



Safe, Reliable Health Care Systems: Will Health Reform Legislation Help Get Us There?

Little-discussed provisions of the health reform legislation have the potential to make health care safer

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Throughout the lengthy debate over health insurance expansions and new regulations in recently passed health care reform legislation, relatively little attention has been paid to the parts of the law that seek to [strengthen the delivery system](#). In fact, several of these less-noted provisions could help build safer, more reliable health care systems—by promoting transparency and performance reporting, encouraging organized care, reforming the malpractice system, and supporting research on evidence-based care.

Federal leadership on these issues is urgently needed. More than 10 years after the publication of *To Err Is Human*—in which the Institute of Medicine declared medical errors a health care emergency with more deadly consequences than car accidents and breast cancer—we still have far to go ensure safe care. Each year, millions of Americans are sickened or injured by medication errors, and an estimated 98,000 are killed. A [recent series](#) on radiation therapy accidents in the *New York Times* makes clear that technology alone won't save us: as care becomes more complex and automated, the

potential for serious and fatal errors remains, and in some cases amplifies.

The good news is that there's a growing portfolio of proven practices to make care safer. In one well-known success story, a group of 90 Michigan hospitals [has been able to achieve](#) dramatically lower rates of bloodstream infections three years after adopting a checklist to ensure providers follow steps to prevent these infections—from a mean of 7.7 infections and median of 2.7 at baseline to a mean of 1.1 and median of zero infections. In spite of such best practices, however, bloodstream infections remain a widespread problem across the nation, with infection rates varying significantly among U.S. hospitals. The recently published [National Healthcare Quality Report](#) found that rates of three types of health care-associated infections are actually increasing, and there has been no change in the rate of central line infections.

The health reform law uses both carrots and sticks to help build a system of reliable care for every patient, every time.

Transparency and Performance Reporting

The new legislation demands greater transparency and public reporting on hospitals' performance—which safety expert Lucian Leape [sees as crucial](#) to motivate providers to do what we know works to make care safer. Later this year, the Centers for Medicare and Medicaid Services (CMS) will begin reporting rates of medical errors and selected hospital-acquired conditions on its Web site, Hospital Compare (www.hospitalcompare.hhs.gov). Starting in 2011, federal

payments for Medicaid services related to hospital-acquired conditions will be prohibited. Beginning in 2015, hospitals that land in the quartile with the highest rates of these hospital-acquired conditions will have their Medicare payments reduced by 1 percent.

For several years, U.S. hospitals have been receiving increased Medicare payments when they voluntarily report how often they deliver evidence-based care for heart attacks, heart failure, pneumonia, and surgical infection prevention. The new reform law will reward providers not just for reporting, but for achieving, benchmark levels of performance on these care standards, to be set by the Secretary of Health and Human Services (HHS). Starting in October 2012, hospitals that meet or exceed the designated performance standards will receive enhanced Medicare payments, taken from a pool of money collected from all hospitals. These process-of-care measures were designed to be achievable—the ultimate goal for all hospitals should be 100 percent performance.

The reform legislation also targets hospital readmissions, which in many cases are triggered by conditions that might have been avoided with proper discharge planning and follow-up care. Medicare payments will be reduced for potentially preventable readmissions for certain eligible conditions or procedures, as determined by the HHS secretary, that are high volume or high expenditure.

It also will require health plans that operate through the new health insurance exchanges to report on their quality improvement activities, including their efforts to prevent hospital readmissions through a comprehensive program for hospital discharge. Hospitals that have high readmission rates will be required to work with patient safety organizations. By 2015, health plans operating in the exchanges will be allowed to enter into contracts with hospitals with fewer than 50 beds only if the hospitals use a patient safety evaluation system and have implemented a comprehensive program for hospital discharge.

In addition, physicians who report quality measures to CMS through a qualified Maintenance of Certification program will be eligible for 0.5 percent Medicare bonus payments. HHS will develop a “Physician Compare” Web site, similar

to its Hospital Compare site, where users can compare physicians on measures of quality and patient experiences.

The law also provides resources for the development and advancement of quality measures. This is sorely needed; current measures are inadequate and many providers are skeptical of their validity and usefulness in improving care. Particular attention should be paid to creating standard patient safety measures and protocols for reporting adverse events.

Organized Care Systems

Many medical errors are rooted in poor care transitions or flawed communications. The reform legislation has the potential to improve safety by fostering greater collaboration and teamwork among providers. It promotes the development and implementation of Medicare pilots that encourage team-based approaches to health care, including “accountable care organizations” (ACOs) comprising local health care providers such as physicians and the hospitals in which they work. ACO participants would have to agree to and show they can take responsibility for the full continuum of care for their patients—and for the quality, treatment outcomes, and costs of that care. They would coordinate care for their shared Medicare patients with the goal of meeting and improving on benchmark levels of performance. The legislation also establishes a demonstration project to allow pediatric providers to organize as ACOs and gain a share in federal and state cost-savings generated under Medicaid.

A typical Medicare ACO would be an organizational entity encompassing one or more hospitals, primary care physicians, and specialists. Under the shared savings provision of the legislation, each of the ACO provider organizations would be able to receive a share of the savings their services generate, relative to a predetermined cost target.

For example, consider a patient with heart failure who is admitted to the hospital for hip surgery. While hospitalized, he stops taking his heart failure medications and, once discharged, fails to resume taking them and winds up back in the hospital two weeks later in pulmonary edema. Had medication reconciliation been performed

at discharge, or transition planning and patient education handled properly, this readmission might have been avoided. Today, not only would payment cover the cost of the rehospitalization but there would be no incentive for putting in place systems to reduce this possibility. In an ACO operating under a shared savings model, providers would have an incentive to deliver care that could avoid the readmission (because they would share in the resulting savings), and they also would have the organizational capacity to provide it.

Malpractice Reform

The new law encourages reform of our current system of medical malpractice. Grants totaling \$50 million will be awarded to states to develop alternatives to the tort system that emphasize patient safety, disclosure of errors, and early resolution of disputes.

The Commonwealth Fund's Commission on a High Performance Health System [has advocated](#) "enterprise liability" as an approach to malpractice reform. Under this approach, hospitals or other health care organizations accept responsibility for the actions of their clinical staff; liability thus becomes the responsibility of the "enterprise," rather than individual physicians. Health care organizations would have an even greater incentive to ensure that clinical staff practice according to the best clinical guidelines and work collaboratively to reduce harm to patients. They also would have an incentive to put in place safeguards, such as ones that facilitate medication reconciliation, to reduce the possibility of harm to patients. Other examples would be organizations' having risk management programs that train physicians in safe practices, require internal reporting of errors and close calls, and not only perform root cause analyses of these events but develop and implement action plans to reduce the risk of similar events in the future.

The goal of any alternative model of tort litigation should be to create a fair and reliable system of justice that ensures transparency. The best tort reform would eventually reduce the need for litigation by helping to pinpoint systemic risks and prevent medical errors in the first place.

Evidence-Based Care

The health reform legislation creates a private, nonprofit Patient-Centered Outcomes Research Institute to conduct comparative clinical effectiveness research. Such a center could help employers, hospitals, and public health programs "spend smarter" on health care. Comparative effectiveness evaluations would focus on the medical benefits and risks of various options, and make this information available to both providers and patients.

Safety is a cost issue, too. Comparative effectiveness research could improve patient safety by furthering research into the most reliable and effective clinical processes, which in turn could reduce treatment complications and hospitalizations and lower spending on unnecessary or inappropriate care.

Moving Forward

Through these and other approaches, the reform legislation provides federal muscle and investment to improve patient safety. In addition, the 2009 stimulus act is providing \$19 billion in incentive payments to encourage providers to make "meaningful use" of health information technology. This could enhance patient safety by encouraging providers to use decision support tools, automated reminders and alerts, and other safety protocols. Much more is needed, from training providers to work in teams, to making sure that hospital Board members and executives make safety and quality part of their job description, to including patients as informed partners in care.

And, of course, the most important work needs to take place on the front lines of care. Studies of 10 health care organizations that have made significant strides in [improving patient safety](#) point to a common factor: all of the organizations sought to create a culture of safety to promote and sustain continuous innovation and improvement.

Organizations also need to move beyond blaming individuals and take responsibility for creating safe systems and reliable processes of care. Lucian Leape puts it this way: "We don't want to hold people accountable for hurting people, we want to hold them accountable for *not* hurting people."