Closing the Gaps:
Making a Better Business Case for Quality

National Committee for Quality Health Care's 2004 Annual Meeting Report

March 24-25, 2004

The Westin Embassy Row Hotel

Washington DC

National Committee for Quality Health Care

Table of Contents

NCQHC Board of Trustees

Chair
Bruce D. McWhinney, Pharm.D
Senior Vice President, Clinical Affairs
Cardinal Health

Immediate Past Chair
Joseph A. Zaccagnino
President & CEO
Yale-New Haven Hospital and Yale New Haven Health System

President & CEO
Catherine E. McDermott
National Committee for Quality Health Care

Secretary
Curt M. Selquist
Company Group Chairman, Medical Devices & Diagnostics Group,
Johnson & Johnson Health Care Systems Inc.

Treasurer
David F. Ertel
Executive Director
Morgan Stanley

F. Kenneth Ackerman Jr.
President
Clark Consulting-Healthcare Group

Tony Alibrio
President Emeritus
Sodexho Health Care Services

Joel T. Allison
President & CEO
Baylor Health Care System

Diane P. Appleyard
President & CEO
HRDI Inc.

Daniel P. Bourque
Group Sr. Vice President
VHA Inc.

Ralph J. Cerny
President & CEO
Munson Healthcare

Thomas W. Chapman
President & CEO
HSC Foundation

William M. Dwyer
Senior Vice President
Cerner Corporation

David J. Fine
CEO
UAB Health System

Kester S. Freeman Jr.
Chief Executive Officer
Palmetto Health Alliance

Edward J. Giniat
Industry Sector Leader–Health Care
KPMG LLP

David R. Hanke
Senior Vice President
McKesson Corp. Solutions

Douglas A. Hastings, Esq.
Partner
Epstein Becker and Green PC

Brent C. James, MD, M.Stat
Executive Director
Institute for Health Care Delivery Research
Intermountain Health Care

William M. Kelly
Chairman
Hill-Rom Company, Inc.

Charles S. Lauer
Corporate Vice President & Publisher
Modern Healthcare Magazine

Richard Marrapese
Partner & National Director, Health Care Sector
Ernst & Young

Paul R. Meyer, PhD
Director, Public Policy
Pfizer Inc.

Richard P. Miller
President & CEO
Virtua Health

Samuel R. Nussbaum
Executive Vice President & Chief Medical Officer
Anthem, Inc.

Ronald R. Peterson
President
Johns Hopkins Health System The Johns Hopkins Hospital

Thomas M. Priselac
President & CEO
Cedars-Sinai Medical Center

William G. Ries
President
Lake Forest Hospital

Kenneth A. Samet
President & COO
MedStar Health

Nancy M. Schlichting
President & CEO
Henry Ford Health System

Craig R. Smith
President & COO
Owens and Minor

Michael Stephens
President & CEO
Hoag Memorial Hospital Presbyterian

Bernard J. Tyson
Senior Vice President Brand Strategy and Management
Kaiser Foundation Health Plan, Inc.

Anthony L. Watson
President & CEO
HIP Health Plans

John H. Weiland
President & COO
C.R. Bard, Inc.

Susan M. Widner
President, Abbot HealthSystems Division
Abbott Laboratories

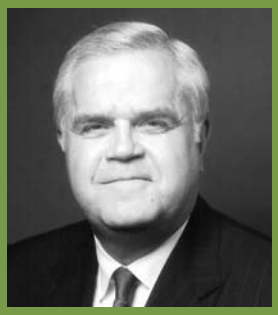
Dan Wolterman
President & CEO
Memorial Hermann Healthcare System

Introduction

On March 24-25, 2004, the National Committee for Quality Health Care (NCQHC) hosted its annual meeting, entitled *Closing the Gaps: Making a Better Business Case for Quality*. This meeting, held in Washington, DC, also served as the 11th anniversary of the National Quality Health Care Award presented by NCQHC each year in partnership with *Modern Healthcare* magazine. This report provides a summary of the highlights and lessons from the meeting, which addressed the business case for quality from a variety of stakeholder perspectives.

Catherine E. McDermott, President and Chief Executive Officer (CEO) of NCQHC, opened the meeting by reviewing NCQHC's many accomplishments over the last year, the organization's 25th-anniversary year. One of the most significant changes is the new NCQHC interactive website (www.ncqhc.org). The updated site keeps members and others informed of the latest news from NCQHC and promotes the sharing of best practices and ideas across NCQHC members. In addition to moving its headquarters, NCQHC recently published a report that describes the best practices of the 2003 National Quality Award applicants.

Joseph A. Zaccagnino, NCQHC's Board Chair in 2003-2004 and President and CEO of Yale New Haven Health System, highlighted several of NCQHC's new programs. The Executive Institute, is a new forum to facilitate in-depth research and discussion of issues important to members as well as other quality healthcare stakeholders. Another initiative is the Task Force on Performance Measurement, the first in a series of task forces on specific aspects of quality. Each task force is comprised of experts in an identified field together with NCQHC members, and will produce deliverables designed to assist members in working through critical topics in the field. NCQHC developed a matrix of organizations involved in performance measurement that will help clarify the sometimes confusing array of quality organizations and measurement activities, many of which overlap with or duplicate each other. Another new project is the NCQHC Clearinghouse report, a twice-a-year publication that catalogues and tracks the activities of approximately 50 national healthcare organizations that have *quality* as a major initiative. Mr. Zaccagnino thanked the co-chairs of the NCQHC Annual Meeting Program Committee, Edward J. Giniat, Industry Sector Leader of Health Care at KPMG, LLP and Kenneth Samet, President and COO of MedStar Health, for their hard work in designing the conference.



Joseph Zaccagnino,
President and CEO,
Yale-New Haven Health System
and Catherine McDermott,
President & CEO, NCQHC

Chapter I

The Current State of Health Care Quality

George C. Halvorson, President and CEO of Kaiser Permanente Health System and author of *Epidemic of Care*, and other books, provided an overview of current and future issues and challenges in delivering quality health care. He began by noting that in spite in increasing interest, quality has not yet become a major factor in buying and selling health care in the marketplace. To help explain this seeming contradiction, Mr. Halvorson highlighted two major concurrent agendas that are driving health care today:

- **Exploding U.S. health care costs:** Double-digit annual increases in health care costs are punishing individuals, insurers, employers, and government agencies, and have become a burden to the overall economy.
- **A critical mass of information has brought a new focus on quality:** Enough studies have been conducted, including those by the Institute of Medicine (IOM) and RAND Corporation that show significant inconsistencies in the delivery of health care across the U.S.

Health care purchasers are feeling the financial pinch and are looking for a market agenda that includes systematic comparative information on quality and on quality improvement. While every other major sector of the U.S. economy has invested in quality, the health care industry seems to view such investments as unnecessary added expenses.

Cost Drivers

Mr. Halvorson reviewed the various drivers that account for the large year-after-year increases in health care expenses:

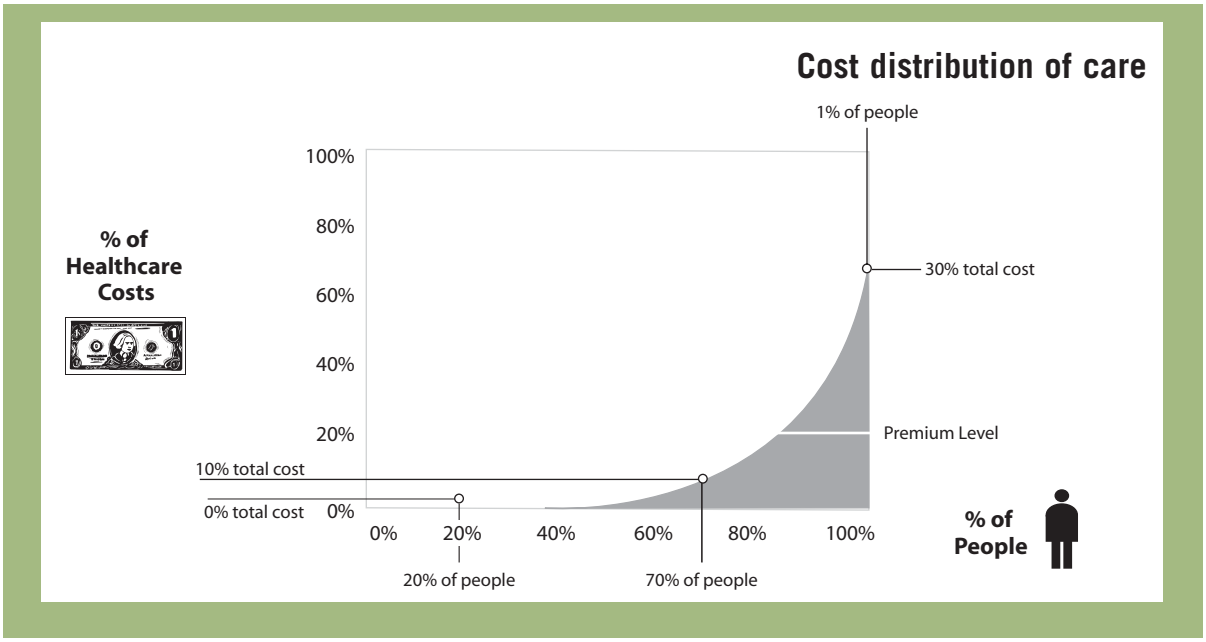
- An aging population with baby boomers reaching the age where chronic diseases are common.
- New health care technologies that Americans expect to have available to them.
- Higher drug costs along with the transition to drugs that are taken over longer periods of time.
- Workforce shortages throughout the health care professions.
- Provider mergers and consolidations that are creating oligopolies and higher prices for hospital and specialty services.
- Greater inconsistency in the delivery of care and the failure to follow best practices.
- Unintentionally perverse financial incentives for care delivery. The current system pays for episodes of care (e.g., visits to the doctor or hospital) rather than caring for conditions over time. That is, there are payments for treatments, not for cures.

> "Every incentive system does what it motivates its actors to do. The health care payment system encourages the provision of units of care. It pays for treatments, not cures."
>
> — GEORGE HALVORSON

Health care is not the same product that it was five or ten years ago. New drugs, new procedures, and new approaches to care make today's health care better than it has ever been. Today's health care improves the

quality of life through implants, transplants, corrective surgery, and pharmaceuticals that are taken for decades. But these changes add costs to the system by expanding the scope of care more often than replacing old care. Even when replacements do occur, new care options generally are more expensive than older ones. This is not the case in other industries, where re-engineering of products tends to lower costs.

Health care, however, is difficult to re-engineer, due in part to the distribution of health care spending. Only a handful of individuals consume the lion's share of resources. As illustrated in the chart below, the one percent of consumers who are most ill consumes 30 percent of health care costs, while the 70 percent who are basically healthy account for only 10 percent of the nation's health care expenditures.



Addressing the Cost Problem: Common Misconceptions

Understanding cost distribution is critical to understanding which approaches may be effective in curbing costs. For example, single-payer, government-run systems deliberately manage the cost distribution of care by limiting high-technology levels of care in certain circumstances. These systems provide excellent care to the 70 percent of healthy individuals who consume only 10 percent of the resources. But they limit availability of transplants and other high-end procedures. While there is increasing momentum for a single-payer system in the U.S., Mr. Halvorson doubts that the American public would ever accept a system where care is explicitly rationed.

Medical savings accounts (MSAs) are another potential solution to the cost problem. The theory is that MSAs, combined with high-deductible health plans, will persuade consumers to use the health care system more efficiently, since they are paying for some of that care out of their own pockets. But because of the way health care costs are distributed, MSAs will likely have little overall impact on costs. For the 70% of consumers who use less than 10% of expenses, MSAs will have virtually no impact, since these consumers have little need for health care services. For those high-cost consumers who need hospital care, surgery, or other expensive services, MSAs will have no impact, because the typical $1,000 deductible and annual cash distribution to the MSA is far below the cost of services. What MSAs will do is shift $1,000 worth of costs to the 30 percent of the population that uses health care on a regular basis. Unfortunately, this cost-shifting has been shown to have an impact on chronic care patients.

What Works: Re-Engineering and the Creation of a Quality-Based Market

The re-engineering of American health care is long overdue. Study after study from respected sources such as RAND, IOM, the Dartmouth Atlas, the Institute for Healthcare Improvement, and the Leapfrog Group, has concluded beyond a reasonable doubt that there are dangerous inconsistencies and inadequacies in the provision of care in the U.S., and that these inconsistencies drive up costs and undermine quality. For example, RAND conducted a study based on 20,000 patients in 12 cities across 30 acute and chronic conditions encompassing 439 quality indicators. It concluded only one-third of diabetic patients get adequate care. It is no wonder, therefore, that patients with diabetes account for up one-quarter of all Medicare costs, and that the overall incidence and costs of diabetes has increased dramatically in the last 15 years. The key to reducing costs and improving quality is to create a market where quality is a real factor in the buying and selling of services.

Key Element of Re-Engineering: Computerized Support Tools

Halvorson noted that virtually every other industry uses computerized tools to support its professionals achieve peak performance. However, many health care professionals do not have access to useful computer technologies. As a result, care is often inconsistent and doctors cannot keep up with the rapidly changing best practice protocols for their patients. Halvorson argues that as a result, resources are wasted and health care cannot be bought or sold on the basis of quality.

> "Five years from now, we'll look back on today's primitive nonsystems…and think of it as the Dark Ages of health care improvement."
>
> — GEORGE HALVORSON

According to Halvorson, quality improvement can be achieved by addressing the following five issues through automation:

- **Paper medical record:** Today's paper record is often incomplete, inconsistent across providers, illegible due to poor handwriting, fragmented, inaccurate, and stagnant. If the process is computerized, doctors and patients will have complete, timely, accurate, and interactive information.
- **Inconsistent access to current science:** It may take a physician up to five years to adopt a new approach or best practice because current information is published in any of 20,000 medical journals which physicians must read or learn through attending seminars, thus making the information dated even before doctors can access it. In other industries, it is not uncommon to see 100-percent adoption of a new innovation within six months
- **Lack of patient compliance:** Patients often misunderstand their physicians' instructions or refuse to follow medical advice. Doctors typically can not tell if prescriptions have been filled or refilled. Computerized systems can track these processes, flag when patients do not comply, and automatically alert the physician, who can then determine what is driving the lack of compliance and how barriers to compliance can be overcome.
- **Patient follow-ups:** Physicians have access to few, if any, reminder or tracking systems for needed follow-up care.

- **Outcomes tracking:** Without computerized systems, it is very difficult to track the outcomes of care. As a result, the industry has relatively little information about what approaches do and do not work.

George Halvorson, President & CEO, Kaiser Permanente Health System

The AMR at Kaiser (AUTOMATED MEDICAL RECORD)

Kaiser has demonstrated that care gets dramatically better and the use of resources becomes much more efficient when doctors have all the information about patients and their conditions at their fingertips. Mr. Halvorson shared a handful of examples:

- Using a system that included only a laptop computer and a copy machine, Kaiser Permanente doctors in Ohio were able to reduce death rates from heart disease (including ischemic heart disease, myocardial infraction, and congestive heart failure) to levels equal to 50 percent of the state average.
- In Southern California, computer tracking of follow-up care resulted in a 31 percent reduction in the death rate from end-stage renal disease.
- In Colorado, the combination of AMR and a pharmacy review program to monitor and track patients on anti-coagulation therapy resulted in a 79-percent reduction in bleeding complications from surgery.

Automation produces other benefits such as reducing the amount of time nurses spend on paperwork, the reduction of drug errors through bar coding, and computerized order entry. Automation has the potential to reduce the length of stay (LOS); one study showed a 0.2-day drop in LOS due to better sequencing of tests.

One additional advantage of automation is in the area of research. With an AMR database, conducting research on processes and outcomes becomes easier and more timely. AMR systems allow such studies to be done almost overnight and to be updated continuously based on the latest available data.

> "Today's research as compared to research with an AMR is like night and day. We are truly in the dark ages today."
>
> — GEORGE HALVORSON

Going Forward

Without the data from automated systems, quality measurement will be limited to rough surrogates of process management. With good, solid computerized medical data, buyers and consumers will be able to make quality-based purchases of care. The AMR is critical, therefore, to the creation of a true quality-based marketplace, and every other reform agenda will fall short of the mark without it. Only health care has attempted to improve quality by micromanaging disparate pieces of the care process that are entirely out of context with each other. For this reason, Kaiser Permanente is investing over $2 billion in the next three years to implement a total computerized physician tool kit built around an AMR. Mr. Halvorson believes that, over time, other major players in the industry will follow Kaiser's lead after they see the value of this approach.

It's time to truly re-engineer care. It's time for an Industrial Revolution in health care delivery

— GEORGE HALVORSON

Additional Observations

Mr. Giniat, discussion moderator, highlighted three key observations from Mr. Halvorson's presentation:

- Health care must be bought and sold consistently if the business case for quality is to move forward.
- The early identification and application of preventive services and treatments to at-risk individuals is much less expensive than are late interventions with seriously ill patients. The key is to put in one place all of the information necessary, but also to provide assurance on the accuracy of the data to make this approach a reality.
- The AMR is critical to health care around the world. The United Kingdom has just committed $17 billion as a first step in building an electronic medical record. Interestingly, unlike in the U.S., British officials are targeting increased health care expenditures as a percentage of the gross domestic product, in large part because their current system rations tertiary care.

Chapter II

Stakeholder Perspectives on the Business Case for Quality

This conference began with the working hypothesis that there is a business case for quality, but the strength of the case varies across stakeholders and geographic regions of the country. The main purpose of this section is to explore the gaps in the business case from the different stakeholder perspectives. Key questions include the following:

- Will those who invest in quality get a return on that investment in a reasonable time frame? Or will the benefits accrue in the long term and to someone else?
- Will patients need to pay more for quality? Are they willing to do so?
- What is the best way to advance the business case from this point? Should the federal government "give up" on the voluntary approach and require investments in quality?

Audience Perspectives

Background

To provide a sense of where the industry is today on these issues, NCQHC took advantage of interactive survey technology provided by KPMG, to gauge the response of attendees on key questions regarding the business case. As background information, a set of questions were presented that helped profile the audience, which consisted primarily of providers (40 percent of attendees) and suppliers (16 percent). Forty percent of individuals identified themselves as being with "other" organizations while sixty percent of attendees identified themselves as having some other titles or positions.

Edward Giniat, Industry Leader-Health Care, KPMG LLP and NCQHC Board Member leads participants in using the Automated Response System donated to this conference by KPMG.

Responses

The next set of questions gauged attendees' views on the business case for quality. Highlights include the following:

- More than half (56 percent) of attendees felt that quality is a proven business strategy, but roughly one in six (17 percent) described it as an unfunded mandate.
- 27 percent of attendees felt that technologies that enable measurement are the most important need in making the business case for quality. Nearly one in five cited pay-for-performance systems, while 16 percent touted the need for standard measures. Thirteen percent highlighted public disclosure of information on quality performance, while five percent voted for standardized clinical guidelines.
- One quarter of attendees believed that the business case for quality always exists. But only four percent thought that it never exists.
- More than half of the attendees believed that providers should take the lead in driving the business case for quality, followed by government (18 percent), payers and managed care organizations (15 percent), consumers and patients (8 percent), and employers (6 percent).
- Almost half of the attendees believed that quality initiatives pay for themselves in terms of cost savings. One in four believed that consumers will pay more for quality. Seventeen percent saw no business case for quality and therefore thought that the government must play a greater role through regulation.

The Provider Perspective

Bruce D. McWhinney, Pharm.D., Senior Vice President for Clinical Affairs at Cardinal Health, Inc., and NCQHC Chair-Elect, moderated the provider panel. Panelists discussed their strategies for investing in quality initiatives and how they balanced competing demands for such investments.

Sentara Norfolk General Hospital

Lois L. Kercher, DNSC, RN, Vice President and Nurse Executive at Sentara Norfolk General Hospital, highlighted three critical points from the perspective of the nursing profession.

Lois Kercher, Sentara Norfolk General Hospital

- **The Relationship Between Nursing and Quality**

  Studies released over the last five to seven years show that nursing care makes a difference in patient outcomes, but additional research is needed on how many and what types of nursing staff are associated with which types of outcomes. Ms. Kercher noted that some states have responded to this data by setting minimum requirements for the number of nurses on staff. She feels such requirements are counterproductive, since the number of nurses needed varies, depending on such things as patient demographics and severity of illness.

- **The Nursing Shortage**

  Nursing shortages have existed many times throughout history; however, the current shortage is much more serious than in the past. The discrepancy between existing and projected supply and demand of nurses has never been greater. While the number of nurses is growing, the increase in demand for nurses is unprecedented, with some estimates suggesting a 40 percent increase in the demand over the next two decades. Unfortunately, a shortage of nursing faculty is limiting the number of entrants to nursing schools, and applicants are being turned away. And while nursing salaries have started to rise, it is unlikely that they can go up rapidly enough to be one of the solutions to the problem.

- **The Need for Planned Disruption**

  Ms. Kercher believes that nurse practitioners can do much of what physicians do today. Nurses can do much of what nurse practitioners do, and other health professionals, such as emergency medical technicians can take on some of the current duties of nurses. Computerized tools will have a further, positive impact on job responsibilities, as time is freed up from paperwork and needed information becomes available at the touch of a button. Ms. Kercher believes that the redesigning of the role of nurses and other professionals will go beyond what anyone has the ability to comprehend today.

Lehigh Valley Hospital and Health Network

Ron Swinfard, M.D., Chief Medical Officer of Lehigh Valley Hospital and Health Network, discussed how his organization views the business case for quality.

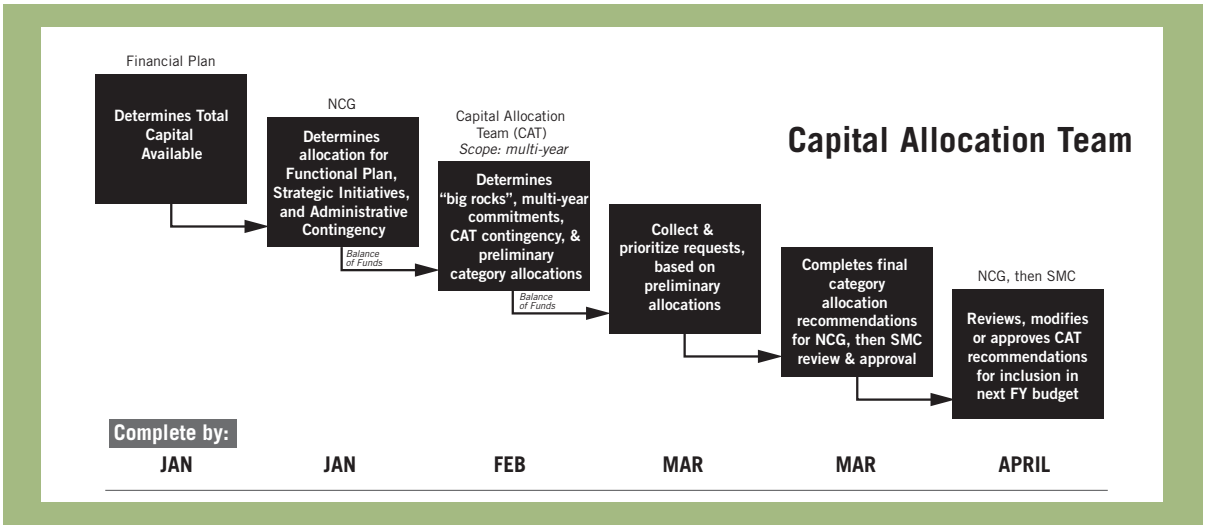
- **No Mission, No Margin**

  Dr. Swinfard began by emphasizing "no mission, no margin." In other words, hospitals must generate margins to afford investments in quality. He believes that generating adequate margins might be the most important thing that a hospital can do to ensure a focus on quality. Another important component is to allow management to run the hospital, with the Board's role being primarily to help management succeed through good governance. To that end, the Lehigh Board looks closely at financial forecasts and metrics for their facilities and services. They set specific targets for spending on clinical and

administrative initiatives, and they are especially attentive to the level of performance needed to maintain their strong overall credit rating, a rating that keeps borrowing costs as low as possible.

Investing in Quality at Lehigh Valley

Lehigh Valley invests in quality through its capital expenditures, which include information services, facilities and construction, health services, engineering, new technologies, and other long-term capital needs. Ten percent of all capital expenditures are dedicated to strategic initiatives and new technology; many of these investments directly relate to quality and quality improvement. The process for allocating and approving capital expenditures is highly structured, as depicted in the chart below.



Several groups and committees are involved in the capital expenditure approval process:

- **Network coordinating group (NCG) and senior management council (SMC):** Chaired by the CEO, these groups have broad representation from individuals who work throughout the organization. Both groups engage in open discussions on what priorities should be emphasized in the capital expenditure budget.
- **Technical assessment committee (TAC):** The TAC is a 12-member group chaired by the chief of cardiology. Members include the medical staff, clinical engineering, information services, nursing, care management, finance, materials management, strategic planning, and administration. This group reviews any request for a new technology that costs more than $50,000.
- **Capital allocation team:** This team has broad representation from across the hospital and helps allocate the total capital expenditure budget across different categories of expenditures. It also helps to prioritize requests for capital.

The strategic initiative process helps to determine which technologies and other quality-enhancing capital programs should be included. A structured proposal must be submitted for each initiative, which includes highlights of the project's contribution to the organization's mission as well as its clinical and strategic objectives, especially those related to quality. Senior management develops a scorecard to rate each proposal; scoring criteria include clinical innovation, service excellence, revenue enhancement or expense reduction, contribution to the organization's vision, contribution to the enhancing of collaboration, and likelihood of implementation. A formal business plan and an analysis of the project's net present value are requested for proposals receiving the highest scores. Based on this information, hospital management develops a list of recommended initiatives, which are subject to final approval from the Board. After two years, every approved initiative is subject to a "lookback" analysis to determine if original expectations and objectives are being met.

Thanks in large part to its focus on quality and quality improvement, Lehigh Valley finds itself in an enviable financial position. The organization also received a number of awards recognizing its outstanding performance, including NCQHC's 2003 National Quality Health Care Award.

Johns Hopkins Medical Institutions

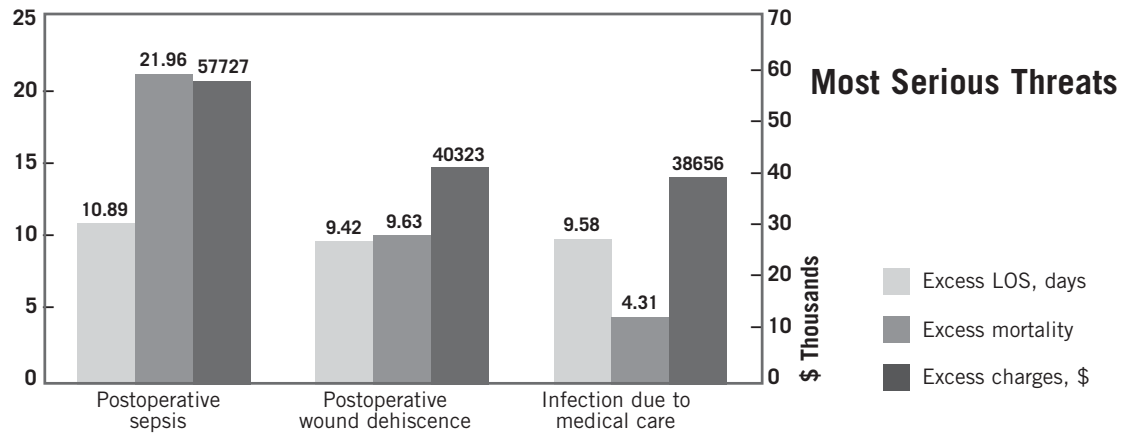
Richard O. Davis, Ph.D., Executive Director of the Center for Innovation in Quality Patient Care at Johns Hopkins Medical Institutions, discussed how his organization promotes the business case for quality. Through the Center, Johns Hopkins has created internal competition around the issue of innovation and quality. Interestingly, when the organization began its efforts in this area, the notion of the "business case for quality" was not articulated. At Johns Hopkins, terms like "re-engineering", "performance improvement", and "business case" became code for budget cuts. To avoid a negative reaction, quality jargon was eliminated and the focus was put on something that everyone understood and supported—patient safety.

The Costs of Poor Patient Safety

Dr. Davis shared data highlighting the tremendous need to improve patient safety, from both a quality and financial perspective.

- Adverse drug events add $2,000 to $6,000 and one to four additional hospital days to a case.
- On average, bloodstream infections add $56,000 and 22 hospital days to each case.
- Ventilator-associated pneumonia can add $9,000 to $12,000 and 10 hospital days to a case.
- Surgical-site infections in patients undergoing coronary artery bypass graft (CABG) surgery cost $19,000, and add an average of 20 days to a patient's hospital stay.

As depicted in the chart below, the most serious problems relate to postoperative sepsis, postoperative wound dehiscence, and infection due to inefficient medical care, each of which significantly increases the patient's risk of dying and adds more than a week to the patient's stay and tens of thousands of dollars in charges.



Source: Zhan C and Miller MR. Excess length of stay, charges, and mortality attributable to medical injuries during hospitalization. JAMA 2003;290:1868–1874

Addressing Patient Safety and Quality

The challenge, therefore, is to choose the best projects for addressing some of these serious quality and safety issues. Johns Hopkins provides the Center with a pool of seed money for funding projects. Proposals are submitted to the Center, and each must include the problem or issue being addressed, data on the magnitude of the problem or issue, past interventions to address it, expected outcomes or benefits for all stakeholders, anticipated resource needs, and current data tracking systems related to the issue. The Center requires that every funded project have clearly defined metrics and data collection systems for gauging the impact of the intervention. Projects are scored along multiple dimensions, including the following:

- **Fit:** This dimension evaluates linkages between the proposed project and strategic objectives. The Center focuses heavily on patient safety, which is the primary "hook" for getting people across the organization on board.
- **Alignment:** This dimension evaluates how well the project is defined and the level of institutional and team interest and effort.
- **Team:** All projects must involve a multidisciplinary team (e.g., physicians, nurses, pharmacy, and administration). The authority and resources of that team are considered in evaluating proposals.
- **Measurement:** There must be existing baseline data and clear metrics.
- **Execution:** There must be the potential for rapid results (within three to four weeks) and for spreading the idea throughout the organization.
- **Project impact:** Factors considered include the project's impact on patients and the resources required for implementation on a broad scale. While return on investment (ROI) is not the primary consideration in choosing projects, team members are likely to recognize the importance of evaluating the financial impact of their projects.

Dr. Davis shared some of the success stories from projects funded by The Center:

- Use of a one-page summary of the patient's goals for the day led to a dramatic increase in the willingness of doctors to discuss these goals with intensive care unit (ICU) patients. The net result was a one-day drop in average LOS in the ICU.
- A safety program implemented in two different ICUs resulted in a significant drop in both LOS and nurse turnover. Nurses appreciate the educational aspects of the program.
- Protocols and other tools dramatically reduced the incidence of catheter-related bloodstream infections and surgical site infections in CABG patients.

Upcoming Challenges

Dr. Davis reviewed the key challenges in promoting quality and safety:

- Realizing true cost savings from quality improvement, especially when the financial benefits are not always direct.
- Conducting detailed cost accounting and clinical data collection and analysis, the costs of which may outweigh the benefits.
- Creating positive incentives for quality improvement for department leaders.
- Creating incentives for the hospital as a whole to improve quality. Too often the reward for quality improvement is lower revenues. Dr. Davis noted, however, that hospitals that invest in quality improvement should see the financial benefit of reduced malpractice premiums. But the link between better safety and quality and reduced malpractice costs needs to be made more explicit.

Discussion of the Provider Role

Following the presentations, panelists and attendees discussed the role of the provider in promoting quality health care. The discussion centered on the following key questions:

Are providers doing all they can to promote quality? Do they have the funds necessary to do so?
An interactive survey of the audience indicated that most felt that providers are not currently doing all they can to focus on quality. 59 percent of attendees believed that providers do not have the ability to fund the necessary activities for promoting quality.

What are the top actions needed going forward?
Dr. Davis reiterated his belief that promoting the business case for quality may not be an appropriate first step with providers. A better bet may be to focus first on patient safety. Dr. Davis also emphasized the need to align the financial incentives for quality both across and within organizations. Dr. Swinfard emphasized the importance of senior management and Board-level support for quality, including providing the tools, training, and time necessary to embark on quality improvement initiatives and processes. He also called for greater education of senior executives, Board members, providers, employers, and payers around the issues that relate to quality. Ms. Kercher concurred about the need to emphasize safety issues. At Sentara, the CEO conducts regular "rounds" in the hospital where he visits employees who represent safety "success stories." This personal involvement sends a strong signal to Sentara employees about the need to take safety seriously. Ms. Kercher also called for greater education of the public about what defines quality health care.

What is the role of IT within the panelist's organizations?
Each panelist provided an overview of their organization's efforts with respect to an automated medical record and computerized physician order entry (CPOE). Dr. Swinfard reported that Lehigh is putting in place both CPOE and, ultimately, a complex AMR. The organization's leadership believes that these investments will improve quality and reduce medical errors in a quantifiable way. Dr. Davis noted that Johns Hopkins was an early adopter of an AMR, and the organization is now rolling out CPOE. But he cautioned that IT is not a "magic bullet" by itself and care processes need to be examined before rolling out new IT. Ms. Kercher noted that Sentara is currently setting aside money to fund CPOE, and is still trying to decide whether to invest in bar coding. Currently, Sentara has a number of smaller systems in place that provide some of the benefits of CPOE and an AMR, such as a pharmacy alert system.

Mr. McWhinney noted that not every successful safety initiative need involve investing millions of dollars in new IT programs. In fact, several of the examples cited by the panelists demonstrate that safety can be improved significantly through low- and/or no-cost programs.

The Supplier Perspective

Diane P. Appleyard, President of HRDI, Inc., led a panel in which the role of healthcare suppliers in promoting quality was discussed. She began by noting the many cost-saving and quality-enhancing opportunities have been touted in recent studies. The key issue, however, is who should be responsible for finding and realizing these opportunities.

Diane Appleyard, President, HRDI, Inc.

The Panelists and Their Organizations in Brief

Panelists began with a brief description of the companies they represent:

- Scott E. Wallace is the CEO of the National Alliance for Health Information Technology (NAHIT), an alliance of 120 organizations that span the spectrum of health care. NAHIT's mission is to drive the implementation of IT in health care by providing linkages across individuals and organizations, convening key groups and stakeholders, educating the government on the role of the private sector, and exchanging knowledge in an efficient manner through interactive sessions that take advantage of technology.
- David R. Hanke is Senior Vice President of McKesson Corporate Solutions. The company's origins are in distributing pharmaceuticals and medical/surgical supplies. In 1998, the company acquired a major IT supplier, enabling McKesson to become an end-to-end solution for clients in the area of supply chain management and quality improvement throughout the delivery system.
- Craig Smith serves as President and Chief Operating Officer at Owens and Minor, Inc. It distributes 120,000 different products, made by 1,200 manufacturers to acute care hospitals. The company's goal is to get the right product at the right unit to the right place at the right time. If this is done correctly, the real benefit for the company's clients is the ability to free up time for health care professionals to focus on patient care. To that end, Owens and Minor works closely with its providers, helping them move to more advanced supply chain logistics by employing new technologies.

Key Questions for Discussion

Ms. Appleyard organized the panel discussion around a set of key questions related to quality, quality improvement, and the supplier's role in promoting both.

Must quality cost more?

Mr. Hanke noted that quality improvement processes such as Six Sigma demonstrate that better quality costs less. McKesson worked with the University of Wisconsin's two-hospital system to revamp two aspects of the medication use process—dispensing and administration. Through process redesign and implementation of bar coding and automated dispensing and delivery, the system achieved an 87-percent reduction in administration errors, from 9.9 percent to 1.2 percent. For another client, McKesson helped to reduce the supply distribution time (from loading dock to the patient) by over 70 percent, from 239 minutes to 69 minutes. Key changes included the implementation of bar coding, hand-held scanners, and software that linked directly to the accounts receivable system. These changes alone cut the time from 239 to 159 minutes, with further enhancements being responsible for the additional improvement.

Mr. Wallace highlighted the potential role of bar coding in improving quality and reducing costs. He noted that his organization helped to forge a consensus on bar coding between hospital pharmacists and the pharmaceutical industry. Drug companies are now ahead of schedule in terms of meeting government requirements for bar coding. Mr. Wallace advocated a system-by-system, building-block approach to IT. This strategy allows providers to reap immediate cost savings and quality improvements from discrete, ready-to-deploy applications such as bar coding, electronic prescribing, or electronic intensivists, and it eliminates the need to invest millions of dollars in a complete system all at once.

Mr. Smith concurred that better quality can cost less, noting that bar coding has the potential to save $10 billion nationally by reducing medication errors. But medical and surgical units throughout the country are far behind in adopting the technology, largely because manufacturers and distributors do not use the same technologies. He called for a neutral organization to forge consensus on a

universal bar coding system, and hopes that a large provider system or group of providers can create the momentum for this change.

Ms. Appleyard challenged the panelists and the audience to think about situations where better quality does in fact cost more. She highlighted the example of drug-coated stents, which have been shown to be effective in reducing the restenosis rate among patients undergoing coronary angioplasty. But these stents cost significantly more money than traditional stents, and hospitals do not recoup all of the additional costs through higher reimbursement. A representative from the industry, the maker of one type of drug-coated stent, noted that their company's overall goal is to improve health and outcomes, and that four years of data on the drug-coated stent show that it is effective and can prevent the need for repeat visits and procedures for many patients. He said he has yet to see any evidence that the number of open-heart surgeries is declining as a result of these new stents. He emphasized that the industry is working on the need to provide a proper level of reimbursement for this new technology. The challenge is to develop clear guidelines for access and to set appropriate reimbursement rates.

How can suppliers and providers partner?

Mr. Hanke believes that the biggest opportunity for suppliers to work with providers is on process redesign with the ultimate goal of reducing the potential for medical errors. He reiterated the need for group purchasing organizations to work for standardization in areas such as bar coding.

Mr. Smith emphasized the need to look for the "greater good" in partnerships. Noting that the grocery industry forged standards on automation 25 years ago, he called for the development of partnerships among major providers and suppliers to forge a similar set of IT standards for the common good of the industry.

In response to a concern that providers might not trust suppliers to look after their best interests, Mr. Wallace noted that there must be a business case for both sides if a partnership is to be successful. Most initiatives that are true "win-win" situations result in higher profits for suppliers and lower costs and better quality for providers. Mr. Smith added that the supplier's job is to generate real bottom-line savings for providers. Mr. Hanke noted that McKesson worked with one provider organization to address patient satisfaction issues, billing delays, and other issues. Within a year, the system had seen dramatic improvements, including a significant increase in the speed with which bills are paid, faster access to data in medical records, and a reduction in the number of staff needed in the medical records department.

Are suppliers doing all they can to promote quality?

An interactive survey of the audience suggested that roughly half believed that suppliers are doing everything they can to promote quality.

Mr. Smith concurred that suppliers need to do more to work closely with providers to promote quality. One of the biggest things that suppliers can do is free up time for providers to focus on clinical delivery, safety, and quality by ensuring that they have all the supplies and tools they need at their fingertips.

Do suppliers have the ability to fund necessary activities?

Seventy six percent of the attendees believed that suppliers are well positioned to fund the activities needed to promote quality health care. Mr. Hanke noted that many of these activities are self-funding, since they generate cost savings.

Mr. Smith acknowledged that health care provider systems need to be focused on maintaining and improving their operating margins, and that the funds necessary to make large investments in these organizations, which may not pay off for many years. Suppliers need to view such investments as research and development activities.

Mr. Wallace noted that there is growing sentiment in Congress that government should not be involved in funding IT systems. Lawmakers instead believe that there is a role for the suppliers of such technologies to offer innovative financing arrangements that recognize the long-term nature of the payoff from IT.

The Purchaser Perspective

Douglas A. Hastings, Esq., a Partner in Epstein Becker and Green PC, led a panel that explored the purchaser perspective on the business case for quality, with a focus on those areas where cost reduction and quality improvement go hand-in-hand.

The AFL-CIO

Gerald Shea, Assistant to the President for Government Affairs at the AFL-CIO, laid out the purchaser perspective on the business case for quality. He sees four reasons for purchasers to promote quality and quality improvement:

- Health care today is not as safe or as good as it should be, purchasers have a responsibility to promote quality on behalf of their employees.
- The re-engineering of industrial processes has shown that quality can be defined, measured, and improved. Many of the principles from other industries still apply to health care.
- Improving quality can reduce the rate of growth in rapidly-rising health care costs, which represents one of the biggest problems facing employers and employees today. Companies are already cutting their level of coverage by eliminating or reducing benefits for vulnerable populations such as retirees, and purchasers have not been successful in controlling costs using other means; now is the time to try quality improvement as a strategy for cost control.
- Quality improvement represents a "safe haven" from the controversial issues that permeate other aspects of health care. People can work collaboratively in the area of quality, since it represents a rare "common ground."

Health care reform is a daunting task that will require tremendous investment, especially in IT systems that allow performance measurement to be a byproduct of, not an add-on to, care processes. Health care practitioners need vastly different and better information than they have today if they are to make the right clinical decisions for their patients. And ultimately, empowered consumers must participate as full partners in this decision-making process.

Gerald Shea, Assistant to the President for Government Affairs, AFL-CIO

Premier, Inc.

Stephanie Alexander, Senior Vice President of Premier, Inc., shared the hospital perspective on the purchasers' business case for quality. Premier recently formed a Quality and Performance Measurement Committee made up of 10 CEOs from health systems that represent over 200 hospitals. This committee has been working with

the purchasing community to implement pay-for-performance initiatives designed to reward better-performing hospitals. To help make the case to the purchasing community, Premier embarked on a study designed to answer several questions.

- Is there a proven association between high quality and low costs? Based on a national sample of 220 hospitals, there appears to be a weak association between high quality and low costs.
- Is it possible for the lowest-cost hospitals to deliver the best care? The Premier study suggests that this is, indeed, possible under certain conditions.
- Can high-quality care coexist with low costs? The study also suggests that under most conditions, high-quality care can coexist with low costs.

The bottom line from Premier's analysis is that high-quality care can be delivered at low cost. The key issue, therefore, is how to ensure that purchasers recognize and reward this high-quality performance. To that end, Premier has partnered with the Centers for Medicare & Medicaid Services (CMS) on a demonstration project designed to create financial incentives for hospitals to deliver high-quality performance. Launched in October 2003, this nationwide demonstration includes approximately 300 hospitals that will be measured on widely accepted indicators within five clinical areas. The top 10 percent of performers will receive an additional two-percent payment from CMS, while the second 10 percent will receive a one-percent bonus. By year three, penalties will be imposed on poor-performing hospitals that do not show any meaningful signs of improvement.

Centers for Medicare & Medicaid Services

Sunil Sinha, M.D., Acting Director of the Division for Acute and Chronic Disease Management, Quality Measurement & Health Assessment Group at CMS, offered his agency's perspective as the nation's largest purchaser of health care. Dr. Sinha believes that there are huge opportunities for CMS to reduce costs and improve quality. He cited a recent report by the Midwest Business Group on Health and The Juran Institute, which concluded that 30 percent of the nation's health bill is wasted on overuse, underuse, and misuse. CMS is involved in a variety of initiatives designed to help realize these savings, including the hospital quality incentive program with Premier. Other initiatives are focusing on providing information on costs and quality to consumers, providing technical support to providers through Medicare Quality Improvement Organizations (QIOs), collaborating with key stakeholders, and issuing new rules and regulations where appropriate. When asked whether there is a conflict between the dual roles of CMS as both a purchaser and regulator, Dr. Sinha noted that the agency has an obligation to promote quality on behalf of beneficiaries, and that he sees no conflict in doing so through both rules and regulations and purchasing initiatives.

Discussion of the Purchaser Role

The discussion portion of the panel focused on several key questions:

Is there a business case for quality from the purchaser perspective?

Ms. Alexander noted that many purchasers, including the Leapfrog Group, believe that there is a business case for quality. More work is necessary to determine which quality indicators correlate with low costs. Mr. Shea believes that the business case for quality will continue to evolve over time, but he thinks there is more than enough evidence for purchasers to act now. Unwarranted variation clearly costs money and reduces quality. The U.S. spends more than any other country on health care, and much of this wasteful spending could better be used on other priorities. Some parameters must be established to ensure that quality is high and costs are affordable.

Are purchasers doing all they can to promote quality today?

An interactive survey of attendees found that the vast majority did not believe that purchasers are doing all they can to promote quality today. In response to this, Mr. Shea and Ms. Alexander noted

that it is only the "leading-edge" employers that are involved in quality improvement. In fact, many more employers are "walking away" from health care because they do not perceive it as being a part of their business. For example, representatives of Wal-Mart, the world's largest company, explicitly say that the company is not trying to provide comprehensive health benefits for employees. The focus instead is on providing catastrophic coverage. Mr. Shea believes that the recent unrest in the grocery store business, where workers recently were forced to accept cuts in benefits, suggests that the Wal-Mart approach may be the wave of the future.

Do purchasers have the ability to fund the necessary activities?

The interactive audience response showed that 61 percent of attendees believed that purchasers have the money necessary to fund quality improvement. But Mr. Hastings and others noted that some experts believe that these activities should generate long-term savings, not new net costs. Dr. Sinha agreed with this statement, noting that too much money is already being spent, much of it inappropriately and the key is to focus on putting in place mechanisms identify and eliminate the waste. Mr. Shea noted that many employers feel they can not afford future double-digit increases in health care costs for fear they may go out of business.

What are the key steps needed to move the business case forward?

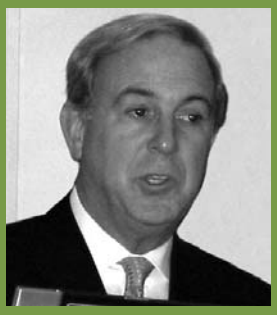
Ms. Hastings highlighted the need for purchasers to align incentives for quality throughout the system. Dr. Sinha emphasized the need for more information for consumers and for collaborative efforts to re-engineer inefficient processes. Ms. Alexander called for greater transformation of information, more pay-for-performance initiatives, and for the creation of a culture of quality within the medical community. Mr. Shea noted that the industry has gotten beyond the notion that perfect data are needed to move forward, but he cautioned that the consensus on this topic is still delicate. He called for continued "give and take" among key stakeholders and for the continuation of small initiatives that serve as building blocks for the future.

The Payer Perspective

John Weiland, President and Chief Operating Officer at C.R Bard, Inc., led a panel discussion examining the payer's perspective on the business case for quality. The panel included presentations by three members of the payer community, followed by a discussion of key issues.

Anthem, Inc.

Samuel R. Nussbaum, M.D., Executive Vice President and Chief Medical Officer of Anthem, Inc., shared his organization's perspective on the business case for quality.



Samuel R. Nussbaum, M.D., Executive Vice President & Chief Medical Officer, Anthem, Inc.

A Brief History of Payer Efforts to Improve Quality

Dr. Nussbaum believes that it is both the best and worst of times in American health care, with the health care system that is very good at managing episodes of illness, but does a poor job in managing overall health status.

Dr. Nussbaum reviewed the history of payer efforts to promote quality and cost control, beginning in the 1980s with health maintenance organizations and aggressive managed care and continuing in the 1990s and the

current decade with capitation and tiered networks. He noted that none of these efforts was particularly successful, in large part because they did not address the underlying drivers of health costs. These drivers include an aging population, an increased incidence of chronic illnesses, rapid advancements in medical technologies and treatments, and, most importantly, poor-quality care, with costs being driven up by medical errors and unnecessary care. At Anthem, one percent of enrollees consume one quarter of all expenses, while five percent account for over half of all costs.

The Role of Pay-for-Performance Initiatives

The IOM's *Crossing the Quality Chasm* report included a specific recommendation that payment incentives be adopted to promote quality improvement by providers. The report highlighted the failure of today's payment systems to promote quality. Fee-for-service systems encourage overuse while capitation rewards underuse, and neither system rewards quality. And while it can be challenging to develop the ideal system, Dr. Nussbaum believes that payers and providers cannot use the difficulty of the task as an excuse for not tackling the issue.

Anthem has put in place a variety of pay-for-performance initiatives that have met with early success. Because of its strong market position in many of the geographic areas in which it operates, Anthem has been able to have a significant influence on its providers by creating financial incentives for clinical performance and high-quality care delivery.

- Anthem provides bonuses worth up to $16 million a year for some organizations that perform well on a balanced scorecard. This scorecard provides risk-adjusted performance on a variety of clinical measures.
- The scorecard includes peer-group data, which allows participating hospitals to see how their performance compares to that of the competition. Anthem notes wide variations in quality across hospitals.
- Anthem is testing an incentive program with Virginia hospitals that would provide additional payments based on performance in three areas of quality: patient outcomes (which would account for 55 percent of the bonus), patient safety (30 percent), and patient satisfaction (15 percent).
- Anthem is rewarding the provision of evidence-based care by physicians in a large obstetrics-gynecology practice.
- Anthem is assisting some hospitals in the eastern portion of the U.S. with investments in new information systems.

At present, hospitals that represent over half of Anthem's admissions have pay-for-performance incentives in place, and more than 13,000 physicians are part of performance-based reimbursement systems with Anthem.

Anthem intends to expand its efforts to promote quality by developing tools to help individual consumers navigate the health system. These tools will become increasingly critical as more individuals enroll in consumer-directed health plans. To that end, Anthem is currently rolling out a tool that provides in-depth, consumer-friendly information on 100 common procedures and conditions. It also includes links to performance data on hospital quality in each of these areas.

Kaiser Foundation Health Plan, Inc.

Bernard Tyson, Senior Vice President of Kaiser Foundation Health Plan, Inc., began by noting that there are pockets of excellence in American health care. But he believes that it is a recipe for disaster for the industry to continue its course of 20-percent annual increases in the costs of care without tangible improvements in outcomes. Roughly 11 or 12 people die from an unnecessary medical error every hour. And the problem of poor health care is even worse for ethnic and racial minorities.

To address these problems, Kaiser, which serves more than eight million members, is trying to build a system that eliminates the historic emphasis on individual episodes and silos of care. Mr. Tyson described the primary building blocks of this revamped system:

- Focus on their enrollees as a population. Individual members will benefit from such an approach, since concerns about the whole population will be applied to individuals.
- Match service capacity to the population's need.
- Integrate care across the continuum of settings.
- Develop information systems that link patients, providers, payers, and other stakeholders across the continuum of care. Transparent data on costs, quality, and member/patient satisfaction should be available to all.
- Use financial incentives as a way to align the goals and motivate the behaviors of all stakeholders.
- Ensure that pay-for-performance incentives are consistent with, and supportive of, the expected outcomes from the system.

Mr. Tyson elaborated on the benefits of pay-for-performance initiatives:

- If done correctly, market-based initiatives should reward population-based care. Kaiser has turned to industries outside of the health care for assistance in setting up some of its pay-for-performance and other quality-enhancing initiatives.
- Pay-for-performance initiatives can encourage application of evidence-based medicine.
- Pay-for-performance initiatives will expose poor performance, including underuse, overuse, and inappropriate care. Mr. Tyson believes that pay-for-performance can help expose the lack of quality and raise the bar for future performance. He also underscored that Kaiser does not create any incentive that is tied to the financial performance of physicians; all incentives relate to quality and patient satisfaction.

Bernard Tyson, Senior Vice President, Kaiser Foundation Health Plan, Inc.

"We're all underperforming. We need to raise the bar, to expose the lack of performance. We need to do some-–thing fundamentally different to achieve fundamentally different outcomes."

— BERNARD TYSON

KPMG, LLP

John Fitzgibbon, a Partner with KPMG, LLP, offered a philosophical perspective on the business case for quality based on his organization's work with the payer community. Evidence supports the view that, while difficult to achieve, improving quality reduces costs. The issue is how to get quality improvement processes implemented.

Most of the debate centers on who will bear the initial costs and who will receive the short- and long-term benefits. These costs and benefits need to be distributed equitably. To make this a reality, payers must accept that they may have to pay more per episode or unit of care, with the savings being realized through reduced utilization of services. He also urged payers not to focus solely on cost reduction, as this could undermine quality and will likely be met with resistance by the provider community. In fact, he believes that payers should adopt the strategy of focusing exclusively on quality, and trusting that costs will take care of themselves. He advocated the following for the payer community:

- Publish performance data for every stakeholder and make it available to all. Many health plans already publish data, as does CMS. Publicly available data creates accountability and transparency. It allows frank discussions about what needs to be improved.
- Focus on innovative plan designs for the future. Consumer-directed plans hold some promise for the future. The real benefit from these plans will not be from cost reduction, but rather from the kind of information sources that consumers will have available to make better choices, particularly in seeking preventive services and adopting health behaviors.
- Work as facilitators. Payers have the financial resources to get the attention of key stakeholders. They can play an effective role in forging collaborations and partnerships.

Discussion of the Payer Role

The discussion that followed the panel focused on questions outlined below:

Is pay-for-performance like rearranging deck chairs on the Titanic "?

Dr. Nussbaum emphasized that pay-for-performance initiatives are not magic bullets, but can be strategies for rewarding investments and achieving results. However, pay-for-performance initiatives must be coupled with investments in integrated and coordinated care management, and in the health of communities to eliminate the high levels of waste and inefficiency that exist in health care delivery today.

> "We're sowing the seeds for health care for the next 20 to 40 years."
>
> — SAMUEL R. NUSSBAUM, M.D.

Mr. Tyson emphasized that simply moving money to and from various stakeholders is not enough. Pay-for-performance programs should create real, long-term incentives for enhanced performance, and they should include penalties for those who fail to perform.

Mr. Fitzgibbon believes that incentives do work to enhance provider performance, but he emphasized that it is more important to encourage individual consumers to take better care of themselves.

What are the best models for aligning the interests of hospitals and physicians?

Dr. Nussbaum touted the benefits of the integrated model that exists at Kaiser Permanente, but noted that many organizations have tried to replicate this model and failed because they did not spend resources to integrate care. But other models are out there that can work, including paying hospitals more for reducing adverse outcomes. Dr. Nussbaum cautioned that if hospitals are not given additional reimbursement for producing appropriate outcomes, they will lose revenues and have little or no incentive to make the necessary investments for quality improvement.

Chapter III

Congress' Role

Mr. Zaccagnino introduced the Congressman Patrick J. Kennedy (D-RI), who highlighted his views on what role the government needs to play in promoting the business case for quality and in transforming the nation's health care system "from one that focuses on sick care, to one that promotes health care."

Representative Patrick Kennedy (D-RI) and Joseph Zaccagnino

Technology as the Driving Force for Quality

Representative Kennedy emphasized the role that technology must play in transforming health care, and the need for health care organizations to adopt new technologies. He sees a variety of things that can be done to make health care more effective and less expensive, however, the key to getting them implemented, however, is to first prove that higher-quality; lower-cost care is possible.

Representative Kennedy is drafting legislation that would help bring the key stakeholders together to focus on how the financial burden of investing in quality-enhancing, cost-reducing programs should be borne, and how the benefits from such investments should be shared. Former Speaker of the House Newt Gingrich, a leading Republican advocate of information technology in health care, is working with Congressman Kennedy to draft this legislation.

The legislation is being modeled on a program that is currently in place in Rhode Island, where a not-for-profit quality institute has been formed to bring together public and private purchasers, insurers, and providers to ensure that the upfront investments in new technologies and systems will be economical for physicians, including those practicing in small groups. Getting the right tools to every physician office is critical, yet many doctors feel that they cannot afford to make such investments because of low levels of reimbursement and high malpractice insurance costs.

Representative Kennedy believes that the legislation should include a pledge from the federal government to support financially the implementation of new information technologies in communities where local stakeholders develop plans for such technologies. The only criterion is that there must be interoperability among the different systems. Representative Kennedy suggested that the federal government could forge the development of basic interoperability standards through Medicare's contracting process with providers and health plans. As the single largest payer in the country, Medicare could create standards that would likely be adopted very quickly on a national level.

Representative Kennedy is calling for the development of systems that begin to standardize evidence-based medicine by giving providers access not only to a patient's medical records, but also to the best available

evidence. Today only about half of Americans get evidence-based medicine. Tremendous, unwarranted variations in care delivery result in tens of thousands of unnecessary deaths each year. He believes that the translation to evidence-based practice could reduce the number of malpractice lawsuits since evidence-based guidelines and protocols will be recognized as the standard of care.

In closing, Representative Kennedy asked NCQHC conference participants to offer their input on his legislation, which is still a work in progress. He is confident that there will be cross-party consensus on the key components of this legislation, and it is his hope that it will move the nation closer to the day when the health care system offers the same high standard of care to all.

Chapter IV

Reflections on Past, Present and Future

The annual conference included several presentations examining the critical next steps to promote the business case for quality.

Industry's Role

Brent C. James, M.D., M.Stat., Executive Director of the Institute for Health Care Delivery Research at Intermountain Health Care, built upon the presentations, panel discussions, and survey results by offering his views on the most important next steps for the industry.

A Brief History of Modern Medicine

He began by providing a brief review of modern medicine, highlighting the development of new standards for clinical education, strict requirements for professional licensing, clinical practice founded on scientific research, and new hospital organizational structures. Since 1912, that time, health care has advanced to the point where the system now routinely performs miracles, and an individual consumer with a health problem today would be foolish not to seek care.

Today's Problems

According to the IOM report, *To Err Is Human*, medical injuries cause 44,000 to 98,000 preventable deaths each year in inpatient settings in this country. The 2001 IOM report, *Crossing the Quality Chasm*, highlighted the enormous gap between today's health care and the health care that could exist, and outlined general recommendations for closing this gap. A recently released IOM study on patient safety offers much more specific recommendations. This new study concluded that there are many more injuries in the outpatient setting than there are in the inpatient arena. These errors include both "injuries of omission" and "injuries of commission." The bottom line is that Americans get the right health care only a little more than half (54.9 percent) of the time.

Tomorrow's Solutions

Dr. James stressed the need for innovative thinking that goes beyond yesterday's solutions, which often are the cause of today's problems. Medicine is changing from a craft-based profession, characterized by individual physicians working alone to develop customized solutions for each patient, to a profession-based practice in which groups of peers treat similar patients in a shared setting using coordinated care delivery processes that are adapted to specific patient needs. The early evidence suggests that this approach is less expensive and it produces better patient outcomes.

A profession-based practice strives for standardized processes that adapt to individual needs. The central components of this approach are evidence-based practice protocols developed by a multidisciplinary team of health professionals. These teams go through a five-step process:

- Select a high-priority care process.
- Generate an evidence-based best-practice guideline.
- Blend the guideline into the flow of clinical work, including staffing, training, supplies, physical layout, measurement/information flow, and educational materials.
- Use the guideline as a shared baseline, with clinicians free to vary it based on individual patient needs.
- Measure, learn from, and eliminate variations arising from professionals and retain variation arising from patients.

This type of profession-based approach to practice produces better outcomes for patients while eliminating waste, reducing costs, and increasing the overall resources available for patient care. A profession-based approach to care sets the foundation for useful shared electronic data, which is an important next step in care delivery improvement.

Dr. James shared a number of examples of these next-generation solutions from Intermountain Health Care.

- **Diabetes:** Physicians receive regular reports comparing their testing rates and test results to that of peers. They also receive a patient-specific diabetes worksheet with critical guidelines for managing that patient. Finally, they receive a diabetes outlier patient list that tells them which patients are in need of tests. The net result of this approach is an expected savings of $2,000 per patient by year three of the program.
- **Elective Labor Induction:** Intermountain generated analysis suggesting an increased risk of babies needing NICU care when labor is induced prior to 39 weeks gestation. Intermountain put in place a rule requiring approval prior to performing elective inductions before 39 weeks gestation and noted a dramatic reduction in the percentage of elective inductions being performed on mothers who had not yet reached the 39-week cutoff, from nearly 30 percent to less than six percent. The savings to the system was over $2 million annually, with obvious benefits to the newborns as well.
- **Adverse Drug Events (ADE):** After analysis indicated that ADEs were a major cause of injuries to patients, Intermountain implemented an ADE detection system. After an initial increase in the total number of reported cases of ADEs, Intermountain has seen a 60-percent decline over the last decade, due primarily to system-based interventions.
- **Post-operative wound infections:** Improvements in the provision of timely prophylactic antibiotics has reduced the rate of infection to less than 0.5 percent, well below the national average. The net savings to the system have been approximately $3.5 million per year.

The Big Barrier: Financial Disincentives for Quality

For all but one of the initiatives highlighted above, Intermountain's reward for investing in quality improvement and cost reduction was a loss in revenues for the system. Dr. James cautioned that there is a limit to what providers will be able to do clinically if they are not rewarded for their investments and performance.

> "You must align contracting incentives to harvest savings back to your organization. Otherwise, clinical quality improvement is a fast way to destroy your organization financially."
>
> — BRENT C. JAMES, M.D., M. STAT.

Intermountain has had some success in negotiating shared-risk arrangements in which the savings generated from quality improvement are evenly split between the provider and the employer. But at the moment these innovative contractual arrangements are the exception. He noted that there is no opportunity to negotiate such arrangements with Medicare, which accounts for 35 percent of the system's revenues, Intermountain's largest payer.

Conclusion

Dr. James estimates that his own organization has generated over $20 million in variable cost savings through its quality improvement initiatives over the last five years. The challenge, however, is to extend these types of activities to a broader scale, with shared involvement and shared accountability from all key stakeholders, including purchasers, payers, provider organizations, and individual practitioners. He urged attendees to become actively involved in defining what the health care system could look like in the next century.

Brent C. James, M.D., M.Stat., Executive Director for Health Care Delivery Research, Intermountain Health Care

"Imagine the miracles we could achieve if we could do it right 95 percent of the time."

— BRENT C. JAMES, M.D., M. STAT.

Chapter V

The National Quality Health Care Award

The National Quality Health Care Award is the first of its kind to recognize outstanding leadership of health care provider organizations that produce lasting and continuous quality improvement for their patients and for their communities. In its 11th year, the award is co-sponsored by *Modern Healthcare* magazine.

The 2004 award winner is Trinity Health, based in Novi, MI. Through the leadership of its senior management and Board, sound management processes, and innovative technologies in the area of quality and safety, Trinity Health pursues an unwavering focus on excellence in health care delivery. The award was presented by Joseph Zaccagnino, President & CEO of Yale New Haven Health System, and NCQHC Chair, and Charles S. Lauer, Corporate Vice President and Publisher of *Modern Healthcare* magazine.

Charles Laurer, Corporate Vice President & Publisher, Modern Healthcare magazine and Joseph Zaccagnino, President & CEO, Yale-New Haven Health System

Too often, Mr. Lauer believes, one hears about the bad things that are going on in the industry, and not enough about the daily miracles occurring in the trenches of health care, incredible feats being performed with dedication and love. He continued by saying that many of those amazing things are happening because of Judith Pelham, President and CEO of Trinity Health. Her dedication to the mission, vision, and values of Trinity has led to a better health care industry and a better world.

The 2004 National Quality Health Care Award Jurors

- Diane Appleyard, HRDI, Inc.
- Daniel Bourque, VHA, Inc.
- Ralph Cerny, Munson Medical Center
- Steven Epstein, Epstein Becker and Green, PC
- Peter Lanser, Press Ganey Associates, Inc.
- David Loveland, Evanston Northwestern Healthcare
- Edward Murphy, MD, Carilion Health System
- Don Nielsen, MD, American Hospital Association
- Daniel Stryer, Agency for Healthcare Research and Quality
- Sue Widner, Abbott Laboratories
- Donald Yesukaitis, KPMG LLP

Ms. Pelham thanked Mr. Lauer, *Modern Healthcare*, Mr. Zaccagnino, Yale-New Haven Health System and NCQHC for the honor, noting that everyone at Trinity is humbled and thrilled by the award. She acknowledged the thousands of hard-working Trinity employees who are responsible for the successes of the organization. Trinity is

only four years old, having been created by the merger of two systems in 2000, and, said Ms. Pelham, "… it is an amazing testimony to the employees that this award be bestowed on Trinity so soon after its formation."

NCQHC Award Winners

- Trinity Health, Novi, Michigan, 2004
- Lehigh Valley Hospital and Health System, Allentown, Pennsylvania, 2003
- Carillon Health system, Roanoke, Virginia, 2002
- Catholic Health Initiatives, Denver, Colorado, 2001
- Munson Medical Center, Traverse City, Michigan, 2000
- BJC Health System, St. Louis, Missouri, 1999
- University of Pennsylvania Health System, Philadelphia, Pennsylvania, 1998
- St. Luke's Health System, Kansas City, Missouri, 1997
- Intermountain Health Care, Salt Lake City, Utah, 1996
- Evanston Hospital Corporation, Evanston, Illinois, 1995
- Henry Ford Health System, Detroit, Michigan, 1994

Trinity is committed to being a national leader in quality and safety, and it has the scope to be a true force in transforming health care, with nearly $5 billion in annual revenues; 45 community hospitals; 402 outpatient clinics; numerous long-term care facilities, home health and hospice programs; and senior housing communities scattered across seven states. Trinity's "niche" is not to conduct original research or to find new discoveries, but rather to facilitate the rapid implementation of best practices and innovation throughout the nation's community hospitals and the local communities they serve. Ms. Pelham believes that Trinity's nearly 44,000 employees and 8,000 physicians are at the beginning rather than the end of that journey. Trinity has set up an "intelligent network" that allows physicians, nurses, managers, and other hospital staff from Trinity facilities all over the country to work closely together. She shared several examples of the kinds of programs that have led to Trinity's recognition as a driving force for quality.

Judith Pelham, President, Trinity Health and William Kreykes, Chair, Trinity Board of Trustees

- **Maternal child care improvement team:** By developing high-reliability perinatal units, maternal and child health tool kits, and other initiatives, the 13 hospitals participating in this project have dramatically improved safety and quality for newborns and their mothers.
- **Potential error and event reporting system (PEERS):** This system, which is based on one developed for NASA, has been implemented in 17 of Trinity's hospitals. The initial impact of PEERS was to dramatically increase the number of reported events because it allows employees to report potential errors without fear of retribution.
- **Core clinical indicator progress:** Trinity tracks performance for core indicators, including appropriate care for patients suffering from a heart attack, heart failure, and pneumonia, and is in the top quartile of performance for the majority of these measures.

- **Project Genesis:** This project relates to creating information systems that will enhance patient care and safety.
- **Community-based Initiatives:** Trinity hospitals are active in promoting health within their local communities.

Ms. Pelham concluded by reiterating her organization's commitment to being a national leader in the transformation of American health care.

Trinity's Mission and Values

The mission: "We serve together in Trinity Health, in the spirit of the Gospel, to heal body, mind, and spirit, to improve the health of our communities, and to steward the resources entrusted to us."

The values: respect, social justice, compassion, care of the poor and underserved, excellence.

Conclusion

Mr. McWhinney offered some closing comments to summarize the two-day session. First and foremost, he emphasized that the current status of the business case for quality depends on perspective. The case may be clear for some stakeholders but not for others. This conference has helped to identify the gaps in the business case and provided concrete ideas for how to close them. He believes that NCQHC is well positioned to continue to move the business case for quality forward in the years ahead through its various activities.

Bruce McWhinney, Senior Vice President for Clinical Services, Cardinal Health, Inc.& NCQHC Chair 2004-2006

Ten Principles of Quality Health Care:

A Commitment to Excellence

Quality Healthcare strives for continuous improvement in provider skills and the delivery of healthcare.

Quality Healthcare is accessible to all.

Quality Healthcare encourages active consumer participation.

Quality Healthcare delivery is value-based.

Quality Healthcare is committed to consumer and provider safety.

Quality Healthcare protects confidentiality and privacy.

Quality Healthcare delivery is a coordinated effort among providers.

Quality Healthcare improves the health status of the community.

Quality Healthcare includes end-of-life patient concerns.

Quality Healthcare measures are accessible to the public.

Mission Statement

Our Mission Statement

The mission for The National Committee for Quality Health Care (NCQHC) is:

To create an assembly of national thought-leaders from the diverse constituencies of the healthcare system concerned with quality healthcare.

To provide leadership in promoting principles of quality as indispensable elements of the American healthcare system.

To anticipate challenges to the system, and to identify and assess alternatives for improving the health of the American People.

To communicate cost-effective means for improving the healthcare system that are based on sound research and evaluation.

1701 K Street, NW
Suite 205
Washington DC 20006
202.331.7535
202.331.7532 FAX
ncqhc@erols.com

www.ncqhc.org