Accelerating High-Value Healthcare in the Delivery System

Co-Sponsored by Ascension Health

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Conference Report

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The Health Industry Forum *is based at Brandeis University, chaired by Professor Stuart Altman, and directed by Robert Mechanic. The Forum brings together public policy experts and senior executives from leading healthcare organizations to address challenging health policy issues. The Forum conducts independent, objective policy analysis and provides neutral venues where stakeholders work together to develop practical, actionable strategies to improve the quality and value of the US healthcare system.*

Conference presentations and other background materials are available at www.healthindustryforum.org.

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Key Themes

Overview

Current national health care reform legislation focuses primarily on changing the health insurance system. Further reforms are needed to begin transforming the delivery of health care. However, as demonstrated by three case studies, individual health systems have successfully reformed important aspects of their clinical operations despite countervailing fee-for-service payment incentives. These transformations are largely attributable to strong leadership, shared organizational vision, and dedication to performance measure and process improvement. The challenge is moving from isolated success stories to a policy framework that will drive broader, more systematic change. Changing payment system incentives is imperative. Expanded authority for CMS to launch new payment and delivery system pilot projects could provide a critical first step.

Context

On October 14, 2009, the Health Industry Forum brought together leading experts to discuss policy options for accelerating health care delivery reforms. This forum examined three case studies of diverse health systems that have successfully implemented delivery system changes despite a reimbursement system that does not reward these efforts. Each case study outlined the system's goals, accomplishments, barriers, and process for implementing change. They offered insights into how local and national health policies affected their strategy. After each case study, we asked respondents from other organizations if they could replicate the presenter's achievements. Participants then discussed current barriers to delivery system reform and potential strategies for diminishing these obstacles and accelerating improvements in delivery system quality and efficiency.

Key Themes

- **Health care reform is primarily insurance system reform. Still needed are payment and delivery system reforms.**

  While called health care reform, the legislation making its way through Congress is better described as health insurance reform. This legislation does little to prod needed changes in the health care delivery system. Transforming delivery into a higher-quality, lower-cost system that addresses the enormous amount of clinical waste will take further policy changes.

- **Even in the absence of delivery system and payment reform, some health systems are transforming how they deliver care.**

  Some delivery systems, in the words of Stuart Altman "are like flowers blooming in a toxic payment environment." These systems, which include Virginia Mason, Alegent Health, and Ascension Health, have made significant improvements in quality, efficiency, and patient safety in important areas of their clinical operations. Despite these important changes, it would be difficult for systems to implement such improvements across their entire business line without significant financial repercussions under the current fee-for-service system.

  Some of the common characteristics of these health systems are:

  —*Leadership*. Transformation at these organizations hasn't been primarily motivated by financial considerations. It has been driven by leadership with a vision of improved care, focusing on quality, safety, and care coordination. This vision provides a sense of collective purpose and motivates large organizations to undertake significant change.

  —*Engagement*. Leaders have broken down silos and created cultures of collaboration where employees feel empowered. These organizations have focused on engaging all employees, especially physicians. While having employed physicians might make change easier, speakers emphasized that this was not essential. More important is engaging non-employed physicians into a common culture of clinical quality and cooperation. Since most US physicians are not employed, physician engagement, whether achieved through dynamic leadership or economic incentives, will be critical.

  —*Process focus*. In each case study, organizations adopted a disciplined process orientation (using foundations like the Toyota production system) in their efforts to transform delivery. They used collaborative processes to develop standards, incentives (compensation), and transparency to ensure that standards were adopted.

- **The challenge is to leverage these and other individual success stories into more systemic changes.**

  The case studies (summarized in the following pages) show what is possible. These organizations have successfully implemented novel approaches to transforming important aspects of their delivery systems to significantly improve performance. The challenge is finding strategies for expanding these examples to a much broader range of organizations and settings.

  Since local leadership is highly variable, policymakers need to structure strong economic incentives to induce delivery reform. Changes in incentives means payment reform—bundled payments or global payments, with incentives for quality—which will encourage health systems to transform how they deliver care. Because of its size, Medicare can lead delivery reform by developing and implementing the needed payment changes. The proposed new authority for CMS, which will allow for the launch of a range of payment and delivery system pilot projects, could be an important vehicle for pushing the delivery system forward, if implemented effectively.

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Health Care Reform, Payment Policy, and the Delivery System: The Imperative for Change

Presenter: **Stuart Altman, Ph.D.**, Professor, Brandeis University

Overview

Current health reform legislation has primarily focused on increasing access through insurance reform, and has mostly overlooked specific initiatives to control spending through payment or delivery system reform. Higher-quality, lower-cost health care demands a more coordinated, more integrated delivery system, yet achieving that goal will require changes in how providers are paid. The purpose of this forum is to learn from individual organizations that are providing more coordinated, integrated care, and explore how these strategies can be expanded nationwide.

Context

Stuart Altman set the stage for this forum by discussing federal health care legislation and the need for fundamental payment and delivery system reform.

Key Takeaways

- **Health care reform is primarily health insurance reform.**

  Current health care reform legislation is mostly focused on changing the insurance system with the goal of covering the uninsured and addressing the (uncompensated) care associated with their illnesses. In addition, the Congress has not addressed the payment system or the delivery system in much detail.

  > *"Most of the health reform proposals deal with health insurance. They don't do much about reforming the delivery system."*
  > — Stuart Altman

  However, there are a few items in the federal legislation that touch on delivery and payment reform. These include:

  —*Readmissions.* The law eliminates payment for some readmissions, forcing hospitals to improve discharge planning.

  —*Bundled payments.* Combining payments for acute and post-acute care will create incentives for more coordinated treatment post-hospitalization.

  —*Pilots.* More flexible and extensive pilot programs are planned to test delivery system changes.

  —*Medical homes/primary care.* Funding is included to create medical homes and to expand the number of primary care physicians.

  The federal legislation, Dr. Altman notes, has followed the same sequence as Massachusetts where the first phase of health care reform dealt with access, but not with payment, delivery, or cost control. Now the legislature in Massachusetts is grappling with how to control costs.

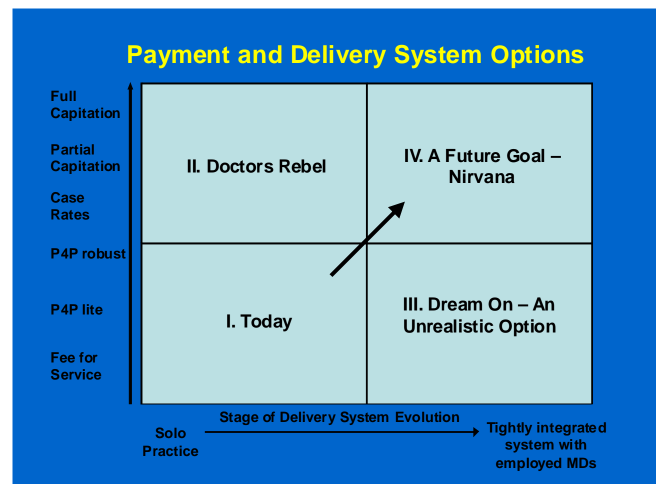
- **Payment needs to drive more coordinated care delivery.**

  The health care delivery system is not efficient. The problem is rooted in the fee-for-service payment system, which creates incentives for high volumes of procedures, often at the expense of preventive care. Because there is no economic rationale to coordinate care, the system remains fragmented.

  A new payment system needs to reward coordinated care by aligning the economic incentives of doctors and hospitals. Without more integrated care, investments in health information technology and chronic care management won't be as efficient.

  > *"If we are going to make any improvement in the efficiency of the system, we need to change how health care is paid for and how it is delivered."*
  > — Stuart Altman

  The delivery system today is largely comprised of solo and small group practices that operate independently under fee-for-service [Regime I]. Previous attempts to move payment toward capitation have been met with physician resistance because the providers were unable or unwilling to re-organize the way they practiced [Regime II]. Ultimately, the goal is to move towards the "Nirvana" stage [Regime IV] where care is delivered by well-integrated systems that are accountable for the cost and quality of care for defined populations.



- **The goal of this forum is to learn from organizations that have implemented meaningful delivery system change.**

  There are important examples of innovative systems that have demonstrated the ability to improve efficiency, quality, and patient safety despite an unfavorable economic environment [Regime III]. The goal of this forum is learn from these organizations and determine how their successes can be duplicated elsewhere.

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Case Study: Virginia Mason Medical Center—Market Collaboratives to Drive Lower Costs and Faster Access to High-Value Care

Speaker: **Robert Mecklenburg, M.D.**, Medical Director, Center for Health Care Solutions, Virginia Mason Medical Center
Respondent: **Allen Smith, M.D.**, President, Brigham & Women's Physician Organization

Overview

The Virginia Mason Medical Center has worked collaboratively with employers to identify medical conditions that are most important to the customers (based on contribution to direct and indirect costs) and has defined quality based on the customer's specifications. It then has created a series of streamlined processes to deliver faster, better, lower-cost treatment that gets patients back to work more quickly. Under this model, all stakeholders benefit, including Virginia Mason which has been able to increase patient volumes and reduce operating costs in order to achieve higher operating margins. Although Virginia Mason has achieved these outcomes under fee-for-service payment, without significant changes in provider reimbursement, the scale of these models is limited. Therefore, even for highly integrated delivery systems, payment reform and regulatory changes will be required to drive large-scale systematic delivery system change.

Context

The Virginia Mason Medical Center (VMMC) is an integrated system in Seattle, Washington with an employed multi-specialty group of 450 physicians, a hospital, and multiple clinics. Dr. Mecklenburg described a marketplace collaborative that VMMC has initiated with local employers and third-party payers to improve the quality and value of services. Dr. Smith, from Partners Healthcare in Boston, responded by discussing key challenges Partners would face in trying to replicate VMMC's model.

Key Takeaways (Mecklenburg)

- **Virginia Mason's Marketplace Collaborative Model brings stakeholders together to deliver better, faster, more affordable health care.**

  The Marketplace Collaborative Model brings together major employers, health plans, and providers to create a marketplace for specific conditions based on quality and access. By concentrating on a private-sector employed population (versus a Medicare population), the Collaborative focuses on specific high-cost conditions important to employers, such as back pain, migraines, and breast nodules.

  Each stakeholder has a different role to play in this quality-focused marketplace.

  —*Employers* use their purchasing power to define the focus of each intervention. They set quality specifications for the health care product, which can include "indirect cost" measures such as absenteeism and presenteeism.

  —*Providers* design and produce a product employers want to buy based on the employers' specifications. This happens in other businesses, but is rare in health care.

  —*Health plans* pay for quality and value, using objective outcomes measures and a transparent reimbursement model.

  The overall objective of the Collaborative is to develop an actionable care pathway that increases quality and employee access, while lowering cost for the purchaser and maintaining or increasing margins for the provider.

- **The early work of the Collaborative has challenged many of the assumptions inherent in existing health care delivery systems.**

  By working with the Marketplace Collaborative, Virginia Mason has focused its improvement efforts toward a specified set of medical conditions using a new set of performance metrics.

  1. *Focus on customers' highest costs*. By looking at claims data, Virginia Mason was surprised to find that the highest-cost health services were not cancer or cardiac treatments, but services like screening and prevention. Specific high-cost services included treatment for back pain, migraines, shoulder pain, breast nodules, and depression. Addressing these areas became the focus of the Collaborative.
  2. *Adopt customers' definition of quality*. While clinical quality is important, employers also focused on employee access and cost. Members of the Collaborative indicated they want care that is:
     - **Faster**. Same day access to care and rapid return to function.
     - **Better**. Evidence-based care processes where all necessary care is provided, but maintains controls over unproven or unnecessary treatment options. "Better" also specifies 100% patient satisfaction.
     - **More Affordable**. Employers believe that if waste is taken out, overall costs should go down. At the same time, they view Virginia Mason as a valued supplier and want it to be financially stable.

     > *"We ask employers how they define quality. They think of quality differently than the traditional view of many providers."*
     > —Robert Mecklenburg

  3. *Create evidence-based value streams.* By implementing specific value streams (or defined care pathways) for specific medical conditions, Virginia Mason was able to embed guidelines and best practices into an explicit clinical process. For example, the conventional pathway for treating back

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pain often includes multiple visits to a primary care physician, an MRI, consultations with specialists, and eventually physical therapy—often with long delays between steps. This process with multiple steps that don't add value also has a high indirect cost to employers by prolonging absenteeism.

However, evidence shows that most back pain is uncomplicated and can be successfully treated with physical therapy. Thus, VMMC created a new evidence-based value stream in which patients obtain same-day appointments at Virginia Mason's Spine Clinic and are triaged immediately. For uncomplicated cases, physical therapy can begin that day; otherwise, patients are referred to an appropriate specialist. This is an expedited, lower-cost process that provides patients the care they need.

4. *Use systems engineering tools.* Once a new pathway is created that delivers faster, better, lower-cost care, the challenge is to "lock it in." Great doctors are necessary but not sufficient; doctors need to be part of a consistent, reliable system. Virginia Mason has invested considerable energy and resources into systems engineering tools to eliminate defects through standardized protocols, electronic medical records, and computerized medication order systems.
5. *Reduce costs for purchasers.* The new back pain/spine clinic alone has saved $1.7 million for purchasers. At the same time, systems engineering tools have dramatically decreased the costs of delivering care, improving margins for Virginia Mason and creating more capacity.
6. *Maintain provider margins*. At Virginia Mason, labor is 65% of the cost of production. Virginia Mason has found that because more than half of back pain episodes are uncomplicated, lower-cost providers can deliver a great deal of care. Proceduralist doctors have a cost of $4 per minute, while non-proceduralists cost $2 per minute and nurse practitioners or physician assistants are $1 per minute. Across all conditions, the care provided is straightforward about 80% of the time. So, these individuals can often be seen by skilled and experienced non-physician providers.

> *"We need changes to the reimbursement model, but the costs of production can be decreased significantly."*
> —Robert Mecklenburg

Virginia Mason has been able to increase revenue by significantly increasing the daily volume of patients. Even though their neurosurgeons now only see a much smaller percentage of patients with back pain, they see a greater proportion of appropriate surgical candidates. In addition, the annual volume of the Spine Clinic has quadrupled since 2005, screening many more patients for appropriate surgery.

There are many benefits of this model: improved outcomes, more rapid employee return to function, and lower employer costs. The Spine Clinic's volumes have increased dramatically, its finances have improved, and patient satisfaction is very high.

- **To achieve this success, the Collaborative has overcome several cultural barriers and conflicting motives.**

  Dr. Mecklenberg cautioned other systems who might be interested in implementing such a model about the hidden barriers faced by each stakeholder.

  —*Employers.* Employers often are not engaged and are ill-prepared in purchasing health care, relying on health plans to serve as their (imperfect) agents. Cost and outcomes must be transparent if they are to purchase care based on value. However, many employers are still reluctant to limit employees' choices by defining "preferred" hospitals or physicians.

  —*Providers.* Many providers are reluctant to change their operations and processes. The new model requires maintaining high volume throughput with same-day access. Established physicians are often comfortable with long wait times, knowing that their "book of business" is full well in advance. In some cases, provider systems will need to recalibrate the mix and type of clinicians, using a higher proportion of non-MD providers.

  —*Health plans.* Theoretically, for-profit health plans face competing interests between their customers and their shareholders. If they root out inefficiencies, how much of the savings should go to the employers versus their bottom line? Some health plans may be unwilling to open their books and provide complete transparency to the partnering health providers and employers.

  —*Public policymakers*. Many aspects of the marketplace collaborative challenge long-held beliefs about the role of physicians as the "captain of the healthcare team." Public policy makers may need to create incentives to train non-MD providers, as well as amend regulations that allow them to practice more independently within an efficient care team. Further, it requires transparency from all constituents and public reporting of quality information.

Key Takeaways (Smith)

- **Like Virginia Mason, Partners Healthcare System has taken many steps to improve quality.**

  Partners Healthcare includes two academic medical centers, a large physician network, several community hospitals, and several specialty facilities. Its mission includes clinical care, research, education, and community service. In complex organizations like Partners, change is challenging. Still, Partners has implemented numerous initiatives to improve quality through care processes and decision support tools. For example, Partners targeted bloodstream infection rates in its hospitals, reducing the rate to near zero in its community hospitals and dramatically lowering it in the academic hospitals. Partners is also employing decision support to decrease variation of outpatient imaging across the system.

  Partners has implemented quality-based payment arrangements for its providers. Hospitals and physicians can earn back 10-15% of a salary withhold by meeting specific quality metrics and care

processes like use of eprescribing. As a result, the use of eprescribing by primary care physicians, for example, has increased from 69% to 90% and use by specialists is up from 36% to 74%.

And like Virginia Mason, Partners has also developed a multi-specialty cardiac clinic and is developing a spine center. Creating these collaborative centers has demanded a significant change in culture and behavior, requiring a great deal of clinical leadership.

- **Other health systems would face significant challenges in trying to replicate the models used by Virginia Mason.**

  By identifying important differences between the Boston and Seattle markets, Dr. Smith posed several barriers to replicating Virginia Mason's experience more generally.

  —*Lack of large employers.* In Seattle, there are several major, self-insured, private-sector employers that are interested in controlling health care costs, but many markets lack a large employer base. The largest employers in Boston include the state government, universities, and hospitals, which don't have the same mentality as large, self-insured companies.

  —*Concentration of specialist physicians.* Like scores of other academic medical centers, most of the physicians at Partners' hospitals (75%) are specialists. Many of these individuals only spend 10-15% of their time practicing medicine, devoting the remaining time to education and research. In such an environment, change is more difficult because the magnitude of the restructuring is greater.

  —*Differing compensation structures*. At Virginia Mason, all of the physicians are salaried. At Partners, some are salaried, some receive salaries plus incentives, and others are paid based solely on a fee-for-service model. It will be difficult to convince physicians who are paid based on how many (and what kinds) of patients they see to give up triage duties to non-MD providers.

Participant Discussion

- **Salaried physicians.** One participant commented that organizations like Virginia Mason and Kaiser have been successful implementing delivery system change because physicians are salaried. In the absence of salaried employees, physicians may have different incentives and may resist changes to the delivery system. However, other participants argued that having salaried physicians is less important than giving physicians clear guidance about desired outcomes and rewarding them accordingly.

- **Specialists' reaction.** Dr. Mecklenburg was asked how the specialists have reacted to the model at Virginia Mason. He responded that they like it because now they only see the complicated cases and they have a higher "conversion rate" of patients who go on to have surgery. However, this reaction is based on a process that results in stable specialist volume. They would be less supportive if the clinics led to reduced volume.

- **Reassessing the clinical workforce.** Participants commented that if systems like Virginia Mason were implemented nationally, there would be an immediate oversupply of specialist physicians. Nevertheless participants generally advocated for policies that would increase the number of primary care physicians and non-physician providers.

- **Waste in the system.** Participants commented that if waste in the system could be completely eliminated, costs could be reduced by 33-50% and the system would face substantial excess capacity. Dr. Mecklenburg commented that this excess capacity should be directed toward caring for those who have been uninsured and underserved.

- **Changes to reimbursement are still required.** Even though Virginia Mason implemented its marketplace collaborative under fee-for-service reimbursement and has taken costs out of the system, changes in reimbursement are necessary to make these models viable on a larger scale. As Stuart Altman noted, "The delivery system can only change so much without payment reform." Dr. Mecklenburg agreed, noting the fact that Congress had not focused its national health care reform debate on aligning Medicare payments with value.

- **The value of Medicare demonstrations**. Medicare could greatly accelerate these changes if it started purchasing care based on value. Participants recommended increased incremental efforts and more federal demonstrations that could show where opportunities exist to improve care processes and gain delivery system efficiencies.

Case Study: Alegent Health
Accelerating Innovation for Quality and Efficiency Gains

Speakers: **Mark Kestner, M.D.**, Chief Medical Officer, Alegent Health
Respondent: **Michael J. Dowling**, President and CEO, North Shore/LIJ Health System, Inc.

Overview

An often overlooked aspect of health care reform is the importance of engaging physicians and employees in the process of delivery system change. To accelerate innovation, Alegent Health seeks to engage employees by involving all pertinent staff in the clinical redesign process and providing a safe place to make collaborative decisions. Alegent explicitly measures physician, employee and patient engagement, and uses that information to inform future initiatives and policies. Through this process, Alegent has made significant strides in their system's clinical performance, ranking the system among the best in the country.

Context

Dr. Kestner described how Alegent Health, a group of ten community hospitals in Omaha, Nebraska, has implemented an innovative change management process and improved quality to become one of the highest-ranked health systems in the country. Mr. Dowling responded, sharing his thoughts on bringing about large-scale change.

Key Takeaways (Kestner)

- **Alegent has set out to transform itself into an integrated delivery system.**

  Currently, Alegent Health represents ten community hospitals, 100 points of service, and 8,600 employees. Of its 1,300 practicing physicians, 15% are directly employed by Alegent. The health system holds 40% of the Omaha market share and is the market leader in several clinical areas, including primary care, cardiovascular services, oncology, and orthopedics. Nevertheless, in 2003, Alegent's quality scores were mediocre. At that point, Alegent set out to transform itself into an integrated delivery system.

- **Alegent's strategy for delivery system change focuses on implementing a transparent, but disciplined, system to make strategic decisions.**

  Alegent created a "decision accelerator" process called the Right Track to facilitate fast and collaborative decision making among all relevant stakeholder groups within the system. The system creates a prescribed, transparent process, establishing a finite timeline to make specific decisions about creating and implementing evidence-based care pathways.

  To date, 58 physician order sets, 29 emergency department order sets, and 20 nursing guidelines have been developed, involving hundreds of physicians and non-physicians. Alegent has implemented projects focused on reducing the complexity of care delivered at the bedside, creating an efficient model of surgical services, and increasing access to Alegent's facilities and services.

  Alegent has created accelerator labs within its system to test concepts before they are broadly implemented. Once order sets are created, they are adopted across all of Alegent's hospitals. Borrowing from concepts of Everett Rogers from the *Diffusion of Innovations*, Alegent believes that the spread of these practices is based on several core principles:

  - An innovation needs to be **better and simpler** than the status quo.
  - An innovation must be **proven** (hence, the need for a test lab).
  - A **communication channel** must exist to transmit the innovation to other adopters.
  - **Time** is required for an innovation to spread.
  - The **social structure** can facilitate or impede an innovation's diffusion.

  To accelerate this spread, Alegent has instituted weekly system-wide calls to provide updates about innovations in development and in the accelerator labs.

- **Alegent believes that the key to transformation and clinical performance is maintaining an engaged workforce.**

  Using a survey developed by its corporate neighbor, Gallup, Alegent estimates that 47% of employees are actively engaged (emotionally attached) with the organization. In comparison, 43 percent are not engaged (neutral), and 10% are actively disengaged (disruptive and oppose change).

  While these rates are substantially higher than the rest of the country, Alegent is trying to engage the non-engaged employees, while managing actively disengaged employees out of the organization. Alegent also evaluates physician engagement carefully; however, a more cautious strategy is required working with its physicians, who are the sources of referrals and revenue for the hospital system. Among Alegent's salaried physicians, engagement is high. But among non-salaried physicians—representing the majority of Alegent's doctors—engagement is significantly lower than employed physicians, particularly among older physicians who are more likely to hold senior medical positions.

> *"Focus on employee engagement results in a big performance boost."*
> —Mark Kestner

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By combining customer and employee engagement, Alegent has demonstrated substantial performance and quality boosts. For the past two years, Alegent's composite quality score on 20 key measures has risen from the mid-70s to near 100%. Its cost per case has steadily declined, and Alegent was ranked the top health system in the country in 2007 based on its combined Medicare quality and patient satisfaction score.

Key Takeaways (Dowling)

- **Mr. Dowling emphasized Alegent's focus on change through people and engagement.**

  Like Alegent, Long Island Jewish (LIJ) stressed that its employees are a priority and supports a change agenda that includes both physicians and non-physician staff. LIJ is extremely selective in its hiring, invests heavily in training—with a corporate university and a simulation center—and utilizes numerous methods to communicate with all 38,000 employees. For example, Mr. Dowling meets personally with each newly hired employee to describe LIJ's transformational goals. Like Alegent, LIJ measures employee engagement. Currently, about 85% of LIJ's employees are engaged.

- **Driving change in a health care system requires strong leadership at all levels of the organization.**

  An essential element in changing a delivery system is strong senior leadership. But this isn't enough. Leadership is required throughout the organization, particularly at the middle management level, whose role includes identifying and dismantling silos that could inhibit change. To get support for change, Mr. Dowling found it necessary to replace many of the leaders at LIJ, which is common among organizations undergoing significant change.

- **Any change initiative requires overcoming specific organizational barriers.**

  At LIJ, a critical barrier is the need to align a fragmented base of non-employed physicians. While having salaried physicians makes change easier, in the absence of employed doctors, alignment is essential. One way that LIJ is seeking to drive alignment is by investing $400 million in information technology so that all physicians, including the solo practitioners, are connected electronically.

Participant Discussion

- **Relationships with outside stakeholders.** Mr. Dowling noted that LIJ is heavily unionized which slows the process of implementing change. Other participants echoed those comments, but added that health system leaders must work closely with external stakeholders for the good of the organization, its employees, and its patients.

- **Sharing success.** One participant noted that in other industries, workers are often engaged in change initiatives because the organizations share the financial success with all employees. For example, Southwest Airlines, which is heavily unionized, has a highly engaged workforce because all employees benefit when the company performs well.

  Others noted that engaging employees isn't necessarily about financial rewards; it is about having an active voice and a shared sense of ownership. Alegent's processes are designed to engage staff at all levels of the organization in clinical design and innovation to provide employees with a sense of ownership over the organization's direction.

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Addressing the Key Policy Considerations

Speaker: **Ann Hendrich, R.N., M.S.N., F.A.A.N.**, Vice President, Clinical Excellence Operations, Ascension Health
Respondent: **Stephen Grossbart, Ph.D.**, Corporate Quality Officer, Catholic Health Partners

Overview

Ascension Health adopted a system-wide focus on preventable injuries and deaths that has transformed how the organization delivers care. Initiated by the system's leadership, this focus has now created a culture of safety and collaboration across the entire system. Clinical teams have worked together to develop standards for the main causes of preventable injuries and deaths. Scorecards have been developed, linking executives' compensation to the organization's quality results.

Ascension attributes its success to leadership, vision, and culture, rather than to any specific technology or process. Thus, the lessons this transformation can provide other health systems are more generalizable, yet less tangible. In the absence of payment reform to incent improved safety, achieving similar results will require similar levels of leadership.

Context

Ms. Hendrich described Ascension Health's "Journey to Zero." Dr. Grossbart responded by comparing Catholic Health Partners' experience with that of Ascension's.

Key Takeaways (Hendrich)

- **In 2002, without any consideration of financial implications, Ascension Health set a goal of zero preventable deaths within five years.**

  Ascension Health, formed almost ten years ago, is a microcosm of the US health care system. It is a "system of systems" with more than 60 facilities in 20 states, ranging from Level 1 trauma centers to rural health facilities. Ascension has over 100,000 employees, including more than 25,000 nurses. More than 100,000 doctors practice in Ascension's hospitals.

  In Ascension's first few years, there were no system-wide clinical quality improvement initiatives. In November 2002, Ascension's leaders issued a call to action under a common vision: Healthcare that works; Healthcare that is safe; and Healthcare that leaves no one behind. Ascension set an ambitious five-year goal of eliminating all preventable deaths. They called this initiative their "Journey to Zero."

- **Ascension identified eight priorities for action.**

  To drive change, Ascension embraced the principles in John Kotter's *The Heart of Change* and Everett Rogers' *Diffusion of Innovations*. Ascension's executives engaged clinicians and patients to develop a short list of priorities for the entire system. After they finalized the priority list, system leaders worked with stakeholders to agree on the evidence that would be used to track system performance. The system developed scorecards, and aligned executive compensation with performance goals. Each hospital's performance on all key measures is completely transparent, and regular calls are held to discuss the results. Ascension created a clinical excellence team that sets priorities for the system, with input from chief medical and nursing officers.

  For example, the clinical excellence team convened a pressure ulcer summit. Chief nursing officers from 67 hospitals attended. They shared 123 different sets of standards, showing high variability across Ascension's facilities. Over the course of two and a half days, this group agreed on a common standard that was adopted across the entire system within 90 days. Within six months the standard was fully implemented and results were being measured. Within a year, pressure ulcers had been reduced by more than 50%. Today, Ascension observes less than 1 pressure ulcer per 1000 inpatient days, versus an estimated national rate of 18.5.

  Ascension has achieved impressive system-wide results for birth trauma, neonatal mortality, falls with serious injury, pressure ulcers, bloodstream infection, and nosocomial infections. Ascension estimates these efforts have resulted in 3,000 fewer deaths.

- **With new initiatives, Ascension supports evidence-based prototype and pilot sites before disseminating more broadly.**

  Utilizing a small, core infrastructure of quality support personnel, Ascension supports creation of new program initiatives in alpha sites. Through literature reviews, trial-and-error, and collaboration with external partners like the Institute for Healthcare Improvement, the alpha sites create prototypes for specific quality interventions. If evidence is available, sites might pilot existing clinical pathways or quality programs, potentially modifying the initiative to better suit the local culture.

  Pilot sites are responsible for recommending specific strategies, identifying metrics for monitoring progress, recommending infrastructure changes and timelines, and suggesting other ways the system can support the program. Only then is the intervention ready to be disseminated across the system.

- **The next step in Ascension's journey is focusing on behaviors.**

  Over the past five years, Ascension has focused on rates of death, injury, or infection in selected conditions. But these rates are now so low that reducing them further may no longer be the most effective way to improve patient safety. Therefore the next phase in Ascension's journey—termed "Healing Without Harm"—is a behavior-based approach to

incorporate patient preferences, shared decision making, and holistic attitudes into a culture of patient safety.

As the prevalence of adverse events has declined, the system's learning process will be guided less by rates and more by specific events. Attention will now shift towards what can be gleaned from each adverse event or near miss. When a preventable event occurs, learning will take place to analyze the event, understand it, share the results across the system, and drive system-wide change. Ascension believes this approach can reduce serious safety events by another 50% by 2012.

Key Takeaways (Grossbart)

- **Any health system could achieve what Ascension has achieved. The keys are leadership and culture.**

  Evidence now exists about what needs to be done to achieve results similar to Ascension's. But why aren't other hospitals doing this? In Dr. Grossbart's view, Ascension is unique because of:

  —*Committed leadership.* Ascension's leaderships are strongly committed to and supportive of safety initiatives.

  —*A culture of safety.* Ascension's results aren't based on technology. They don't have uniform system-wide electronic medical records or a central data warehouse. The key to Ascenion's success is its culture of safety, which is uncommon.

  —*A strategic planning process that makes safety a priority*. Safety is a prominent goal in the organization's strategic plan. The focus on safety is evident just by looking at the system's website. By making safety a strategic priority, Ascension is saying, "We can do better." Many health systems are unwilling to make this admission.

  —*A willingness to be transparent*. While many hospital executives talk about transparency, there is still great reluctance to report potentially adverse data. Publicly reporting data on preventable adverse events, even if it shows improvement, means admitting that the health system has caused patients harm.

  —*Linked compensation to safety results*. By tying the leadership's and middle management's salary to hospital quality results, Ascension has created aligned incentives throughout the system.

  Dr. Grossbart noted that Catholic Health Partners has benefited from Ascension's work. By documenting what Ascension has achieved, he has convinced others in his organization to strive to match Ascension's results.

Participant Discussion

- **The need for leadership.** Participants acknowledged Ascension's leadership and its focus on safety, not for financial reasons, but because they thought it was the right thing to do. Leading change across a large, diverse organization and achieving the results that it has documents Ascension's strong stewardship. In addition, Ascension was commended for having clear, specific, and bold goals.

- **How can payment system changes promote safety?** One participant asked, "What payment policies would get providers to adopt the types of changes that have been described?" Participants offered the following answers:

  1. *Kick poor performers out of networks.* Health systems delivering substandard care should be thrown out of a payer's network. This would provide a significant incentive to provide high-quality care.
  2. *Bundle payments*. One participant suggested bundled payments for hospitals, with very few exceptions for readmissions. He felt this would encourage greater safety. In addition, bonuses could be paid to reward certain outcomes.
  3. *Population-based reimbursement*. Capitated payment could drive integration and coordination, and would increase the role of the primary care physician.
  4. *Incentives for safe practices*. Payers might offer financial incentives for providers to adopt practices that are known to improve safety, such as eprescribing.

  Dr. Adrian Long, Ascension's chief medical officer, responded that Ascension's success is not related to money. He emphasized that the efforts are based primarily on a shared vision, leadership, and transparent results.

- **Legal impediments.** Participants discussed legal barriers to closer collaboration between hospitals and physicians, suggesting that antitrust and Stark laws need to be revised to recognize the needs for more healthcare coordination.

- **Redefining harm.** Stuart Altman noted that there are incentives for safety in a fee-for-service world. In the DRG-based world of hospital admissions, increased safety is usually associated with reducing overall costs of care associated with injuries. Ascension's work is commendable, but after these important wins (which still take a lot of coordinated work), the nation needs to work on metrics of quality that are in conflict with financial goals, like misuse of CT scans.

  One participant suggested defining "harm" more broadly than just death or preventable injury. He suggested that subjecting patients to unnecessary MRIs and CAT scans and various diagnostic procedures is in fact a type of harm.

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The Health Industry Forum

How Can Payers, Purchasers, and Policymakers Support Delivery System Reform?

Moderator: **Stuart Altman, Ph.D.**, Professor, Brandeis University

Panel: **David Helms, Ph.D.**, President, AcademyHealth
Arnold Milstein, M.D., Chief Physician, Mercer Health and Benefits, Inc.
William Streck, M.D., President and CEO, Bassett Healthcare
Janet Wright, M.D., Senior Vice President, American College of Cardiology

Overview

This panel made clear that progress on delivery system reform requires individual system leadership and new financial incentives. Government action is needed to drive payment changes and to mandate greater quality transparency.

Context

A panel of national thought leaders discussed how public policies and coordinated efforts could translate these individual successes into systemic changes in the delivery system. Each confirmed the dire need for reform and discussed how much responsibility should rest with individual provider systems versus insurer payment policies to provoke the necessary changes.

Key Takeaways (Wright)

Dr. Wright discussed the practical hurdles in helping to improve the quality of cardiac care, and expressed a need for a better alignment of incentives.

- **The American College of Cardiology (ACC) is strongly focused on improving the quality of care.**

  ACC is working on clinical guidelines, performance measures, and appropriate use criteria. In addition, it is involved in several targeted quality improvement projects and registries. The goal of these efforts is to collect data, define what practices and processes work best, and disseminate those findings broadly.

- **ACC's experience with registries shows the importance of policies and incentives.**

  For 12 years ACC has had registries for diagnostic catheterizations and stenting. However, even after 12 years only about 60% of all hospitals participate. Those who participate want to understand how they are performing so they can improve. But it requires work from hospitals to collect and submit their data, and they receive no additional compensation. In comparison, CMS requires hospitals to participate in a separate registry in order to get paid for defibrillator placement by Medicare. As a result, 100% of all hospitals were participating in the registry within three months.

  Without financial assistance for data collection, the ACC has experienced "buckets of hurdles" when trying to gather quality information. For example, the ACC enrolled 600 ambulatory practice sites to monitor how cardiac care is delivered in clinic settings. Although it wanted to collect process and outcome information via the practices' electronic medical record systems, the ACC has been unable to broadly engage EMR vendors to incorporate the necessary data elements used to calculate performance measures. Without additional monetary incentives and systems that embed data collection and submission into clinician workflow, it will not be possible to get physicians and other health groups to focus on and strikingly improve quality. Even with current obstacles, Dr. Wright is optimistic about the future and sees physicians becoming more engaged.

Key Takeaways (Helms and Streck)

Dr. Streck discussed why he worked with the Commonweath Fund to convene a meeting of health systems from group employed models, and Dr. Helms summarized the key findings from this meeting.

- **Reducing waste in health care represents significant funding, yet it has received scant attention in national health care reform.**

  Total health care spending in the Unites States is around $2.4 trillion. If 30% is waste, it would represent $720 billion annually, roughly equivalent to the stimulus package. Even assuming savings just 10% of that amount, $72 billion per year roughly equals the projected annual cost of health insurance reform. However, no one is talking about this savings because it isn't "scorable" by the Congressional Budget Office.

- **Physicians are increasingly targeted as a reason why health care is inefficient; group-employed models may provide a viable solution.**

  Physicians directly control about 65% of health care resources. For years physicians have gotten a free ride, avoiding scrutiny of their role in the inefficiency of health care. But attitudes are changing. The Dartmouth data show high variability and significant physician inefficiency. Studies have shown that physicians often don't even follow basic checklists and that effective prevention occurs only about 50% of the time.

  Group models, where physicians are directly employed by the provider system, can produce higher quality and lower costs. They can function as accountable care organizations (ACOs) without being viewed as directly rationing care. When representatives from the country's most successful group employed models came together, they identified their most important characteristics as:

—*Strong physician leadership.*

—*A collaborative, integrated system.*

—*Alignment with other stakeholders*.

—*Coordinated governance and strategy*.

—*Transparency leading to greater physician accountability*.

These characteristics foster a strong sense of "groupness" and collective responsibility. They work closely with hospitals, health plans, and other physician groups, coordinating care for their patients and explicitly measuring results at a population level.

- **Because most health systems cannot rapidly transform into a group model, there must be a transition plan for non-employed physicians.**

Currently, only a minority of physicians (25% at most) work in group employed models. More physicians will need to be recruited into accountable care organizations. To account for the majority of physicians who earn their income based on their procedural volume, our health system needs to devise a transition plan away from the current fee-for-service world to encourage doctors to deliver higher-quality, lower-cost care.

The way to engage them is through money. Driven by Medicare, there should be transitional payments within the FFS system to coordinate care and incent the meaningful use of health information technology. Such a plan can drive accountability with both rewards and penalties based on data and measurements.

Key Takeaways (Milstein)

Dr. Milstein described the systemic problems he sees and offered thoughts on solutions.

- **It is hard to get people's attention about the problems that exist in health care.**

Dr. Milstein compared the current situation in health care to walking along a road littered with trash. At a certain point, people simply no longer notice the litter; it seems normal. In health care, long-standing inefficiency and quality flaws go largely unnoticed. Even more painful consequences may be needed to get leaders' attention.

In the long term, complex health care systems need more sophisticated management. Individual healthcare organizations can leverage external organizations like the Institute for Healthcare Improvement to simplify management's job by boiling down opportunities into simple care bundles. Over time, performance management can progress to more complex approaches such as the Toyota Production System.

The healthcare system can realize substantial savings by re-engineering high-cost areas like the emergency department, operating room, intensive care unit, and ambulatory care for high-risk patients. While it has long been known that 20% of patients represent 80% of health care spending, it is only recently that predictive modelers can identify in advance the 20% who will incur 55% of the following year's spending. IT-enabled clinical performance management systems will help clinicians to intercede with this 20% more cost-efficiently.

- **Dr. Milstein offered a plan that focuses on a few specific actions to drive change.**

The problems in health care are caused by many factors. But driving change in complex adaptive systems requires picking a few actions offering the highest leverage on clinical performance improvement. Dr. Milstein advocated policy changes that should be implemented collaboratively by both Medicare and commercial plans, including:

—*Full transparency of physician's quality and cost.* When doctors' performance is shared publicly, they make more effort to improve their performance. Cost measures should include total risk-adjusted spending per patient per year.

—*Payment reform*. Payment policy must not penalize cost-effective providers; it must reward them. Physician groups and health systems that deliver efficient, high-quality care should be identified and rewarded.

—*Patient incentives to selected high-quality, lower-cost providers*. Consumers must have a role in transforming the delivery system. This might mean creating narrow networks of high-performing providers, or requiring patients to pay greater copays or coinsurance when receiving treatment from less cost-effective physicians.

Participant Discussion

- **Leadership versus incentives.** Stuart Altman noted that there are two ways to drive behavior change—through leadership and through financial incentives. Organizations that have successfully implemented delivery system change usually seem to have strong leadership. The challenge is expanding reforms from a few isolated success stories to system-wide change. Changing one hospital or health system may be possible through leadership, but changing the entire health system will require changes in incentives.
- **Medical school training.** Medical schools do not do a good job teaching clinicians how to collaborate or dealing with the process of delivering care. Medical education must be changed, although medical educators are reluctant to do so. One participant believes that the younger generation of physicians will be more comfortable with team medicine and their propensity to want a reasonable work-life balance could lead to more group models and ACOs. Other participants noted that the vast majority of students are training to be specialists, not primary care physicians.
- **Simplifying quality measures.** One participant expressed frustration regarding his health system's ability to satisfy numerous quality rating groups and referees. A solution would be if Medicare would clearly state ten measures of quality in hospitals. Other payers could adopt these ten quality metrics.
- **Value of demos.** Health reform legislation was criticized for not addressing payment or delivery reform. However, the legislation will create many new payment and delivery system pilots. Participants were hopeful that these pilots will be large enough to initiation true health system change.