

SPECIAL
EDITION

Hospital Outlook

AUGUST, 2008; VOL. 13, NUMBER 3

INSIDE THIS ISSUE

- 2 Is "Systemness" Achievable?
- 3 "President's Perspective"
- 4 P4P: Past And Present
- 5 Measures and Value-Based Purchasing
- 5 Accountability: Where The Rubber Hits The Road
- 6 A Framework For Increasing Integration
- 7 The Promise Of Health Information Technology
- 8 Conversations With Drs. Perlin and Paul
- 12 End Notes

Can Payment and Other Innovations Improve the Quality and Value of Health Care?



For the last 15 years, the nation's leading health policy experts have met in Princeton, New Jersey to analyze and discuss topical and impending issues. This year's Princeton Conference – "Can Payment And Other Innovations Improve The Quality And Value Of Health Care?" – examined current efforts to link payment with quality and value, and whether the current construct of quality measurement and payment really works to improve overall health care quality and efficiency.

This edition of *Hospital Outlook* is devoted exclusively to summarizing several of the presentations that took place at this year's Princeton Conference. The Federation of American Hospitals played an organizational role in the conference by joining with the Council on Health Care Economics and Policy and serving as co-organizer and presenter. Both groups also organized and presented a subsequent "mini" Princeton Conference in Washington, DC for the benefit of Capitol Hill staff.

On page three, FAH President Chip Kahn's column provides an overview of ongoing health care quality efforts and sets the context for the conference.

Conference co-organizers Chip Kahn of the Federation of American Hospitals (at head table) and Stuart Altman of Brandeis University/Council on Health Care Economics and Policy (at podium).

Additionally, page two's report on "systemness" serves as a stage-setter for the presentations to follow.

This year's conference is the third in a series of conferences developed by FAH President Chip Kahn, Stuart Altman of the Council on Health Care Economics and Policy, and *Health Affairs*, in conjunction with several co-sponsoring organizations. Information about the previous two conferences, which are not associated with the annual Princeton Conference, is available on the FAH's home page: www.fah.org.

(Editor's note: archived webcasts and transcripts of the 15th Annual Princeton Conference are available by utilizing the following URL: www.kaisernet.org [search for "The 15th Princeton Conference" within "HealthCast"] Additionally, the policy journal *Health Affairs* will publish some of the conference presentations in an upcoming edition).

POLICY AND MARKET NEWS FROM AMERICA'S INVESTOR-OWNED COMMUNITY HOSPITALS

Is “Systemness” Achievable?

The consensus among attendees at 2008’s Princeton Conference is that the U.S. health care system is fragmented, does not produce enough value, and remains based primarily upon a fee-for-service payment model.

Acknowledging these “givens,” how can we “move the dial” and improve quality and efficiency in the health care system?

So asked Kathleen A. Buto, Vice President, Health Policy and Government Affairs with Johnson & Johnson, who moderated the conference’s first panel, pertaining to “systemness”: whether greater integration in the health care delivery system is necessary to achieve these goals – and if so, to what degree?

Dr. Corrigan also directly referenced a subsequent IOM report – “Crossing the Quality Chasm: A New Health System for the 21st Century” – as the basis for her conclusions about new organizational models.

Research indicates that more sophisticated organizations outperform smaller, less integrated groups; lack of organizational supports leads to poor quality and inefficient use of resources; and health information technology can help achieve “significant improvements” in health care safety, effectiveness, affordability and efficiency, she said.

Consequently, policymakers should establish a set of national priorities and goals requiring higher degrees of organizational capacity, along



Robert Berenson, M.D.

“accountable health systems.” Each of these accountable health systems would contain organizations such as multispecialty group practices and interdependent physician organizations, each of which could assign accountability at a different organizational level.

Robert Berenson, M.D., another responder and a Senior Fellow with the Urban Institute, was less sanguine. All of these reforms would be optimal and would produce improvements in quality and value, but current trends are moving in the opposite direction, he observed.

Among these trends are fewer staff group HMOs; the growth of preferred provider organization (PPO) coverage which threatens the use of capitation to increase efficiencies; the increasing number of “focus factories” and single specialty mergers; and “stunning” Medicare readmission rates, according to Dr. Berenson.

Dr. Berenson said that these trends, along with other decisions that are being made within the current payment system, make it increasingly difficult to increase accountability and form integrated health systems, and if anything, show movement toward more fragmentation.

The only countervailing trend is the phenomenon of hospital employment of physicians, which brings about “automatic alignment.” However, it is too facile to say that we need to do something new and ignore the current, predominant fee-for-service payment system, Dr. Berenson remarked.

Audience member Allen Dobson, Ph.D., President of Dobson/DaVanzo, LLC, concurred with Dr. Berenson’s assessment of current trends. Capital goes to financial reward, “fee-for-service is enormously profitable,” and “physician ownership of everything is highly profitable,” he observed.

“But unless you get the incentives to take away the enormous profitability for the alternatives (to an integrated system), I think you guys are dead in the water.”



Kathleen A. Buto, Janet Corrigan, and Stephen Shortell

Janet Corrigan, President and CEO of the National Quality Forum, the panel’s first presenter, called for new organizational models featuring greater integration and “fundamental payment reform,” while observing that there are several options for aligning payment systems.

New organizational models and fundamental reform are necessary due to prevalent quality problems, particularly “absolutely entrenched” overuse, misuse, and underuse of services, as well as a lack of accountability for critical aspects of care.

“Our quality problems and challenges in the health care system are legendary,” she remarked.

Nevertheless, “in spite of our best efforts over the last 10 years, we see very meager improvements in quality over time,” she added.

Dr. Corrigan’s 10-year time frame is an implicit reference to the 1999 release date of “To Err Is Human: Building a Safer Health System,” a landmark report published by the Institute of Medicine (IOM). “To Err Is Human” concludes that tens of thousands of Americans died each year due to preventable mistakes in their care.

“Our quality problems and challenges in the health care delivery system are legendary.”

*– Janet Corrigan,
National Quality Forum*

with a new set of performance metrics for quality and cost, she remarked.

The next presenter, Stephen Shortell, Ph.D., Professor and Dean of the School of Public Health at the University of California-Berkeley, agreed strongly with Dr. Corrigan’s conclusion that more organized practices produce greater value – at least in terms of processes. He believes that we can achieve systemness that improves quality within the current diffuse health care system – “but with great difficulty.”

To do so, desired health outcomes must become the central focus, through the use of

It's More Complex Than Rocket Science

By Charles N. Kahn III

Simply stated, delivering health care in the U.S. is extremely complicated and its problems are no less complicated. Truth be told, though, there is no silver bullet. If anything, achieving and assuring improved health care quality and efficiency is more complex than rocket science.

There are many reasons why. Perhaps the major factor is, despite all that medical science has achieved and the tremendous efforts and professionalism of our physicians and providers, we too frequently provide care in a non-systematic way. "Crossing the Quality Chasm," the landmark 2001 report by the Institute of Medicine (IOM), asserts that one of the primary reasons for quality concerns is that health care delivery in the U.S. is "highly fragmented," and that more integrated delivery will yield more efficient, high quality patient care.

In response to the IOM report as well as other studies, many have been trying very hard to improve health care quality and efficiency, employing a wide variety of tools from organizational reforms to financial incentives or penalties. The state and federal governments, large and small businesses, insurers and providers all have been experimenting with a wide variety of possible solutions to gain better results and more value from our health care. We are witnessing more and more activity and enormous commitment from all sectors.

However – and it is a big however – it is not clear whether all of this activity has led to any significant change. Are Americans getting better health care? Are we getting more value for the dollars spent?

This uncertainty, coupled with the need to assess the effectiveness of the collective responses to the IOM report, became the *raison d'être* for this year's Princeton Conference. For the first time, the Federation of American Hospitals and a number of other generous sponsors joined forces with the Council on Health Care Economics and Policy – the conference's long-time organizer – to examine payment reform and other innovations that could boost our nation's overall health care delivery.

Given the conclusion of the IOM's "Crossing

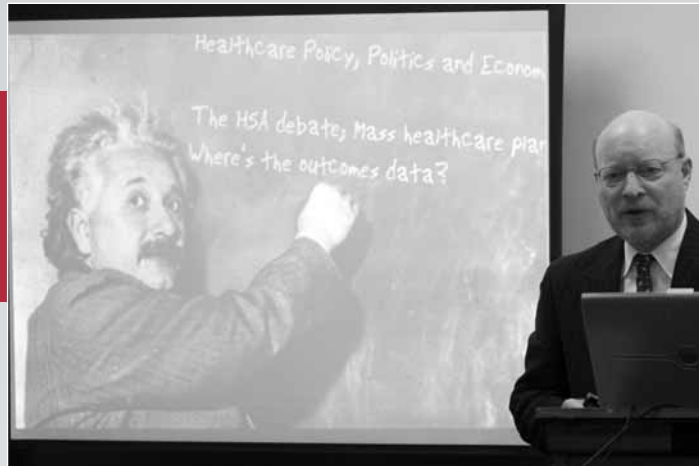
the Quality Chasm" report, we set up this year's Princeton Conference to examine whether "it takes a system" and fundamental reform to achieve our goals for health care quality and efficiency, and if so, how we should achieve it. The conference also was intended to examine whether and to what extent "systemness" is a realistic goal, given the cottage-industry nature of health care delivery in the U.S., where most health care is paid for under fee-for-service or similar arrangements.

This, in turn, leads to other questions: what should be our expectations about quality and safety; what tools do we need to meet these expectations; how effective are our current tools; and how likely are the tools we are building to be effective??

Our current tools to properly align care and payment include the use of standardized clinical care measurements. The National Quality Forum (NQF) has evolved as the national standard-setting organization for performance measures. To date, HCA has adopted 62 measures, and, with the Department of Health and Human Services, has reported on 30 process and performance measures posted on its public website: www.hospitalcompare.hhs.gov.

Pay-for-reporting, evolving into pay-for-performance, is one tool that public and private organizations may use to encourage physicians and medical organizations, including hospitals, to do a better job. This year's Princeton Conference sought to explore the impact of pay-for-performance, and whether it can move beyond current performance payments for process and clinical outcomes to provide payments that reward patient-centered care that maximizes quality and efficiency.

Health information technology (HIT) is heralded as another tool that offers the very real prospect of enhanced quality and performance through enhanced communication to better coordinate care. At the moment, the nation's largest integrated or closed health systems, such as the



Veterans Administration and Kaiser Permanente, are best able to tap into HIT's promise for improving clinical care. Two questions remain: the long-term question as to whether and how we get to interoperability; and the short-term question about how we can get most providers and physicians plugged into some type of HIT to better serve their patients.

More integrated care delivery has been a watchword for improving health care quality and value. Yet over the last few years, there have been trends in a different direction with the advent of so-called consumer-directed health plans, which are intended to boost quality and value through enhanced consumer choice of physicians and providers.

Under these plans, consumers generally have more skin in the game because they would pay more of the costs of care out-of-pocket. The concept is that with more skin in the game, consumers would have enhanced incentives to recognize value when they purchase individual care and can obtain higher increments of care. Doing so, though, does not assure that they will receive coordinated care.

Consequently, this year's Princeton Conference included a session on whether consumer-directed health plans are an effective and efficient way of helping consumers to get better care for their health care dollar.

This special edition of *Hospital Outlook* provides an overview of "Can Payment And Other Innovations Improve The Quality And Value Of Health Care?," including the issues of "systemness, pay-for-performance, measures, accountability, and a framework for payment reform intended to spur greater integration. It also examines the promise of HIT, reviews consumer-directed health plans, and features some parting thoughts from Stuart Altman of Brandeis University and Chairman of the Council on Health Care Economics and Policy.

See *It's More Complex Than Rocket Science*
Page 4

P4P: Past And Present

The Institute of Medicine published its seminal “To Err Is Human” report about hospital quality in 1999. Since then, hospitals responded collaboratively by forming what now is known as the Hospital Quality Alliance (HQA), a private/public partnership with hospitals, physicians, organized labor, consumers and two government agencies (CMS and AHRQ). HQA has adopted for public reporting 60 measures of quality care. (Editor’s note: a subset of these measures is available on the Hospital Quality Alliance’s “Hospital Compare” website: <http://www.hospitalcompare.hhs.gov>)

Nevertheless, uncertainty abounds as to whether these measures are significantly improving health care quality, safety, and efficiency. “There is a lot going on, but it is not clear yet that all of that activity has led to much change,” observed FAH President Chip Kahn, who described existing measures as primitive, frequently unproven, and often not aligned properly.”

What are these measures, what should be measured, and do our measures measure up to our expectations, asked Reed Tuckson, M.D., Executive Vice President & Chief of Medical Affairs, UnitedHealth Group, moderator of a panel examining pay-for-reporting (P4R) and pay-for-performance (P4P) models.

“Pay-for-performance (P4P) is but one tool in a continuum of tools to improve quality, efficiency, and patient satisfaction,” he observed. “But remember that it is a part of a continuum that begins with research; then moves to translation of research into clinical guidance that must be led by the profession.”

“We own this problem and if we cannot figure this out like tomorrow, shame on us,” he added.

To look forward with P4P, we first must look back, observed panelist Meredith Rosenthal, Ph.D., Associate Professor with the Harvard School of Public Health. Concerns expressed five years ago that P4P was all hype have been mollified by its current prevalence and evolution and a lack of evidence showing adverse consequences.

And while most P4P awards have gone for attainment, payers also are starting to award improvement, she observed.

There exists evidence that P4P can work if used appropriately, and can be an important part of payment reform. However, looking backwards shows that “even substantial bonuses using P4P cannot undo the stronger incentives that are coming from fee-for-service,” she added.

Panelist Cheryl Damberg, Ph.D., Senior Analyst with the RAND Corporation, reported that experiments featuring “pay-for-performance” (P4P) are taking place around the country.

However, these programs are very new and the research examining P4P’s effectiveness is limited, preliminary, and shows only mixed or modest results. P4P “really is working at the margins and in a very toxic payment system” and is unlikely by itself to solve our nation’s health care quality and cost problems, she remarked.

However, Dr. Damberg said that P4P may be useful when combined with other policy options, such as bringing about improvements in measurement and accountability, public reporting or transparency, and investing in information systems.

“I do think it is reasonable to ask the question of if we are going to invest in various policy mechanisms, how much (of an) incremental bump do you need to get to say that it was worth the investment,” she concluded.



Reed Tuckson, M.D.



Meredith Rosenthal



Cheryl Damberg

There’s No Silver Bullet To Improve Quality And Efficiency from page 3

I hope that this special edition of *Hospital Outlook* will provide at least a window to the vast content that the conference covered through presentations and discussion. To view the conference and obtain full transcripts, you may utilize the link on the FAH home page (www.fah.org) to access archived webcasts and transcripts of this year’s conference from www.kaisernetwork.org. Additionally, Health Affairs will produce an electronic supplementary issue which will include most of the presentations, as well as

additional useful work in the area of better understanding the impact of efforts to improve delivery of care in America.

Mr. Kahn is President of the Federation of American Hospitals. His e-mail address is ckahn@fah.org.

Measures And A Value-Based Purchasing System

The greatest opportunities for improved health care value will occur at the system level.

Most notably, improving health care value, among other activities, entails improving the ability of a health care system to navigate Medicare beneficiaries to avoid hospitalizations, premature death, and predictable readmissions, according to Christopher Tompkins, Ph.D., associate professor and director of the Institute on Health Care Systems at the Heller School at Brandeis University.



Christopher Tompkins

Dr. Tompkins' comments followed his description and discussion of CMS's value-based purchasing scoring system. He presented a three-tiered hierarchy of change, the easiest of which, he said, would be providing incentives to physicians for reducing or increasing the frequency of service units (such as fewer images or more well-baby visits).

More difficult, he said, would be to provide physicians with incentives to encourage them to provide services or tests that they are not already providing, such as asking a primary care physician to screen or offer preventive care services.

Most difficult of all is achieving shared information and accountability among providers. To get to this level, the societal "we" have to ask whether we want physicians to conduct practice management, patient management, or both.

"Are we asking them (physicians) to better manage their own practices, to put their heads down and stick to the knitting and do a better job with that? Or are we asking them to raise up, look around, notice each other and notice that there are a lot of hand-offs – that there are a lot of patients that are falling through the cracks – and actually finding a way to look more like a delivery system,"

he remarked.

Composites are part of the answer, according to Dr. Tompkins. Insisting that every measure is important in and of itself overlooks that many measures are very small on their own but belong to larger categories, he added.

Accountability: Where The Rubber Hits the Road

Nancy Nielsen, M.D., Ph.D., President of the American Medical Association, moderated a panel examining accountability, and succinctly set the tone at the outset: In any discussion about improving health care quality and efficiency, holding a provider or providers accountable for the well-being of patients is where "the rubber hits the road," she observed.

One way for achieving accountability is looking to Medicare as a model through a framework called "Accountable Care Organizations" (ACOs), advocated by panelist Mark B. McClellan, M.D., Ph.D., currently with the Brookings Institution and formerly CMS's Administrator.

ACOs would be able to receive Medicare payments and share bonus payments among participating providers, thereby bringing improvements in quality and efficiency by supporting coordination and accountability among providers. ACOs would emphasize quality and costs at the patient level, as opposed to short-term steps for quality reporting or e-prescribing, he asserted.

A pilot version of ACOs can be implemented now in Medicare and potentially in the private sector. Shared savings in the early years under the ACO system would result in continuing care improvements and savings for Medicare, thereby allowing the revision of baseline Medicare spending. ACOs also would enable payment reforms to go beyond individual physician quality measures and toward overall quality and coordination measures, according to Dr. McClellan.

The second panelist, Jonathan B. Perlin, M.D., Ph.D., Chief Medical Officer and Senior Vice President of Quality at HCA, offered what he termed as a slightly different approach, based upon research: poor quality and safety reflect bad business practices and affect the bottom line.



Nancy Nielsen, M.D., Ph.D.

Value-based health care rectifies poor quality and safety breaches by creating a rational business case for providers to produce better safety and higher quality health care. Value-based health care is inevitable and results in real improvements for real patients. Furthermore, "the stars are beginning to align" where incentives can assure that health care "does well by doing good," he remarked.

Prior to joining HCA, Dr. Perlin was instrumental in developing and implementing value-based health care while Undersecretary for Health at the Veterans Administration.

Dr. Perlin also pointed to what he described as another big change in health care: not paying for highly preventable hospital-acquired health condi-

See *Accountability: Where The Rubber Hits The Road* Page 7

A Framework For Increasing Integration

The U.S. has the most expensive health care system in the world, but are we getting our money's worth? Not by a long shot, according to Stuart Guterman, M.A., Senior Program Director with the Commonwealth Fund.

Mr. Guterman established his case for payment reform by referring to a national scorecard prepared by the Commonwealth Fund, which compares the U.S. health care system to those of other countries. The U.S. got a score of 66 out of 100, a score that he termed as being "not acceptable."

He also presented information showing that the inefficiency and expense of the U.S. health care system is hurting families and causing national health care costs to increase significantly. One of his charts depicts that families' health insurance premiums and out-of-pocket spending on health care grew at a significantly greater rate than had workers' incomes.

Nationally, at the current growth rate, projected health care spending over the next 10 years will double to \$4.4 trillion, compared to \$3.6 trillion for the same time period if spending stays at its current rate of 16.2 percent of gross domestic product, he noted.

These statistics lead to what panel moderator Susan Nestor Levy, Chief Advocacy Officer of Ascension Health, referred to as the "where's the beef?" question: what is the best way to transform the payment system and introduce appropriate incentives to raise health care quality and efficiency?

In response, Mr. Guterman offered "carrots" – in this case, a framework of escalating financial incentives designed to move providers away from what was referred to during the conference as the current "toxic" fee-for-service payment system.

The Commonwealth Fund framework of organizational and payment methods features two main axes: a horizontal axis of a continuum of payment bundling and a vertical axis of a continuum of pay-for-performance design.

The horizontal continuum of organization axis starts with a small medical practice with unrelated hospitals, and continues up to an integrated delivery system. The vertical continuum of pay-for-performance design axis starts with fee-for-service and DRGs and works its way up to integrated system capitation.

At the bottom, small medical practices that incorporate simple process and structural measures would receive, as additional payment, a



Stuart Guterman



Susan Nestor Levy



David Pryor, M.D.

small percentage of its total payment. Moving to the top of the organization continuum, an integrated delivery system using outcomes measures would receive a financial incentive consisting of a large percentage of total payment.

"The underlying philosophy here is that you start out by recognizing that there is an array of different kinds of organizations and you basically try to make different payment models available to those different organizations on a voluntary basis, with incentives built in to choose the most bundled payment that you can handle as a practice," he explained.

Medicare could serve as the initial testing ground for the framework, which would push Medicare toward more bundled payment. Also necessary are underlying system reform with accountability, "real" transparency, information technology, comparative effectiveness, and universal access, he asserted.

However, much can be done, and has been done, without payment reform, observed panel discussant David Pryor, M.D., Chief Medical Officer of Ascension Health.

Dr. Pryor offered three examples, based upon Ascension's experience: putting in place an information infrastructure to ensure that every patient gets the right care at the right time, a "just" reporting culture to improve outcomes by learning from medical errors or near-misses, and transparency to enable consumers to participate in "value-based decisions" about their health care.

More broadly, Dr. Pryor predicted that policymakers may take incremental steps in 2009 regarding cost and quality, adding that he does not underrate the chances of some type of coverage reform. Big payment reforms, though, in the short term probably are unlikely because of their controversial nature and because a lot of people have a "strong stake in the status quo," he maintained.

The Promise Of Health Information Technology

Lawmakers, policy experts and others actively are promoting the use of health information technology (HIT) to improve quality, increase value, and improve performance, and there has been great progress in setting standards and engendering interest on the HIT front. However, it remains unclear whether and how we will achieve interoperability, remarked FAH President Chip Kahn.

Mr. Kahn, who moderated the Princeton Conference's HIT panel, is a commissioner on HHS Secretary Michael Leavitt's American Health Information Community advisory panel.

There are examples of successful HIT interoperability, such as within the Veterans Administration and other large health care organizations, which improved very specific aspects of care. Nevertheless, implementing interoperable HIT systems nationwide is a very difficult proposition, he noted.

"HIT has transformed all aspects of VA care," agreed panelist Paul G. Shekelle, M.D., Ph.D., with the Greater Los Angeles VA Healthcare System and Director of the RAND Corporation's Southern California Evidence-Based Practice Center. But HIT did not do it alone; it also took a culture of cli-



Paul G. Shekelle, M.D., Ph.D.

nicians who value quality, a culture of scientific evidence and accountability, and other aspects, he said.

Dr. Shekelle's conclusions about HIT are based upon a literature review that he and his colleagues at the RAND Corporation conducted on behalf of the government's Agency for Healthcare Research and Quality.

The amount of published literature was limited, he said, but of all of the articles that they found, 25 percent came from just four of the nation's largest integrated health systems, where HIT was revealed to have created a significant improvement in quality – such as reductions in redundant lab tests and a significant reduction in medication errors.

Based upon this literature review, "there exists good evidence that HIT can dramatically improve quality and safety," he observed. "However, evidence of cost-savings is much less clear, and the challenges of implementing HIT have been underestimated and poorly studied."

Successful HIT implementation will take time, resources and leadership. Above all, the most important requirement is to align the financial incentives. Health care practices are being asked to bear the implementation cost, but are not garnering the savings, he added.



FAH President Chip Kahn

HIT cannot be used just to examine process indicators and certain measurements, remarked Steven Corwin, a discussant on the panel and Executive Vice President and Chief Operating Officer of New York-Presbyterian Hospital.

Instead, it should be used to improve upon the system of care. To this end, successful HIT needs to provide real-time analytics and support of clinical decision-making, reduce errors, and enable connectivity across the continuum of care, according to Mr. Corwin.

HIT is critical to bring about quality improvement, he concluded. "It is not desirable – it is necessary," he concluded."

Accountability: Where The Rubber Hits The Road from page 5



Mark B. McClellan, M.D., Ph.D.

tions, which can be mitigated by better practices.

As an example, Dr. Perlin mentioned HCA's concept of ABCs – targeted active surveillance, barrier precautions, "compulsive" hand hygiene, disinfection, and executive ownership (accountability). "ABCs" have resulted in HCA recording a 1000 percent improvement in hand hygiene and "a very real reduction" in health care associated infections related to MRSA and other multidrug-resistant organisms, he noted.

Consequently, value-based health care means that hospitals have a "compelling" business rationale for justifying the importance of higher quality and improved safety. It also gives patients an incredible and life-saving return on quality, he added.



Jonathan Perlin, M.D., Ph.D.

"...the stars are beginning to align' where incentives can assure that health care 'does well by doing good.'"

– Jonathan B. Perlin, HCA

Wither Consumer-Driven Health Care?

Seemingly, opinions about so-called consumer-driven (or consumer-directed) health care, also referred to as high-deductible health coverage, are that it either is the *deus ex machine* or the *bête noir* of the U.S. health care system – and sometimes, somewhere in between.

James C. Robinson, Ph.D., Professor of Economics with the University of California, Berkeley admits to being an advocate.

"I do not really see what the alternative is," he remarked during his presentation at the Princeton Conference. "What do we want? A physician-driven system? Insurance-driven system? Employer-driven system? Government-driven system?"

Market share for high-deductible health insurance has grown very slowly, he acknowledged. However, the design of high-deductible health coverage has evolved considerably. Currently, every kind of high-deductible health plan incorporates various forms of medical management and are built on the "chassis" of a PPO network – "the health plan design of our times."

Dr. Robinson predicted that over time, the percentage of people in the U.S. covered by public coverage will grow, and that public programs likely will outsource the management of these plans to the private sector, *à la* Medicare Advantage. "The tragedy from a consumer-

driven perspective is it is really a losing battle against the expansion – the inexorable horrible expansion of public insurance," he remarked.

Dr. Robinson also envisions two models for the private coverage system: first-dollar coverage for preventive screenings and primary care, and a specified indemnity amount from insurers, with patients picking up the rest of the tab.

He predicted that the indemnity model likely will take place in specialty areas – dedicated facilities that provide cardiology or orthopedics, "where the big dollars are," and where patients have "passed their deductible by the time they get to the elevator," he predicted.

Regarding health care delivery, those in the policy world only would have to say "let the best model win," so long as it wins based upon efficiency instead of cherry-picking and skimming patients – which is easier said than done, he admitted.

Single payer health financing "is balancing



James C. Robinson

limited resources and unlimited expectations," Dr. Robinson observed. Concentrating this responsibility into one place – the government – "would be pouring oil on the fires of American anti-government sentiment, which is strong and very vibrant."

Dr. Robinson offered a parting thought for those who object to insurers' overview of health care delivery: "If you do not want the health plans to be doing medical management, do it yourself."

Sponsors For The 15th Annual Princeton Conference



Robert Wood Johnson Foundation



United Health Foundation



Princeton Conference Perspectives

Conversations with Dr. Perlin and Dr. Paul

Quality As The Best Business Case

HOSPITAL OUTLOOK: During your presentation, you said that quality simply is good business. Would you please elaborate?

DR. PERLIN: Quality is increasingly the best business case in health care; the truth of the matter is that it always was. If one looks at other industries and thinks about how quality or safety might relate to the value proposition for investment, I think the answer you come up with is that you wouldn't want to invest in an industry without high quality, or that had breaches of safety. If you further probed as to why, you'd say of course there would be liability; there would be lots of rework.

So attending to quality really was an efficiency, not a cost center. In a world where we're now moving to value-based health care – where the CMS pay-for-performance (or really non-pay for non-performance) program will put reimbursement at risk, where value-based health care is emphasized by commercial payers, and where inclusion in networks is based on measured efficiency and clinical outcomes – it's increasingly clear that good quality is the best business case. Beyond the economic principle that underlies this, it reinforces the ethos that all of us bring to health care: to do the right thing.

HOSPITAL OUTLOOK: Are quality improvements generally incremental? Can they be exponential? Do they plateau over time? Typically how do they progress?

DR. PERLIN: That's a great question. Most quality improvement is framed incrementally, and that can be frustrating. Some approaches, like Six Sigma (a business strategy to identify and eliminate causes of errors, defects or failures in business processes), seek exponential improvement. And using new technologies like electronic health records can accelerate improvement.

One of the greatest challenges remains clinician, especially physician behavior change. I'm a very data-driven person and my experience providing information back about why the recommendation underlying a measure is evidence-based helps to provide the moral authority to change clinician behavior, and providing the data about actual performance also can be illuminating.

Again, I start with the perception that people come to health care who want to do their best, but oftentimes the paper-based systems don't let us know how we're doing. But there also are approaches to re-engineering care that can be really much more revolutionary rather than evolutionary.

HOSPITAL OUTLOOK: Such as?

DR. PERLIN: Moving from a paper-based to an electronic environment, where patient data and clinical decision support come together to create information for clinicians that's sensitive to the context of how old the patient is, what chronic diseases they might have, and that contains links to recommendations for the evidence-based intervention. This makes it easy to do the right thing.



Jonathan B. Perlin, M.D., Ph.D., and Barbara Paul, M.D.

We Don't Need To Wait For Big Initiatives

HOSPITAL OUTLOOK: Dr. Paul, what in your view are some of Princeton Conference highlights?

DR. BARBARA PAUL: First and foremost, I'm gratified to meet so many smart people who are working to find better answers to incentivizing and enabling higher quality care. It is great to hear a full discussion of all the avenues that need to be worked in order to truly do 'value-based purchasing.' The presenters nicely described the bigger changes that have to be made in order to help us get to what we all want, which is higher quality and lower cost. This is in contrast to what most of us experience day to day right now, namely a narrow focus by CMS and other payers on the public reporting of more and more detailed quality measures. This narrow focus fails to acknowledge the costly impact of all of the data collection, and the fact that all of this public reporting is still just chipping around the edges of a flawed payment system.

Second, today has been a reminder of the distinction between measures of quality that are excellent tools for doctors and nurses to use internally with their process of improving care, versus those measures of accountability. And that in many cases the most effective approach to these measures is to have levels of accountability at an aggregated level – namely the hospital level, group level, et cetera. We all work within a system of one size or another – the accountability needs to be at that level.

Quality As The Best Business Case

from page 9

HOSPITAL OUTLOOK: Why was quality not considered previously as a good business practice?

DR. PERLIN: I think some people secretly - or not so secretly - felt that quality improvement simply was a cost center. If you don't link the improvements in quality in one part of the hospital or healthcare process to the overall hospital or healthcare episode, then it might appear as such. For example, using a more expensive, infection-resistant catheter might add to the "cost line," but the model also requires subtracting the cost of avoidable expenses.

A healthcare-associated infection is not cost-neutral. In a study of 1.96 million hospital-acquired infections, the average excess costs were \$5,018 per patient. And central-line infections, even with Medicare reimbursement for this often avoidable complication, result in losses of \$29,000 per case.

Obviously, the losses to the patient were profound, and CMS has changed the game, removing reimbursement this year for 11 "highly preventable hospital-acquired conditions." This perhaps is less evolutionary than revolutionary - saying that certain highly preventable conditions should not be reimbursed. So, we too need to rethink our approach to quality: are we going to continue to be incremental or can we make exponential improvements?

HOSPITAL OUTLOOK: Are there certain types of transparency, in your view, that have the most

"The average losses on the care of the patients who were affected by healthcare-associated infections were \$5,018 per patient."

-Jonathan B. Perlin, HCA

immediate payoff for consumers and that healthcare providers should focus upon first?

DR. PERLIN: I really want to applaud the work of the Hospital Quality Alliance, and the Federation (of American Hospitals). These (HQA) measures aren't picked out of the air. They're strongly evidence-based. If you look at the measures for beta blocker, for example, I'd want one if I had a heart attack because it reduces my chance of a second heart attack and dying by almost half for the first six months after that infarct.

Why are payers interested? Well, it also reduces avoidable health care expenditures by about \$20,000 in the first two years after that heart attack as well.

HOSPITAL OUTLOOK: Per patient?

DR. PERLIN: Per patient. So the clinical measures are generally strong. There may be a couple that are not quite as robust as others, but generally these clinical measures make a real difference: real outcomes for real patients.

I know we're all feeling a bit buffeted by the HCAHPS satisfaction survey - or patient experience survey, to be correct - because it is a different approach. I think many people want to assure that patients have a good experience under the adverse circumstances of hospitalization, or even during the positive experience of certain episodes like childbirth. The reason that payers and the government are so interested is that the answers to these questions correlate strongly with health-resource utilization. For example, the HCAHPS question about explaining discharge medications is a strong predictor of likelihood for readmission.

That's a good example of quality being a good business case. Readmission for things that might be anticipated is bad business. It uses excess resources, it reduces the margin for providers, and it's not what any of us would want for ourselves and our family. By reducing readmission, not only do we reduce unnecessary healthcare expenditures for society and for the employers and aggregates of small businesses and individuals who ultimately shoulder the bill, we create new capacity for additional patients and infrastructure which in many situations already is taxed to capacity.

HOSPITAL OUTLOOK: Innovation leading to additional innovation.

DR. PERLIN: That's right - and quality as the best business case.

Jonathan B. Perlin, M.D., Ph.D., is Chief Medical Officer and President, Clinical Services, HCA.

STEERING COMMITTEE FOR THE 15TH ANNUAL PRINCETON CONFERENCE



Stuart Altman of the Council on Health Care Economics and Policy and Chip Kahn of the Federation of American Hospitals review the conference agenda.

Stuart Altman, Chairman, Council on Health Care Economics and Policy; Sol C. Chaikin Professor of National Health Policy, Heller Graduate School, Brandeis University

Chip Kahn, President, Federation of American Hospitals

John Iglehart, Founding Editor, *Health Affairs*

Tom Ault, Principal, Health Policy Alternatives

Kathy Buto, Vice President, Health Policy and Government Affairs, Johnson & Johnson

Janet Corrigan, President and CEO, National Quality Forum

Mark McClellan, Senior Fellow and Director, Engelberg Center, Brookings Institute-AEI

Reed Tuckson, Executive Vice President and Chief of Medical Affairs, UnitedHealth Group

Theresa Doyle, Senior Government Affairs Director, Medtronic, Inc.

Alexandra Clyde, Vice President, Health Policy and Payment, Medtronic, Inc.

Richard Deem, Senior Vice President, American Medical Association

Mel F. Hall, President and CEO, Press Ganey Associates

We Don't Need To Wait For Big Initiatives
from page 9

HOSPITAL OUTLOOK: Do you believe that policymakers have been focusing sufficiently on accountability?

DR. PAUL: The accountability is not balanced. Current policymakers think they're doing a good thing by piling on more and more measures and don't realize that they're really not getting at the problem. Here is an example of what I mean: to be accountable for success with the cardiac core measures is good – but it is better to be accountable for excellent cardiac care – which doesn't necessarily happen just from core measures success. I think some current policymakers don't realize they're not getting what they want. What they're getting is people scrambling as fast and hard as they can to meet these measures, and they're not necessarily getting the broader quality-related results. In this (conference) room, they get it. Now we must translate that out to Congress, to CMS (Centers for Medicare & Medicaid Services), to the commercial carriers, to physician groups, hospitals, and others.

HOSPITAL OUTLOOK: Focusing upon measures alone will not be sufficient to get at real quality, as you've expressed it. Does that, in your view, require a total systemic change, and if so, what type of systemic change would that be?

DR. PAUL: There needs to be change in payment methodology, and some of the speakers talked about that in a way that I could finally get my arms around. For example, we need to institute new ways of bundling payments. And particularly on the primary care side, we need to add payments for all of the work that primary care doctors do in creating a medical home, doing counseling, providing care coordination and generally managing people with a multitude of chronic illnesses. These are important physician/patient needs and they don't get paid for now. It's part of the reason why primary care is withering on the vine.

The acknowledgement that the payment structure itself has to be modified fundamentally was a key take-away, and it's a big part of true 'value-based purchasing.' The way that Stuart

Guterman (Commonwealth Fund) talked about trying to incrementally change payment structure made sense to me in terms of really getting at enabling and supporting hospital administrators and nurses and doctors in doing what they really want to do, which is provide the highest quality care. He is a credible person to be presenting these proposed changes, building from his work at CMS where he came to understand how the Medicare payment structure works and now with his perspective from the outside.

HOSPITAL OUTLOOK: Are there any other observations that you'd like to add?

DR. PAUL: A few more thoughts. One speaker talked about how when he works with doctors that he doesn't talk about cost or efficiency. What

report very, very similar measures. And with the same question still unanswered, which is how are they being used, and is quality care really being improved?

I think it would be healthy for us to take a step back and ask: is quality of care being improved with what we're doing right now, how much is it improving, and what are the costs in terms of dollars and diverted focus? Then with this fresh perspective and the addition of broader payment reform, we could move forward more quickly on this quality journey.

Finally, I'd say this conference made it clear that to fully realize high quality care, we of course need quality measurement, public reporting and payment reform, but we also need to incremen-

"I think it's kind of healthy for us to take a step back and ask is quality of care being improved here with what we're doing right now with the individual process measures that are being publicly reported. . ."

—Barbara Paul, Community Health Systems, Inc.

he talks about is underuse, overuse, and misuse. That was a helpful construct for me in thinking about how I can more effectively work with our physicians on our efforts.

During the conference we had presentations from Drs. Reinhard Busse from Germany and Edna Bar-Ratson from Israel, and what struck me about it afterward is how many in the Western world are collecting and reporting individual process measures. When I was at CMS, I was a part of creating what is now the 'core measures' effort (as CMS's Director of the Quality Measurement and Health Assessment Group), and it's dramatic to see how they're doing the same thing overseas, and it's a similar phenomenon, where they are getting people to collect and

tally do more. We need the right enabling IT infrastructure, continued consumer education, the right rewards and recognition, standardization of measures and data collection across payers and on-the-ground process improvement expertise. We also don't need to wait for big initiatives – many of these changes can be incrementally achieved.

Barbara Paul, M.D., is Senior Vice President and Chief Medical Officer, Community Health Systems, Inc.

End Notes

Over the years, The Council on Health Care Economics and Policy and its Chairman, Stuart Altman, Ph.D., have been integral to the organization and success of the annual Princeton Conference. This year, as in years past, Dr. Altman's closing remarks brought the conference back to its theme: whether and how policymakers could structure payment system reforms to improve overall health care quality and efficiency.

Dr. Altman's closing observations were based largely upon responses to questions that he posed to conferees during the conclusion of the conference. He found general consensus that there will not be "substantial" improvements in quality and patient satisfaction unless we truly move to a big, integrated system.

Yet in response to his follow-up question, almost all of the conferees agreed that current activities within health care policy are trending away from integrated health systems. Jeffrey T. Stensland, Principal Policy Analyst with the Medicare Payment Advisory Commission, demurred, noting that there are a lot of financial incentives in place "for physicians and hospitals to be a single entity," and that physicians align with hospitals because they enjoy the hospitals' financial leverage when negotiating with private insurers.

Few conferees responded positively to Dr. Altman's question as to whether we are moving in the direction of accountability "in a positive way." However, Elliott S. Fisher, M.D., Director of The Center for Health Policy Research with the Dartmouth Institute, noted "a lot of momentum in the performance measurement world" that encourages looking at episodes of care and outcomes over time. "So I am not only hopeful. I am optimistic," he observed.

In closing, conferee William D. Marder, Ph.D., Senior Vice President and General Manager of Thomson Reuters, said that we could "reconvene a real primary care system" in the U.S. by enabling nurse practitioners and physician assistants. Doing so, though, would not be without risk, would displease physicians, and not be supported easily by existing performance measures, he added.

All of which provided Dr. Altman with a perfect segue to next year's Princeton Conference, which he said would be about changing who provides services and how they are provided.

"The reality of it all is all of us are going to be part of that aging society. So come back next year and it's going to be a story about lives," he remarked.



Stuart Altman at the Capitol Hill "mini Princeton Conference" presentation, with Cheryl Damberg (left) and Janet Corrigan (right).

Hospital Outlook Staff

Editor.....Richard Coorsh
Production Editor.....Julie Cawthron
Editorial Assistant.....LaQuanda Washington
Designer.....Felicia Kahn

Mailing List Changes

Please submit requests for mailing list changes either by e-mail to mdurham@fah.org or by calling (501) 661-9555.

Editorial inquiries to:

The Federation of American Hospitals
801 Pennsylvania Ave. NW, Suite 245
Washington, D.C. 20004
phone: (202) 624-1500
fax: (202) 737-6462
hospitaloutlook@fah.org

Hospital Outlook

is published approximately five times a year by the Federation of American Hospitals
801 Pennsylvania Ave. NW, Suite 245
Washington DC 20004

Visit our website at www.fah.org



PRESORTED
FIRST-CLASS MAIL
U.S. POSTAGE PAID
FEDERATION OF
AMERICAN HOSPITALS
PERMIT NO. 90