Final Thoughts by Paul Cunningham

From meager beginnings in 1929 as a small group of hospitals loosely aligned to remove obstacles to the provision of hospital care, the Arkansas Hospital Association (AHA) has grown into an organization of more than 100 hospitals working together with a unified voice to address issues impacting their ability to serve their patients and communities. Today, AHA holds a seat among the state’s most effective, admired, successful and trusted advocacy organizations due to its track record of success over the years in addressing and resolving those issues.

Digging back through the past 89 years, it would be difficult to list every issue that AHA has tackled, but it’s a safe bet that, although healthcare has changed significantly since the mid-20th Century, the underlying issues have remained essentially the same. Most of them easily can be grouped under a few broad categories such as governmental mandates, personnel shortages, access to care, physician/hospital relations and the enduring champion of them all, financial challenges, including reimbursement concerns.

The newest additions to the list of financial and reimbursement challenges which hospitals are facing relate to the progression toward value-based purchasing (VBP). What began as a seed planted in the Patient Protection and Affordable Care Act of 2010 as a new way to change the Medicare fee-for-service payment model has grown into a full-blown revolutionary movement among practically all groups which pay for healthcare services. They’re advancing to reform the payment system like the troops in Sherman’s March to the Sea during the Civil War, and are rushing to reduce healthcare spending by tying their payments to improved healthcare quality and outcomes, including the quality of care provided in hospitals.

It’s all about value rather than volume and it’s not necessarily a bad thing. Hospital groups, including the American Hospital Association, recognize the need to incorporate principles that promote improved healthcare value into policy and advocacy activities. Already, hospitals and health systems across the country are working hard to transform the way healthcare is delivered in their communities, improve quality and outcomes, manage risk, explore new payment models, and implement operational solutions to improve patient outcomes and efficiency.

Getting there won’t be easy without cooperation from all players. However, regardless of the buy-in and the various alignment and incentive arrangements, VBP simply won’t work if decisions are not based on useful data. Insurers, businesses, hospitals, physicians, nurses, employers and patients might all be onboard the VBP train, but managing the risks and achieving continuous improvements in quality of care won’t be possible without reliable data and analytic components.

To address this issue on the hospital side of the equation, the Arkansas Hospital Association (AHA) is partnering with the Hospital Industry Data Institute (HIDI), an affiliate of the Missouri Hospital Association (MHA), to improve the caliber and timeliness of data available to AHA-member hospitals. It isn’t the first data partnership for the AHA, but it is probably the best. Data and reports available through this program will help hospitals measure whether initiatives implemented to improve quality are proving effective and will also allow them to identify demographic, sociodemographic and health characteristics needed for community health needs assessments. As a bonus, the program will also help AHA support advocacy efforts related to proposed policy changes.

Participation in the data program will be voluntary on the part of member hospitals and there will be a charge for participating. But, with AHA sponsoring half of the program’s cost, the per-hospital amount is significantly less than other data vendors charge.

Whether or not VBP succeeds in the long run remains to be seen. The road to healthcare cost containment is littered with sure-fire efforts that failed along the way. Nevertheless, AHA strongly encourages all member hospitals to participate in the new HIDI program. Hospitals will always need meaningful data to counter the inevitable financial challenges, which, history tells us, will resurface time and again. As the Biblical proverb notes: What has been done will be done again; there is nothing new under the sun.

Knowing that, we can be reasonably sure that payer groups, whether government or private, will never be satisfied with the amount of spending reductions they can corral. Their exact savings target likely will forever be “just a little bit more.” In the end, without good data, hospitals are left with little choice but to accept the advice found in Jimmy Buffett’s song, Breathe In, Breathe Out, Move On.

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