CABG extends 40 years.
- No other intervention has been so regularly and rigorously scrutinized for outcomes and costs
About PHC4

- Independent state agency established in 1986
- Improve quality and restrain costs by publicly releasing data and reports
- Promote competition in health care marketplace
- Council members include state government officials, insurers, purchasers, and providers
Cardiac Surgery Report in PA

- First published 1992
- Initially limited to CABG procedures
- Now includes Valve and Valve-CABG procedures
- Hospital and surgeon specific data
## Hospital Data

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<tr>
<th></th>
<th>Number of Cases</th>
<th>Hospital Data 2008-2009 (Two Years Combined)</th>
<th>2008 Average Medicare Payment</th>
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<td>Readmissions</td>
<td>Post-Surgical Length of Stay</td>
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<tr>
<td>Total Valve</td>
<td>27</td>
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We Report, You Decide…
--the intended results

- Measure quality, ensure accountability
- Educate the public about health care delivery
- Encourage consumers to choose to access high quality providers
- Persuade surgeons and hospitals to improve their outcomes
- Help control costs
If you measure and report...

Measure Only
Care improves...

Measure and Report
Care improves even more!
Ernest Amory Codman, MD

December 30, 1869-November 23, 1940
Ernest Amory Codman, MD

- Advocate of hospital reforms and “outcomes management”
- Kept track of his patients using “end result cards”
- Life-long pursuit to develop an “end results system”
- He believed that all of this information should be made public so patients would have choice of their doctor and hospital
- Started first M&M conferences at Massachusetts General Hospital
- Heavily criticized by his colleagues – the hospital refused his plan to access physician competence and as a result he lost his privileges
- Founded the American College of Surgeons and its “Hospital Standardization Program” (The Joint Commission)
Of 337 patients discharged between 1911-1916, Dr. Codman recorded and published 123 errors.

"We believe it is the duty of every hospital to establish a follow-up system, so that as far as possible the result of every case will be available at all times for investigation by members of the staff, the trustees, or administration, or by other authorized investigators or statisticians."
“So I am called eccentric for saying in public that hospitals, if they wish to be sure of improvement:

- Must find out what their results are…
- Must analyze their results…
- Must compare their results with those of other hospitals…
- Must welcome publicity not only for their successes, but for their errors…

Such opinions will not be eccentric a few years hence.”
Society of Thoracic Surgeons National Database
Health care quality: “the degree to which health services for individuals and populations increase the likelihood of desired health outcomes and are consistent with current professional knowledge.”

Between 44,000 and 98,000 patients die each year as a result of medical errors.
What is Quality?
Crossing the Quality Chasm (2001)

- The Right Care
- At the Right Time
- For the Right Reason

“Quality Care Costs Less”
Nash’s Immutable Principle

High quality care costs less!
Where does the cost-cutting optimism come from?

**Significant observed variation in health care costs.**

Little relationship of costs with outcomes.
Practice Makes Perfect!
PHC4 Data Suggests Higher Volume Surgeons and Hospitals Have Better Outcomes
Higher Volume Hospitals Have Better Outcomes

“Patients undergoing cardiovascular procedures can significantly reduce their risk of operative death by selecting a high volume hospital.”

The New England Journal of Medicine

HOSPITAL VOLUME AND SURGICAL MORTALITY IN THE UNITED STATES

JOHN D. BIRKMEYER, M.D., ANDREA E. SIEWERS, M.P.H., EMILY V.A. FINLAYSON, M.D., THERESA A. STUKEL, PH.D., F. LEE LUCAS, PH.D., IDA BATISTA, B.A., H. GILBERT WELCH, M.D., M.P.H., AND DAVID E. WENNBORG, M.D., M.P.H.
On the other side of the coin...

- By the time the PHC4 data is published, the information is obsolete (2-3 years old)

- The PHC4 data is limited
  - Does not include “complex cases”
  - Does not include “other cases” such as aortic dissection, cardiac trauma, transplants, pediatric, thoracic, etc.
  - Does not distinguish between conventional and less invasive techniques, or other new technologies.

- There is a high standard deviation, resulting in a short, wide Bell Curve – made worse by decreasing volumes
Patients shouldn’t make simple judgments about surgery

To the Editor:

As the newest heart surgeon in the Lehigh Valley, I wish to discuss the recent publication entitled “A Consumer Guide to Coronary Artery Bypass Graft Surgery” published by the Pennsylvania Health Care Cost Containment Council.

The concept that patients should be aware of the quality and cost of health care is clearly an excellent idea that has been long in coming. Furthermore, it is not surprising that cardiac surgery would be the first field of medicine to be evaluated, considering its high profile and expensive technology.

To illustrate, this year approximately 5.5 million people will be diagnosed with coronary artery disease in the United States and 580,000 people will die from their disease. The yearly cost to the health care system to treat this one disease is approximately $8 billion and, when one includes loss of work and disability, the overall impact on the economy is over $50 billion per year to treat coronary artery disease alone.

Although the need for quality assurance in cardiac surgery is immense, this study does not completely achieve this goal. Indeed, the data presented in the Consumer Guide was helpful, but may be misleading to both the hospitals and surgeons who fared well and those who did not.

For example, the study listed mortality rates of patients adjusted for their expected risk of dying. Dr. Farrokh Sadr and Dr. Luke Yip, two of the most experienced heart surgeons in the region, were given a minus for having more deaths than predicted by the study. What the study does not list is how many extremely high-risk patients lived because of Dr. Sadr and Dr. Yip, nor does it list how many of those high-risk patients were transferred from other hospitals, some of which have their own heart surgery programs.

Secondly, the report is limited in its scope. It describes just one procedure that cardiac surgeons perform, leaving out the more complex procedures such as valve surgery, aneurysms, arrhythmia surgery, and chest trauma.

Finally, there is the human factor. Patients understand that a certain number of people will die as a result of cardiac surgery, and anyone reading the newspapers can see that the differences in the numbers between the hospitals and surgeons is not as great as may have been suggested. Perhaps what is more important is how well we care for our patients.

My concern is that good surgeons across the state may turn away high risk patients to avoid unfavorable publicity. Our philosophy at the Lehigh Valley Hospital has always been to operate when requested by the cardiologist and the family, even in those circumstances where the chance of survival was slim, but when surgery was the patient’s only hope.

Yes, we need to evaluate hospitals and doctors. But, let’s not take one set of numbers on one item and judge devoted, talented people who have dedicated their entire lives to helping this community. Last year, after interviewing for positions in cardiac surgery from New England to New Mexico, I chose to begin my career at the Lehigh Valley Hospital because of the extraordinary talent of the surgeons and staff, the variety and complexity of the cases, and the obvious commitment and pride to giving quality care.

Let’s improve the health care system, but let’s not destroy it, or the people that make it work, in the process.

Raymond L. Singer, M.D.
Division of Cardiac Surgery
Lehigh Valley Hospital Center
Allentown
“Although the need for quality assurance in cardiac surgery is immense, this study does not completely achieve this goal... may be misleading to both the hospitals and surgeons who fared well and those who did not.”

“The report is limited in its scope. It describes just one procedure that cardiac surgeons perform, leaving out the more complex procedures such as valve surgery, aneurysms... and chest trauma.”

“My concern is that good surgeons across the state may turn away high risk patients to avoid unfavorable publicity.” –Raymond L. Singer, MD
Unintended Negative Consequences

- Surgeons refusing to operate on high risk patients
- Intentional up-coding to inflate expected mortality (gaming of risk)
- Intentional addition of procedures to high risk cases, shifting case to being not reportable
- Prolonging life in hopelessly ill post-op patients to the end of the reporting period (hospital discharge and/or 30 days)
And… Some Controversial Consequences

- The creation of a quota system – minimal volumes to maintain credentialing
- Low-volume surgeons losing their privileges largely independent of outcomes
- Increased competition for cases, straining collegiality and collaboration
- Increased competition for cases also resulting in new practice relationships, for example… cardiologists hiring their own cardiac surgeons
Denial of Surgical Treatment to High-Risk Patients

62% of surgeons admitted they refused to operate on at least one high-risk CABG patient over the prior year.

45% of surgeons observed to have coded the risk of the patients incorrectly… gaming?
EDITORIAL COMMENT

The Big Chill*

The Deleterious Effects of Public Reporting on Access to Health Care for the Sickest Patients

Zoltan G. Turi, MD, FACC
Camden, New Jersey

Intentionally adding procedures?

Intentionally prolonging life?

Say it isn't so!

REPORT OF THE SOCIETY OF THORACIC SURGEONS

Public Reporting of Cardiac Surgery Performance: Part 1—History, Rationale, Consequences

David M. Shahian, MD, a Fred H. Edwards, MD, b Jeffrey P. Jacobs, MD, c Richard L. Prager, MD, d Sharon-Lise T. Normand, PhD, e Cynthia M. Shewan, PhD, f Sean M. O’Brien, PhD, g Eric D. Peterson, MD, MPH, g and Frederick L. Grover, MD h
Volume Credentialing - Quotas

- ACS 1975 recommendation 200 cases per year
- ACS 1996 recommendation 100-125 per year
- LVHN 75 cases per year – No national standard
- Current national average < 100 case per year
Surgeon dropped by LVH loses appeal

But, the data on volume is not clear...
Pennsylvania Certificate of Need Law for Cardiac Surgery Repealed in 1996

Contemporary Impact of State Certificate-of-Need Regulations for Cardiac Surgery: An Analysis Using the Society of Thoracic Surgeons' National Cardiac Surgery Database
Verdi J. DiSesa, Sean M. O'Brien, Karl F. Welke, Sarah M. Beland, Constance K. Haan, Mary S. Vaughan-Sarrazin and Eric D. Peterson

Certificate of Need and the Quality of Cardiac Surgery
Jamie L. Robinson, MS, David B. Nash, MD, MBA, Elizabeth Moxey, MPH, and John P. O'Connor, PhD
...from centers of excellence to centers of mediocrity?

New surgery programs are cutting into established ones. Quality of care is at issue.

**Competition is at the heart of a struggle**

By Karl Stark
INQUIRER STAFF WRITER

Consider the following scorecard: Doctors at Abington Memorial Hospital performed 422 open-heart surgeries in their first 18 months in business.

Surgeons at Lower Bucks Hospital, in another new surgery program, did 104 open-heart operations in its first eight months.

Turn to the established heart program at Temple University Hospital, and the number of open-heart surgeries is falling by 27 percent in fiscal 1998, which ends June 30. Temple will perform 469 open-heart surgeries this fiscal year if trends continue — down from 645 in 1997.

Temple's decline is less severe than it might seem, because it is Temple doctors who are performing the open-heart surgeries at Abington and Lower Bucks. But the shift is evidence of a wider trend. Many of the region's premier heart units are reporting declines. New competitors are taking open-heart business they once sent to established providers. And the proliferation of open-heart surgery is occurring as both managed care and new technology are likely to reduce the number of such operations altogether.

In short, the number of suppliers is climbing when open-heart operations, which include bypass surgery, are expected to decline.

Many experts fear the trend could jeopardize quality. They cite research showing that lower volume is closely linked to higher mortality at a given facility.

"We are really putting people's lives at risk," said Michael Zeik, a former senior health-care consultant for S.R. Wojdak Associates, a lobbying firm. "I think we're heading for lower-quality care."

This throbbing heart competition dates from December 1996, when Pennsylvania's legislature declined to renew regulations that had stopped hospitals from starting open-heart units and other facilities unless a community need could be clearly shown. In the Philadelphia area, new approvals were usually impossible, because 13 hospitals already offered open-heart treatment.

Data from 1994 showed that Pennsylvania already had one of the nation's highest levels of open-heart programs per capita. Pennsylvania's rate of programs per million residents was 3.9 in 1994 — more than double the 1.8 rates of neighboring New Jersey and New York.

Still, executives at many community hospitals, See HEART SURGERY on D6
CABG procedures shifting to lower-volume hospitals

Declining CAB Volumes

EXHIBIT 1
Annual Number Of Coronary Artery Bypass Graft (CABG) Procedures And Number Of Hospitals Performing CABG In The United States, 1992–2003

Thousands of procedures

190
180
170
160
150

1,050
1,000
950
900
850

Number of hospitals

Hospitals

Procedures


Health Tracking

TRENDS

U.S. Trends In CABG Hospital Volume: The Effect Of Adding Cardiac Surgery Programs

Opening specialty cardiac hospitals can reduce the overall volume of procedures performed and thus affect the quality of cardiac care.

by Chad T. Wilson, Elliott S. Fisher, H. Gilbert Welch, Andrea E. Siewers, and F. Lee Lucas

More Hospitals Marketing Comprehensive Cardiac Care
Controversial response to competition... ...cardiologists hiring cardiac surgeons

**Ethical and Legal Concerns in Relationships With Cardiologists**

Richard G. Sanderson, MD
Chairman, Standards and Ethics Committee, The Society of Thoracic Surgeons

During the past year, the Standards and Ethics Committee has received a variety of pertinent and thought-provoking communications from STS members about ethical concerns regarding their relationships with referring cardiologists. This editorial reflects the committee’s deliberations on these issues.

The most common concern is the invitation by a large group of cardiologists for one or more cardiac surgeons to join their practice, many times under the expressed or implied threat of withholding surgical referrals if the invitation is not accepted. Thoughtful members asked a number of questions related to the conflict of interest raised by this practice: Is retaining and distributing a portion of the surgeons’ fees to the associate cardiologists the equivalent of fee splitting? Is trading the security of a referral base for negotiated compensation ethically acceptable? Does the employment arrangement cause surgeons to lose their perspective as practitioners and patient advocates? Does the arrangement adversely affect the surgeon’s decision-making process?

practitioners. However, because referral of cardiac surgical patients is almost exclusively from cardiologists, and often from only a small number of them, cardiac surgeons are more vulnerable than other surgical specialists. Further, inasmuch as these two subspecialties offer competing “revascularization services,” the interrelationships may be unusually sensitive.

**Ethical Concerns**

Patients are uniquely vulnerable in medical matters, not only because of the illness itself but also because of their relative lack of knowledge, particularly in high-risk, complex situations such as cardiac surgery. Physicians thereby assume obligations to serve as moral fiduciaries, above all protecting and promoting the patients’ best interests. These obligations are of paramount importance in the relationships between cardiac surgeons and cardiologists.

A scholarly discussion of conflicts of interest...
All told, 20 years of stress...

- PHC4 public reporting of CABG outcomes
- Establishment of a quota system and minimal volumes for maintaining privileges
- The elimination of the Certificate of Need (CON) in Pennsylvania
- Continued steep cuts in reimbursement
- Development of more and more catheter-based procedures with loss of territory—technology turf wars over stents, pacemakers, now valve surgery
Cardiothoracic Surgery Residency Positions Go Unfilled in Recent Match

The recent news that approximately one third of the residency slots for cardiothoracic surgeons went unfilled for 2007, coupled with a large number of retirements planned in the upcoming decade, may combine to create a future shortage of cardiothoracic surgeons.
What’s in store for my next 20 years...

OPINION

ANOTHER VIEW

As baby boomers hit 60, health-care costs escalate

When we were young, birthdays were a lot more exciting. For example, my daughters will begin planning next year’s birthday party about two hours after their friends go home from this year’s event. It’s funny how birthdays get less exciting as we get older. I’m embarrassed to admit that I was depressed on my 30th birthday because I thought I was getting old. What I would give to be 30 again! My next “big” birthday is two years from now when I turn 50, and I’m already in a middle-aged crisis.

This January, though, marks one of the most significant birthdays in our nation’s history as the first of 78 million baby boomers turn 60. No doubt, we’re about to see a slew of surprise parties and very melancholy baby boomers. But will all turn 60 this year.

The real impact of so many people reaching senior status, however, is not a rush on red Corvettes and yellow Porschches. Instead, we are seeing a major impact on our economy, most notably a stress on health care unlike anything seen in modern times.

Let me throw some daunting numbers at you. Health-care spending in the United States has grown rapidly during the lifetime of the boomers. From $277 billion in 1980, it grew to $1.4 trillion in 2001. National health-care expenditures are projected to reach $3.3 trillion in 2012, growing at a rate of 7.3 percent, roughly 2.2 percentage points faster than the Gross Domestic Product (GDP). As a percentage of GDP, health-care spending is projected to reach 17.5 percent by 2012, up from 14.1 percent currently. By comparison, health-care spending in Canada is 9.6 percent of GDP, 7.8 percent in Japan and 7.7 percent in England.

In practical terms, baby boomers are having three significant impacts on health care. The first, of course, is the simple fact that there will be 78 million of them reaching an age when they will need both acute and long-term health facilities. The second impact is that this generation already demands and utilizes medical care more than any previous generation. Finally, baby boomers are going to live longer. The longer you live, the more likely you are going to need further medical care.

For example, when I was training to be a heart surgeon in the 1980s, it was uncommon to perform open-heart surgery on any patient over the age of 60. Now, a significant part of my practice includes octogenarians. Recently, I performed a combined aortic valve and bypass operation on an 88-year-old woman. Despite her advanced age, she was extremely independent and wanted the life-saving surgery. She was discharged to home five days after the surgery and has resumed her normal active life-style.

With increasing health-care demands by the baby boomers, it seems likely there will also be a physician shortage, particularly in specialty care. Indeed, the Association of American Medical Colleges (AAMC) published a position statement in 2005 predicting a national shortage of doctors in the near future. In fact, the AAMC went on to recommend a 15 percent increase in the number of medical school graduates by 2015. Nurses are already in great demand, so along with physicians, this gap will only widen as the baby boomers age.

Predicting the future, of course, is not always easy. A year ago, most of us would have predicted the Philadelphia Eagles to return to and win the Super Bowl. The same unknowns occur in health care. For example, as medicine improves and technologies become more advanced, it may come to pass that fewer physicians actually are needed. Who knows? Perhaps we will see a day when a doctor simply takes out a hand-held device like the one used by Star Trek’s Dr. McCoy, to diagnose and treat practically everything.

Until then, my advice to fellow baby boomers is to take your vitamins, exercise daily, and be grateful we live in a community surrounded by premier, and yes, successful health-care facilities that are preparing for the future—whatever it may be.

Raymond L. Singer, M.D., is associate emeritus, Division of Cardiothoracic Surgery, at Lehigh Valley Hospital and Health Network. He lives in South Whitehall Township.
Patient Protection and Affordable Care Act (PPACA)  
March 23, 2010
Supreme Court to Rule on PPACA
June 2012 (this month!)

Supreme Test for Health Law
High Court Agrees to Landmark Review of Federal Powers; Ruling Due Amid Election

BY JESS BRAVIN

The Supreme Court agreed Monday to review President Barack Obama’s health-care overhaul, in a landmark case that could define not only Mr. Obama’s presidency but the scope of federal power well into the 21st century.

The case is likely to be heard in March, and reflecting its significance, the court ordered an extraordinary 5½ hours of argument, compared with the 60 minutes typically allotted. A ruling is expected by June 30, in the midst of a presidential election campaign where perceptions of the Patient Protection and Affordable Care Act, Mr. Obama’s signature legislative achievement, could be pivotal.

The justices ordered arguments on several contested provisions of the health law, but the flashpoint is its requirement that most Americans carry health insurance or pay a penalty along with their income taxes.

The individual mandate has emerged as the new crucible of states’ rights, with the principal case pitting 26 Republican state attorneys general and governors against the administration. Both sides previewed their 2012 campaign arguments over the law Monday.

Republicans have pledged to repeal the law if they win the 2012 election. Senate Minority Leader Mitch McConnell of Kentucky said in a statement that Congress should repeal the law “as a matter of priority” after the election.

Democrats have vowed to defend the law in court. And President Obama’s administration says it has already expanded coverage to more than a million young people whom the law allows to stay on their parents’ plans until they are 26 years old.

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Aligning Payment with Quality
If you measure, report, and get paid…
(or not)

Pay for Performance:
The Train Has Left The Station

The Chicago Chop House is one of my favorite restaurants. During one trip to the American College of Surgeons Meeting held in Chicago, I ate dinner at the famous steak eatery four nights in a row! On the fourth night, the maître d’ gave me the honor of sitting by myself at the mayor’s table with a private phone. I was in my glory— and I have the photograph to prove it!

I’ve never had a bad meal at the Chicago Chop House. That’s a good thing because it’s good or bad care, whether there is a good outcome or not, or even when a mistake is made. If a surgeon leaves a sponge in a patient requiring a second hospitalization and return to the operating room, the hospital readmission, as well as the repeat procedure and O.R. costs, historically have been billable — that is, until now.

Starting in October 2008, Medicare will stop paying hospitals for infections or injuries that occur in the hospital. Under new rules published this past August, Medicare soon will stop payment for at least eight conditions, including common hospital-acquired infections, blatant surgical errors, and injuries that result from a fall.

Pennsylvania’s Medicaid program also plans to adopt similar rules and may expand them to other preventable conditions. The National Quality Forum, a non-profit organization that focuses on the quality of health care, has identified 27 events that should never happen, ranging from wrong-site surgery to serious medication errors. Governor Rendell included plans for Medicaid to stop reimbursing medical mistakes as part of his “Prescription for Pennsylvania” program that he announced in January.
Value-Based Purchasing 2014-2017 & Beyond
(Begins 7/1/12-6/30/13)

- **Mortality Measures**
  - Acute Myocardial Infarction (AMI) 30-day mortality
  - Heart Failure (HF) 30-day mortality
  - Pneumonia (PN) 30-day mortality

- **AHRQ PSI and IQI Composite Measures**
  - Complication/patient safety for selected indicators (composite)
  - Mortality for selected medical conditions (composite)

- **Health Care-Acquired Condition (HAC) Measures**
  - Foreign Object Retained After Surgery
  - Air Embolism
  - Blood Incompatibility
  - Pressure Ulcer Stages III & IV
  - Falls and Trauma (includes fracture, dislocation, intracranial injury, crushing injury, burn, electric shock)
  - CLABSI
  - CAUTI
  - Manifestations of Poor Glycemic Control

- **Readmissions**
**Scope of LVHN Surgery Quality Initiatives & Public Reports**

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<td>Peri-Operative Antibiotic Collaborative Group</td>
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*Surgery Quality Council Lehigh Valley Health Network March 2013*
Do patients read any of these reports?
In Summary

- Heart surgeons in Pennsylvania have 20 years of experience measuring and reporting outcomes.
- The intended and unintended consequences are real and need to be understood by all stakeholders.
- CMS & private payors are scrutinizing more and more data and developing even more complex P4P programs.
- Patients are slowly becoming more aware of performance reports amid challenges and limitations.
- Public reporting is here to stay and the Internet will increasingly become an important resource to patients.
- And thus ... my own web site: www.heartlungdoc.com.
“Medicine is not all science!”
One thing is for sure...
Report Cards are Here to Stay!
Valley hospitals get high marks for safety

Lehigh Valley Health Network earns an A in national hospital safety evaluation.

BY MILTON D. CARRERO
Of The Morning Call

Lehigh Valley hospitals received their report cards Wednesday when a group that evaluates health care quality and safety published the results of its most recent survey.

The largest local health networks earned better grades than many of Philadelphia’s leading hospitals. Lehigh Valley Health Network earned an A for its Cedar Crest and Muhlenberg campuses, according to the Leapfrog Group's report card.

LOCAL HOSPITALS’ REPORT CARD

The Leapfrog Group, which evaluates hospitals nationwide based on efficiency, quality and safety released its report card Wednesday. Here are the grades for the main local hospitals:

- Lehigh Valley Hospital - Cedar Crest
  - Grade: A

- Lehigh Valley Hospital - Muhlenberg
  - Grade: A

- St. Luke’s University Hospital - Fountain Hill
  - Grade: B

- Sacred Heart Hospital
  - Grade: C

- Easton Hospital
  - Grade: C
Questions?

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Please fill out your evaluation

Thank You!
For more discussion on this topic and other cutting-edge health care issues, visit the Nash on Health Policy blog at:
http://nashhealthpolicy.blogspot.com

Did you know you can listen to past Health Policy Forums online? Check out Health Policy Forum Podcasts at:
http://jdc.jefferson.edu/hpforum/