American Hospital Association

HOSPITALS AND HEALTH REFORM

As your national representative, the AHA is working on two fronts to ensure that the needs of your hospital and community are reflected in the debate over health care reform. They are:

Policy Initiatives that will be crafted through legislation and regulation; and
Field Leadership that will demonstrate improvements that can be made without legislation.

All of our efforts are being informed and guided by the essential elements of the AHA's framework for reform, *Health for Life: Better Health. Better Health Care.*

(See www.aha.org for more on *Health for Life*.)

POLICY INITIATIVES

EXPANDING HEALTH CARE COVERAGE

Health coverage for all, paid for by all is an essential element of reform. Expanding coverage also is key to cost control, as health care costs are higher when patients do not receive care at the right time or in the right setting. Providing coverage to all will help mitigate the "cost shift" that moves the financial burden of non-coverage from public to private payers.

Shared Responsibility

The AHA supports balancing a mandate for individuals to obtain coverage with a strong requirement that employers continue to participate in the provision of health care coverage for their employees. To ensure that an individual coverage mandate is meaningful, it is important that insurance market reforms are not only thorough but also implemented rapidly. And because employers have served as the backbone of our health care insurance system – providing health insurance to U.S. workers and their families for more than half a century – one of the overall goals in moving toward expanded coverage should be to support their continued role. Employers who do not participate in providing coverage should be assessed a penalty, which would be used to support the programs through which their employees obtain health care coverage.

The AHA strongly supports subsidies for low-income individuals and families to purchase affordable and meaningful private health coverage. We support the option to make the premium subsidy/tax credit refundable and advanceable. And we support tax credits for small businesses, and tying the credits to the size of the firm with respect to the number of employees and average wages.

The Public Plan Option

A national health insurance exchange could organize the insurance market to be a useful medium in providing coverage for those who don't receive it through their employer or qualify for public programs. The AHA has serious concerns, however, about establishing a new public plan that could exacerbate the underpayment of providers by paying rates at Medicare or Medicaid levels. The Medicare Payment Advisory Commission (MedPAC) projects that hospitals will have a *negative* 6.9 percent Medicare margin in 2009 – down from a *positive* 6.2 percent Medicare margin in 1999 – the lowest level in more than a decade. Hospitals also experience severe payment shortfalls when treating Medicaid patients; on a national level, the Medicaid payment shortfall amounted to $10.4 billion in 2007. These underpayments affect families as well. A recent AHA study by Milliman, Inc., found that annual health care spending for an average family of four is $1,788 higher than it would be if Medicare, Medicaid and private employers paid hospitals and physicians similar rates, with total provider reimbursement unchanged. The scope of such a plan should be limited to the uninsured, the self-employed and small businesses.

Medicaid

The AHA supports expanding Medicaid eligibility with federal financing for the new populations covered through expanding eligibility for children, parents and pregnant women up to 150 percent of the federal poverty level. It is important also to include provider payment protections as Medicaid expands. The AHA also supports a permanent process that, in times of economic downturn, provides states temporary increases in the Federal Medical Assistance Percentage (FMAP) to help support their Medicaid programs.

Through maintenance of effort criteria, states should be required to maintain their current levels of eligibility and enrollment, benefits and provider payment rates. Any FMAP increase should apply to Disproportionate Share Hospital (DSH) payments, with a corresponding increase in DSH allotments to accommodate the enhanced federal match. These reforms are critical because, in times of economic turmoil, states typically target their Medicaid programs in a search for savings through provider payment freezes or reductions, as well as benefits and eligibility changes.

Section 1011 Extension

The AHA will work to reauthorize this program, which provides assistance to hospitals that serve high volumes of undocumented immigrants in their emergency departments. It expired in September 2008.

DELIVERY SYSTEM REFORM

Hospital leaders recognize that delivery system changes are needed. Current payment systems are based on volume when they should be based on incentivizing care coordination, quality and efficiency. A broad spectrum of ideas can improve care delivery and save money.
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Removing Barriers to Clinical Integration

The ability of physicians and hospitals to work together and clinically integrate is an important element of delivery system reform, so it is critical that current legal and regulatory barriers to care coordination be removed or modernized. In addition to antitrust laws, four federal statutes have a significant impact on hospitals' ability to form financial relationships with physicians: the *Ethics in Patient Referrals Act*, also known as the "Stark" law; the anti-kickback statute; the Civil Money Penalty (CMP) law; and the tax-exemption provisions of the Internal Revenue Code. Existing regulations also can inhibit care coordination and would need to be reformed or withdrawn as delivery system changes occur.

For example, the inpatient rehabilitation facility "60% Rule," long-term care hospital "25% Rule" and the skilled nursing facility "3-day Inpatient Stay Rule" would hamper care management and should be rescinded under the bundled payment system cited below. Also, state laws prohibiting the corporate practice of medicine should be reevaluated to assess their impact on the ability of providers to collaborate.

Value-based Purchasing

Rather than cutting payments and using penalties, we strongly believe that value-based purchasing should be implemented in a budget-neutral manner, and that both high-performing and improving hospitals should be eligible to receive bonus payments as a reward for their achievements. We also recommend that no more than 1 percent of hospital payment be set aside and used to reward performance, and that measures used to assess achievements be developed through an open, transparent and consensus-based process using only National Quality Forum-endorsed and Hospital Quality Alliance-approved measures.

Bundled Payment

The AHA strongly recommends careful design and testing of any bundling provision prior to widespread implementation. Bundling Medicare payments may be a way to encourage the delivery of efficient and effective care, but this is an extremely complex issue. An incremental approach that tests different models of bundling is critical, and hospitals should be allowed to participate in bundling demonstrations on a voluntary basis. Various approaches should be allowed and tested – such as hospital-physician, hospital-physician-post acute care, and post-acute care-only bundling. And because physicians are critical players in the delivery of health care services, they must be included in the bundle to ensure incentives are aligned to achieve better care coordination, quality and efficiency.

Readmissions

Public policies seeking to reduce readmissions should focus exclusively on certain types of unplanned readmissions that are related to the initial admission for which there are evidence-based approaches or actions that hospitals can take to prevent the occurrence of the readmission.

Readmissions planned as part of the recommended course of treatment or unrelated to the *(American Hospital Association 3)* original admission should be excluded. Readmissions that can be reasonably "paired" with an initial admission would be a good place to start, such as an orthopedic surgery followed by readmission for a blood clotting disorder.

Incorporating measures of quality into the readmissions policy such that only hospitals with both high readmission rates and low quality performance scores are penalized should be considered; this would allow high-performing hospitals with outstanding quality not to be penalized for treating complex patients who might have higher rates of readmission. Certain conditions, identified as preventable using currently available administrative data, should be excluded, including cancer, burn and trauma care, scheduled surgeries, psychoses, maternity and neonatal, and end-stage renal disease. In addition, hospital payments should be reduced only *after* a readmission occurs, and a seven-day timeframe, rather than the 30-day timeframe suggested by some policy analysts, is more appropriate for a readmission policy that affects hospital payment.

Congress should require that the Centers for Medicare & Medicaid Services (CMS) release patient-identifiable claims data to hospitals and others, in an appropriate manner, so they can duplicate the hospital readmission rates calculated by CMS. This is critical to ensuring that the readmissions policy is fully transparent.

Comparative Effectiveness

Medical innovation improves health outcomes but can contribute to rising costs. More than 50 percent of the growth in per capita health spending can be accounted for by medical technology, but those involved in health care decisions have little information about what treatments are most effective. Evaluating the risks and benefits of current and new technologies, medicines, practices and procedures and making this information readily available can improve treatment decisions. When this information includes the cost of these innovations, it can be used to help increase the value of every dollar spent. Specific actions include creating centers whose responsibility is to assess the relative risk, benefit and cost of diagnostic and treatment options and making comparative effectiveness information available on a public Web site in a way easily understood by clinicians, purchasers and patients.

Administrative Simplification

The AHA recommends that Congress require the adoption of a standardized framework and terminology within which all health plans (whether subject to federal and state or just federal regulation) would be required to describe their plans, the benefits covered, the conditions for coverage, and the cost-sharing required, including any differences related to the use of in-network or out-of-network providers. Such a requirement would allow plans to continue to develop customized plans for different purchasers, as long as their descriptive information adheres to the standard framework and terminology so consumers can more easily compare health plans and better understand their coverage and its limitations.

AHA supports other streamlined and simplified eligibility and coverage determination processes. For example, health plans should provide enrollees and providers with a means to predict with

(American Hospital Association 4) some certainty what a patient's out-of-pocket costs will be for specific planned care. Health plans are moving toward cost-sharing approaches that are based on a percentage of what the plan will pay a provider for the care provided – referred to as coinsurance.

This makes it impossible for an enrollee to know their out-of-pocket liability before deciding to proceed with the care, and for providers to respond to patient questions or collect nominal cost-sharing amounts at the time of service. Health plans should adopt cost sharing based on specific copayment amounts; when cost sharing is based on a percentage of what the plan will pay the provider, plans should provide access to a Web-based portal or other real-time means of determining cost sharing for specific services, or they should assume responsibility for collecting cost sharing from the enrollee and pay the provider the full amount when the claim is submitted.

Hospitals also recommend expanding the scope of the administrative simplification provisions of the *Health Insurance Portability and Accountability Act* (HIPAA) to include greater standardization of claims transactions and adopt routine business practices associated with claims submission, processing and adjudication.

In addition, we recommend that the collection and reporting of clinical information for quality measures be standardized under the Hospital Quality Alliance, using measures approved by the National Quality Forum. The ever-increasing burden to collect, analyze and submit vast amounts of patient care data associated with quality and patient safety, along with the lack of consistency in public and private payer requirements, has made it more difficult for providers to spend their time treating patients. All payers should adhere to common definitions for data elements and standard practices around data collection, submission and frequency of reporting.

Health Plan Consolidation

Some health care reform proposals hinge upon competition among plans. The AHA has urged the Department of Justice to take a more aggressive role in understanding how health plan market power and consolidation harm hospitals and other providers, because numerous health plan mergers during the past decade have created a highly concentrated industry. Public hearings should be held to explain why health plans are consolidating in most markets around the country, how they affect consumers and providers, and how they may affect reform initiatives.

Information Technology

The AHA will continue to work to expand eligibility for health information technology (IT) funding and to push for flexibility in the definition of "meaningful use" over time. Electronic health records (EHRs) and other forms of health IT provide clinicians with important patient information and clinical decision-support tools they need to provide safe, high-quality care. A recent AHA survey shows that hospitals are making progress toward IT adoption, but the field still faces many hurdles to achieving the national goal of an EHR for every patient.

The American Recovery and Reinvestment Act provides $19 billion in IT funding, including more than $17 billion in incentive payments to encourage hospitals and doctors to adopt EHRs, to acute-

care prospective payment system (PPS) hospitals (subsection (d) hospitals) and CAHs. *(American Hospital Association 5)*

Hospitals in Puerto Rico should also be eligible for these incentive payments. But the measure also carries penalties in the form of Medicare payment reductions if providers fail to demonstrate they are "meaningful users" and adopt EHRs by certain target dates.

A Better Alternative to Today's Liability System

Hospitals and physicians face skyrocketing costs for professional liability insurance. Unaffordable insurance is affecting access to care as physicians leave states with high insurance costs or stop providing services that expose them to higher risks of lawsuits. Particular areas of concern include obstetrics, neurosurgery and emergency services. In addition to the rising costs of insurance, physicians also practice "defensive medicine" – providing extra care to minimize the risk of lawsuits. Estimates place the national cost of defensive medicine at between $50 billion and $100 billion per year.

The AHA asks Congress to consider including liability system reforms in the context of health care reform. We continue to support traditional medical liability reforms – including capping economic damages at $250,000, limiting punitive damages to the greater of two times economic damages or $250,000, reforming rules to ensure each party is only liable for their share of damages, and allowing periodic payments.

We also recommend that the following specific actions be taken to lower the costs of professional liability insurance and defensive medicine: using administrative compensation systems and health courts to determine when an avoidable, preventable event has occurred; providing prompt compensation to injured patients and families based on agreed-upon payment schedules when an error takes place; and adjusting provider's liability insurance premiums based on the occurrence of preventable errors.

Physician Workforce: GME

The AHA recognizes that, as more Americans receive coverage under reform, there will be a greater need for primary care services. The AHA supports *The Resident Physician Shortage Act of 2009 (S. 973)*, introduced by Sens. Bill Nelson (D-FL), Harry Reid (D-NV) and Charles Schumer (D-NY), which recommends increasing the number of Medicare-supported training positions for medical residents by 15,000 slots.

The bill would redistribute unused Graduate Medical Education (GME) slots to encourage training in and increase access to primary care and general surgery. Additionally, the measure prevents the loss of residency slots if a hospital closes, by redistributing them to nearby hospitals. It also expands hospitals' flexibility in training residents in clinical, non-hospital settings such as community health centers, freestanding clinics and physician offices. Similar legislation *(H.R. 2251)* was introduced in the House by Rep. Joseph Crowley (D-NY).

Physician Payment

The AHA supports a permanent fix to the Sustainable Growth Rate (SGR) under the physician fee schedule. The repeated threat of cuts puts physicians in a difficult position. However, such a fix should not be accomplished by cutting reimbursement to other providers.
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Physician Self-referral

The AHA supports a ban on physician self-referral to limited-service hospitals, with limited exceptions for existing facilities that meet strict investment and disclosure rules. We support a congressional proposal that the current "whole hospital" and rural exceptions be repealed under the *Ethics in Patient Referrals Act*, better known as the "Stark" law, and be replaced by an exception for physician-owned hospitals with a Medicare provider number as of July 1, 2009. These hospitals would be "grandfathered" and allowed to continue to self-refer, subject to certain conditions. The proliferation of physician ownership of hospitals is stimulated by opportunities for physicians to earn additional income and gain greater control over their operating environment, but the effect on health care delivery and costs to communities can be devastating.

FINANCING HEALTH CARE REFORM

The AHA supports a fair and balanced approach to the financing of health care reform that considers revenue-raising options such as modifying the exclusions for employer-provided health coverage, imposing tax incentives on lifestyle-related choices, and other non-health related revenue options. Efforts to address affordability must consider the value of the economic, social and medical contributions of health care alongside the costs.

Hospital Update Factor

The AHA strongly opposes the severe hospital Medicare and Medicaid payment cuts that the White House has proposed to help fund reform. The proposal, which includes cuts to hospitals that treat large numbers of the uninsured and under insured, as well as cuts to inflation updates, is misguided, and ignores that the Medicare program already underfunds hospitals. The Medicare Payment Advisory Commission (MedPAC) projects that hospitals will have a *negative* 6.9 percent Medicare margin in 2009 – down from a *positive* 6.2 percent Medicare margin in 1999 – the lowest level in more than a decade.

According to AHA annual survey data, a staggering 58 percent, or 2,840 hospitals, lost money serving Medicare patients in 2007. Hospitals cannot withstand additional reductions to Medicare rates. In addition, consideration should be given to improving Medicare and Medicaid payments to Puerto Rico hospitals.

Disproportionate Share Hospital Programs

The AHA maintains that reductions in federal support for the Medicare and Medicaid Disproportionate Share (DSH) programs should be rejected until coverage expansions are universal and fully implemented, and Medicare and Medicaid payment shortfalls are addressed. Including DSH payments, hospitals received, on average, payment of only 91 cents for every dollar spent caring for Medicare patients and only 88 cents for every dollar spent caring for Medicaid patients in 2007. For hospitals that provide significant levels of care to Medicare, Medicaid and uninsured patients, DSH payments are a lifeline. Even if universal coverage is *(American Hospital Association 7)* achieved through health reform, some populations will remain uncovered, and hospitals will be asked to bear the burden of their health care as well as essential community services.

Indirect Medical Education

The AHA is urging CMS to withdraw the remaining portion of a policy that originally phased out, over two years (FY 2009 and 2010), the indirect medical education (IME) adjustment paid to teaching hospitals for their capital expenditures. The policy was initially implemented on October 1, 2008, and was scheduled to be fully phased in beginning on October 1, 2009. Congress, in the *American Recovery and Reinvestment Act*, eliminated the first year of these cuts. If this rule were fully implemented, eliminating the IME adjustment to the capital PPS would result in nearly $375 million in aggregate annual losses to U.S. teaching hospitals.

Modifying the Requirement for Tax-exempt Hospitals

Since 1969, the Internal Revenue Service (IRS) has applied a "community benefit" standard for determining whether a not-for-profit hospital is meeting its charitable, not-for-profit mission. That standard has been appropriately flexible to allow hospitals to respond to the needs of their unique communities. Proposals to change the community benefit standard and replace it with requirements to provide minimum (but undefined) annual levels of charitable patient care, or imposing an "excise tax" on tax-exempt hospitals that do not meet their yet-to-be-determined standard, are premature.

Next year, in an unprecedented national effort, the IRS will begin collecting information from not-for-profit hospitals on the benefits they provide to their communities and the policies and programs they employ to do so in a single document called "Schedule H." That form will give policymakers more complete information on which to make important decisions about whether the requirements for tax-exempt status need to be updated.

OTHER KEY HOSPITAL ISSUES

Medicaid Regulations

If finalized, these rules would disrupt existing funding systems on which hospitals depend to provide care to Medicaid and uninsured patients, to provide access to specialty services, and to train future physicians and nurses. As a result, the hospital community, along with states and beneficiaries,

continues to oppose these regulations. Congress included in the *American Reinvestment and Recovery Act* a "Sense of the Congress" resolution that the rules concerning cost limits and GME payments should not be promulgated.

● **Medicaid cost-limit rule.**
This rule would restrict payments to financially strapped government-operated hospitals, narrow the definition of "public" hospitals, and restrict state Medicaid financing *(American Hospital Association 8)* through intergovernmental transfers and certified public expenditures. It also would limit reimbursement for government-operated hospitals and restrict the ability of states to make supplemental payments to providers through the Medicaid upper payment limit.

● **Medicaid Graduate Medical Education (GME) rule.**
This proposed rule would eliminate any federal Medicaid support for GME. While CMS claims the rule is a clarification, it is in fact a reversal of more than 40 years of agency policy and practice, would cut nearly $2 billion in federal support for training physicians when the demand for health care professionals is high, and would put safety-net hospitals in financial jeopardy.

● **Medicaid provider tax rule.**
This final rule, delayed until July 1, 2010, would change Medicaid policy on health care-related taxes by making it difficult for states to adopt or implement health care-related tax programs with reasonable assurance they comply with federal rules. The vaguer and broader standards CMS proposes would limit states from implementing legitimate provider tax programs consistent with the Medicaid statute and congressional intent.

● **Medicaid DSH reporting and auditing regulation**.
This rule for implementing the Medicaid DSH reporting and auditing requirements in the *Medicare Modernization Act of 2003* (MMA) took effect January 19. While the AHA advocates for greater transparency in the operation of the Medicaid DSH program and more consistent federal standards, the final rule fails to achieve these goals and makes substantive policy changes that exceed congressional intent. The rule alters the definition of uncompensated care to largely exclude both bad debt and physician services, despite the fact that the MMA left the underlying law governing DSH limits in place, and that Congress expressed no concern about the calculation of uncompensated care costs. The policy changes to the Medicaid DSH program, which is a lifeline to many safety-net hospitals across the country, will have a significant negative impact on these institutions. The rule should be withdrawn.

Section 508

The AHA continues to work to extend provisions contained in the *Medicare Improvements for Patients and Providers Act of 2008* that expire September 30, including provisions pertaining to section 508 geographic reclassifications, which are geographic reclassification opportunities for hospitals meeting certain criteria to appeal their wage index classifications.

Rural Hospitals

Medicare payment systems fail to recognize the unique circumstances of small, rural hospitals. Many rural hospitals are too large to qualify for critical access hospital (CAH) status, but too small to absorb the financial risk associated with PPS programs. Also, existing special rural payment programs – CAH, sole community hospital (SCH), Medicare-dependent hospital *(American Hospital Association 9)*(MDH) and rural referral centers – need to be updated. The AHA urges Congress to pass the following legislative relief:

● ***The Craig Thomas Rural Hospital and Provider Equity Act (S.1157).*** Sens. Kent Conrad (D-ND), Pat Roberts (R-KA), Tom Harkin (D-IA) and John Barasso (R-WY) introduced this AHA-supported legislation to improve Medicare reimbursements to rural hospitals. It would provide a temporary payment increase for hospitals with low-volume inpatient discharges, and would continue allowing direct payments to independent laboratories for the technical component of pathology services, and the 5 percent rural add-on payment for home health services. In addition, the bill would extend the outpatient hold-harmless provision for sole community hospitals and rural hospitals with fewer than 100 beds, remove the cap on disproportionate share adjustment percentages for all hospitals and improve payments for ambulance services in rural areas.

● ***The Critical Access Hospital Flexibility Act of 2009 (S. 307/HR. 668).*** Introduced by Sens. Ron Wyden (D-OR), Mike Crapo (R-ID) and Rep. Greg Walden (R-OR), this bill would provide flexibility in the manner in which beds are counted for purposes of determining whether a hospital may be designated as a CAH under the Medicare program.

● ***The Medicare Rural Health Access Improvement Act of 2009 (S. 318)*** **and** ***the Rural Hospital Assistance Act of 2009 (H.R. 362).*** Introduced by Sen. Charles Grassley (R-IA) and Rep. Leonard Boswell (D-IA), these bills would improve Medicare payments to rural hospitals that are too large to be CAHs, but too small to be financially viable under the Medicare PPS, and would allow MDHs to receive the non-wage-adjusted payment rate and a low-volume adjustment for Medicare inpatient services.

● ***The 340B Program Improvement and Integrity Act of 2009*** **(H.R. 444)**. Introduced by Reps. JoAnn Emerson (R-MO), Bobby Rush (D-IL) and Bart Stupak (D-MI), this bill expands the 340B program to include inpatient drugs at DSH hospitals, and inpatient and outpatient services at CAHs, SCHs, MDHs and rural referral centers.

In addition, the AHA will work with Congress to provide small, rural hospitals with cost-based reimbursement for outpatient lab services and ambulance services; ensure CAHs are paid at least 101 percent of costs by Medicare Advantage plans; reinstate the 5 percent rural add-on payment for home health services; remove the cap on DSH adjustment percentages for all hospitals; extend and expand the Rural Community Hospital demonstration program; and remove unreasonable restrictions on CAHs' ability to rebuild.

Conrad 30 Extension

The AHA supports the *Conrad State 30 Improvement Act*, S. 628, which would permanently reauthorize the Conrad State 30 program, set to expire in September 2009. Under current law, foreign physicians admitted to the U.S. on a J-1 visa to participate in educational exchange programs are required to return to their home country for two years before they are eligible to return to the U.S. The Conrad State 30 program allows state health departments to request J-1 visa waivers for up to 30 foreign physicians per year to work in federally designated Health *(American Hospital Association 10)* Professions Shortage Areas or Medically Underserved Areas. *S. 628* permanently reauthorizes this valuable program.

RAC Program

CMS currently is rolling out the permanent Medicare Recovery Audit Contractor (RAC) program in two phases. The prior RAC demonstration program caused significant problems for hospitals in the five demonstration states. Based on that experience, the AHA is working with CMS to make the program more transparent and reasonable for hospitals. We also are offering the AHA RAC Education Series to provide hospitals with resources to help manage RAC audits and appeals, and we are developing legislation with further improvements to the RAC program. Some of the AHA's key legislative remedies include eliminating RAC medical necessity review and establishing a method to re-bill denied claims at a lower payment level.

FIELD LEADERSHIP

The AHA's field leadership strategy includes specific actions that can be taken in the immediate term, as well as longer term initiatives, to "bend the cost curve." It also includes actions that can be taken to collaborate with other stakeholders. Some of these initiatives would be further enabled by public policy changes that the AHA will continue to pursue on Capitol Hill.

IMMEDIATE COST SAVINGS INITIATIVES

The AHA will work with our hospital association partners, as well as other stakeholders such as the Institute for Healthcare Improvement (IHI), to design and implement the *Hospitals in Pursuit of Excellence* campaign. The goals of this campaign will be to facilitate hospital and health system performance improvements that have meaningful quality improvement and associated cost savings; further the use of known best practices, initially in the areas of infection prevention and patient safety and expanding over time into other areas; facilitate the sharing of best practices among hospitals, health systems and national, state, regional and metropolitan hospital associations; and demonstrate the commitment of the hospital field to achieve these improvements.
Specifically, *Hospitals in Pursuit of Excellence* seeks to:

- Reduce surgical infections and complications: Promote adoption of the World Health Organization (WHO) Surgical Safety Checklist to enable teams to implement critical safety steps.

AHA has co-sponsored with IHI a webinar to encourage hospitals to test an adaption of the checklist and will accelerate sharing and learning among hospitals.

● Reduce central line-associated blood stream infections (CLABSI): Promote best practice strategies to reduce central line-associated blood stream infections through reliable implementation of infection prevention and monitoring strategies. In conjunction with *(American Hospital Association 11) (American Hospital Association 12)* AHRQ, AHA has been working with multiple states and hospitals to spread best practices in implementing a culture of safety and teamwork and accelerating the elimination of CLABSI.

● Reduce methicillin-resistant Staphylococcus aureus (MRSA): Promote best practices in screening, hand hygiene and contact precautions to prevent the spread of MRSA. AHA and several health systems are collaborating with The Joint Commission on a broad ranging, new initiative to improve patient safety and reduce preventable complications, starting with an effort on hand hygiene.

● Reduce clostridium difficile infections (c diff): Promote best practices in screening, hand hygiene and contact precautions to prevent the spread of c diff. AHA and several health systems are collaborating with The Joint Commission on a broad ranging, new initiative to improve patient safety and reduce preventable complications, starting with an effort on hand hygiene.

● Reduce ventilator-associated pneumonia (VAP): Promote the spread of reliably tested best practices for patients receiving mechanical ventilation.

● Reduce catheter-associated urinary tract infections: Promote best practices in the appropriate use, insertion and care of catheters to minimize urinary tract infections.

● Reduce adverse drug events from high-hazard medications (e.g., anticoagulants, narcotics, opiates, insulin, sedatives): Promote best practices in the prevention of adverse drug events focused on high-hazard medications by using standardized protocols, adequate monitoring and increased patient and family education.

● Reduce pressure ulcers: Promote best practices in helping hospitals assess the risk of a hospital-acquired pressure ulcer, daily skin inspection and optimizing prevention.

LONGER TERM HOSPITAL INITIATIVES

Hospitals also will continue to increase their engagement in a number of longer-term initiatives. The *Hospitals in Pursuit of Excellence* campaign will help promote these initiatives as the evidence, tools and nationally endorsed measures for these opportunities develop:

● Improving Care Coordination: Focus in particular on the discharge process and care transitions.

● Implementing Health Information Technology (HIT): Focus on leadership and clinical strategies to effectively implement HIT.

● Promoting Efficient Resource Utilization: Promote palliative and hospice care through the use of advanced directives and best practices.

● Preventing Patient Falls: Further the implementation of effective fall prevention programs and use of fall risk assessment tools.

● Improving Perinatal Care: Promote best practices to improve perinatal care and reduce birth trauma and complications.

● Reducing Supply Costs: Create a more efficient and transparent purchasing environment, including greater alignment of hospital and physician incentives, greater product standardization and other measures