

ROUNDTABLE

THE LEADERSHIP OF QUALITY

Quality in healthcare is not one thing. It's a theme, a goal, an overall thought or movement that extends across all branches of the industry. It's a movement without antagonist. If anything, it's a movement with many well-meaning supporters all convinced that they have the secret key. Quality makes enormous progress in chunks, but struggles mightily to gain the kind of momentum that only comes from consensus. Whether the quality movement lives up to its lofty title rests ultimately on the ability of its leaders to come together. In this final Roundtable of a four-part series on quality, *HealthLeaders* brought together some of the leading voices in the quality movement to talk about lessons learned so far and what the top of the industry might consider to get quality right.

Panelist Profiles



JIM MOLPUS, editor of HealthLeaders Media, served as moderator



MARGARET O'KANE, President, National Committee for Quality Assurance



WILLIAM ROPER, M.D., Dean, University of North Carolina School of Medicine, CEO, UNC Health Care System



DONALD M. BERWICK, M.D., President and CEO, Institute for Healthcare Improvement



MARK PICKRELL, Waller Lansden Dortch & Davis

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Roundtable Highlights

The state of quality

JIM MOLPUS: (*HealthLeaders Media*): All of you have been quoted at various times about the state of our healthcare system. But despite the gains we've had in quality in recent years, we're still talking about this issue of consistent delivery of high level of quality healthcare. At a basic level, can each of you give me your state of quality right now?

DONALD M. BERWICK, M.D. (Institute for Healthcare Improvement): There have been major gains certainly since I've been in this field. In the area of awareness, although the research background for identifying defects has been well known to the research community for decades, it really was a turning point around the Institute of Medicine's *To Err Is Human* and *Crossing the Quality Chasm* reports that a much larger segment of the healthcare community and a good swath of the public became aware that healthcare is underperforming. The second piece of good news is that science has advanced in areas with respect to reliability and safety. We really know a ton about how systems ought to be functioning. The third piece of good news is we have emerging prototypes; we now know of about two dozen hospitals, for example, that have gone for more than one year without a single ventilator pneumonia, and there's a long list of such successes now in our hands. The gaps right now are still enormous. The majority of American hospitals or health systems still haven't centered improvement as a strategy. We have serious governance gaps. The boards of trustees are not yet feeling the stewardship of quality of care as a fundamental board duty at the same level with, for example, financial management. We haven't aligned the financial system to support improvement as a goal for organizations. And at the large

er level, I don't think as a nation we've tackled some of the larger issues around the dominance of the hospital segment compared to a much more integrated view of care, the proper management of chronic illness, and control of cost as a national agenda at anything like the level we should. So good steps forward. We're in square one of 50.

WILLIAM ROPER, M.D. (UNC): Maybe it was Winston Churchill who said it this way: "We are not at the end or the beginning of the end, but we are at the end of the beginning." I think we have made a very good start but have a whole lot further to go. Where I would characterize the nation's effort in quality and patient safety is it's now a legitimate and full part of the consid-

"We have got to get to some kind of organizational structure that has the clout and the organizational capabilities and the wherewithal to make these things happen."

erations we bring to healthcare instead of being the extra thing that somebody would pester us with at the end of the conversation and say, 'Oh, don't forget quality.'

MARGARET O'KANE (NCQA): I agree that we are at the end of the beginning and it is a moment of tremendous opportunity. It is a time to be looking ahead and asking ourselves what are the missing pieces of the platform for the future, and there are a couple of things that come to

mind immediately for me. One is that we have big issues with the evidence base. Those of us who have been in the measurement business for a long time have been standing under the lamppost, as the metaphor goes, measuring areas where we well understand what quality is. But there are huge gaps in knowledge that need to be addressed, and a lot of science and investment in science that hasn't been translated into practice. And there are lots of missing guidelines, as well. Second, the whole issue of appropriateness of care seems to be not high enough on our agenda. The third piece is how do we create an enterprise that covers a broad enough scope that we're not measuring at the micro unit while ignoring the gaps between the units where many of the quality problems happen?

MARK PICKRELL (Waller Lansden Dortch & Davis): If we look at the global situation, I think it's great that we're talking about improving the quality of care. One of the things when we talk about being at the end of the beginning, rather than the beginning of the end, is that we have to look at where we've come from. By historical or even worldwide standards, we started out from a very high base, and so as we are looking at ways to improve the quality of healthcare delivery we have to keep in mind that in many respects a lot of the low-hanging fruit has already been picked. So as we're making a cost-benefit analysis for how to improve some of these quality of care issues, we have to keep in mind that we're starting out from a pretty high level of care. That's not to disagree with the need for improvement, but as we try to create public policy incentives and pressures in order to improve the situation, I think it's important we keep in mind we're working at the margins here, even though the margin is still pretty wide.

HealthLeaders Quality Roundtable Series

Underwritten by Waller Lansden Dortch & Davis

To view previous installments in this series, go to: www.healthleadersmedia.com and click on the "roundtable" link at top.

Part 1: July 2006, *HealthLeaders* magazine

Building a Business Case for Quality Healthcare

The basic economics of healthcare don't necessarily jibe with the rules that are the nature of other industries. In manufacturing and any service industry, the quality of the product and the cost of creating that product are the X and the Y that equal success. In healthcare, there are certainly punitive business consequences for poor quality—liability and market share drain, among a few. And there are some demonstration projects from the Centers for Medicare & Medicaid Services to reward quality, along with some payor-based pay-for-performance programs. But do these add up to the seeds that will create a true business case for healthcare quality in the near future?

Panelists:

FRANÇOIS DE BRANTES, national coordinator for Bridges to Excellence in Washington, D.C.

MAUREEN SPIVACK, managing director in the healthcare practice for UBS in New York, N.Y.

DANIEL VARGA, M.D., chief medical officer for Norton Healthcare, Louisville, Ky., and president of the Kentucky Medical Association.

THOMAS BARTRUM, partner, Waller Lansden Dortch & Davis of Nashville.

Part 2, October 2006, *HealthLeaders* magazine

Healthcare Quality: The Dynamic System

Providing quality healthcare for patients is not just one initiative, but a multilayered program encompassing everything from patient safety to information technology. The gauntlet was laid down in 1999 when the Institute of Medicine's *To Err is Human* report attributed 98,000 hospital deaths per year to preventable medical errors. Fixing medical errors—and the larger question of quality improvement in hospitals—has been a focus of attention ever since. But as with any system, when hospitals started to take a renewed look at unraveling their care processes, the solutions to improving quality only became more complicated. *HealthLeaders* convened a panel of experts

to discuss the dynamics at play when a hospital decides to tackle a broad program of addressing quality in the way it delivers care to its patients.

Panelists:

PAUL DAVIDSON, partner, Waller Lansden Dortch & Davis

MICHAEL DEEGAN, M.D., E.D.M., executive vice president/chief clinical & quality officer, Texas Health Resources, Arlington, Texas

JANE ENGLEBRIGHT, R.N., Ph.D., vice president of Quality, HCA Inc., Nashville, Tenn.

PAUL KECKLEY, Ph.D., executive director, Vanderbilt Center for Evidence-Based Medicine, Nashville, Tenn.

STEVE MAYFIELD, Director, American Hospital Association Quality Center, Chicago.

Part 3, November 2006, *HealthLeaders* magazine

The Federal Stake in Quality

The government of the United States spends \$450 billion annually on Medicare alone. No single player in the healthcare industry has as much weight to throw around in the push to promote higher quality healthcare, and lately Washington has not been afraid to use it. An executive order issued by President Bush this summer is the latest in a string of legislation calling for more accountability in how information on quality is disseminated. Beyond the government's role as a payor and regulator, a key role is to bring together hospitals, payors, physicians, employers and other stakeholders to find common ground in the push for higher quality. *HealthLeaders* recently gathered a panel of experts in Washington, D.C., to assess where the federal government's role in quality stands now and where it is headed.

Panelists:

CHIP KAHN, president, Federation of American Hospitals

J. REGINALD HILL, partner, Waller Lansden Dortch & Davis

CAROLYN M. CLANCY, M.D., director, Agency for Healthcare Research and Quality

PETER PRONOVOST, M.D., medical director, Center for Innovation in Quality Patient Care, Johns Hopkins University School of Medicine

BERWICK: Although Mark's comment about starting at a very high base is correct about the technologies we use, our base is very low with respect to reliability. We have Rand Corporation studies showing 45 percent of needed care is not given. We have 47 million uninsured. We have racial gaps in longevity that approach eight years for a newborn in Baltimore. We have the most wasteful system on Earth, which is performing probably at the 22nd or

23rd rank among developed countries according to objective measures of system performance, even though we're spending double the money. So we have a broken system, and we need federal governmental leadership to declare that that's not acceptable, and then board level leadership around the country to say the infection rates we have and the defect rates we have no longer are correct. So I think deciding is probably first step.

What comes next?

MOLPUS: *The 100,000 Lives Campaign* has shown results of more than 122,000 lives saved by following the six recommended interventions. Dr. Berwick, what's next as far as some of the types of interventions and measures we need to get to?

BERWICK: First I want to make one minor qualification. Although the campaign has been thrilling to be involved with and I've never seen such

an outpouring of energy, it would not be proper to seek to take credit for this drop in mortality. These gains are attributable to many more things than the campaign. My view is that we should be broadening the agenda to injury, not just unwanted deaths and unnecessary deaths. And the injury rates in the country in hospitals are very, very large, and now we have the science in hand to decide to stop them. I really do believe that now. Infections, complications from surgery, pressure sores—these are no longer inevitable at all. So I personally think the right way for the country to go in the next wave is to seek to achieve breathtaking reductions in injuries to patients and measure that result.

O'KANE: Putting waste and harm at the top of the list is a perfect example of aligning of the interests of the patient with the interests of society. I also want to go on record to congratulate Don for the brilliance of the 100,000 Lives campaign, because I think it uses incredibly effective rhetoric to motivate action. And it gives real clarity to what the goals are. One of the big enemies of progress that we all have to be very vigilant about going forward is confusion with too many people having different priorities. On one hand, I think we need to be strategic and realistic about what we can accomplish. But at the same time, we need to be very bold about taking action.

ROPER: The complexity of solving the problem is much greater when we get to outpatient and independent practitioners and so on. We here in our UNC Health Care system have about 1,000 clinicians who are physician faculty, and I'm supposedly the dean of all of them. It's a real challenge to get them headed in the same direction, to say nothing of what it would be like were they all practicing in small settings out across the community. But the fact that it's daunting is not a reason to

abandon it, to be sure. What Don has demonstrated in this national effort is that it is doable. You can get people to rally around a manageable set of activities and get them done on a widespread basis.

MOLPUS: *Dr. Roper, you have a national perspective on quality from your position as former HCFA administrator and as chairman of the National Quality Forum, and now you have the opportunity to leverage those lessons with the UNC system. Can you tell us what your hospitals have been able to do?*

ROPER: UNC Health Care has long had an interest in quality and patient safety. But about two years ago I—with the help of a lot of other people—said we're going to be much more focused, not just with a committee that meets on Tuesday afternoon, so to speak, but across the organization beginning at our board of directors, me as CEO, the clinical department chairs, the hospital leadership and so on. We're going to embrace quality improvement and patient safety as job one. And the organization has responded to that in wonderfully positive ways. I thought when we signed on to the 100,000 Lives campaign people would view this as drudgery or busy work or something that they shouldn't be troubled with. To my pleasant surprise, that's not been the case. Physicians, nurses, other clinicians, residents and the whole organization have come forward to embrace the notion of quality and patient safety as a thing that's very important to them. And one further thing I would just say: Soon we will be having our annual board retreat for the board of directors to whom I report. And we're going to spend a whole day talking about the board's role in quality and patient safety. They asked for that. This is not something that I'm trying to interest them in. They asked for it.

MOLPUS: *When we talk about the levers on quality such as pay for performance, which ones have worked so far and which ones have not?*

O'KANE: If you have a predominantly fee-for-service payment system that pays for quantity, and then you add in a little bit of pay for performance, I don't think that really takes us where we want to go. Granted, it's a start, and I think we've pushed it as a start. But I believe very strongly that we need to move pay for performance forward as part of a more comprehensive payment reform. Where we've seen the most success with pay for performance is in California, where 230 medical groups are reporting data standards. They're also investing in IT systems because that is part of the basis of the pay for performance program run by the Integrated Health Association. They've been able to show very impressive improvements over time. That goes to the idea that where there is an enterprise that's big enough to invest in IT, you have a much better chance than with the small practices, where I think IT investment can really be a very difficult thing to take on.

ROPER: We need to give even stronger incentives for quality and investing in the things that will produce quality. And we need to recognize that it's absolutely essential to have organized systems of care if we are going to make substantial progress. I well remember that what the American people believed they were saying in the mid 1990s was that they hate large-scale organizations that deliver healthcare, otherwise known as HMOs. But for the life of me, we have got to get to some kind of organizational structure that has the clout and the organizational capabilities and the wherewithal to make these things happen.

Negative reinforcement

MOLPUS: *We've talked a lot about the incentive side of things, but there is also the other side: punishing poor care. Mark, you deal with this*

with your clients somewhat. Are those punishments enough to get hospitals to move upward? What kind of impact do they have?

PICKRELL: They have great impact. In fact, they have such great impact that you have to be careful when you do it. An example would be if you penalize everyone who had patients who received infections, would you have a different rule for those who have HIV or other immune compromised systems? How do you penalize them? How do you create a system that stops some of the behaviors that you want and encourages some of the behaviors that you want, and where you have enough data and information to be able to make those judgments? In my experience, our legal system and the payment system in healthcare is not very good at making those determinations. The cost of making those determinations is sometimes far greater than the actual damage involved. So we have tools legally that can let us affect behavior, and they do get responses. The law of unintended consequences, though, often exacts a great price.

MOLPUS: *Does pay for performance really need to have more consolidation to be effective where it's a little more predictable for a hospital to follow?*

BERWICK: It would probably be helpful to move in the country toward a more textured or segmented discussion about pay for performance. It's not one thing. It's just that it's a zoo of approaches, some of which are great, some of which I think are very risky. I want to first return to what Peggy and Bill both said, which is the key to me about payment: figuring out how we're going to pay as a nation for the care populations integrated over time and place. If we can come up with integrated payment schemes we stand a much better chance of getting a lot of other stuff integrated, and I'd trade any pay for performance in an instant for integrated payment for the care of populations. That said, the idea that we pay in such a way as to support the performance we want is rational. So designating when we pay for care what we expect from the care seems to me very important. Contingent payment, where you pay more or less depending on performance, is risky stuff. At the entity level, hospitals or integrated care systems, absolutely I think we need to alert them to what we want by attaching payment to performance. There's a recent Medicare proposal, I believe, to withhold pay-

ment from hospitals when patients get infections, and I think that's a good idea well worth trying as an experiment to see what effect it has. The part of pay for performance that scares me is individualized pay for performance of individual physicians.

PICKRELL: I'm curious what the group thinks—by putting brass tacks on whether we can identify individual areas where we can find improvements. We're talking about some sort of global change to the payment system, but the question really is how do you combine the two, how do you make sure that in the various areas where you can have clinical improvement can you also integrate those by a payment structure?

O'KANE: I think we need a bundled payment system where we're not paying for each little thing. While that may sound to some like capitation, I think we're talking about something that is some degree short of that. We also need transparency. There is no perfect payment system, as we all know, but right now we're living through a payment system that's exploding costs. But in order to avoid the dark side of bundled payments, transparency seems to me to be part of what's required

Avoidable deaths and costs

Below are avoidable deaths and medical costs due to unexplained variations in care for some select measures and conditions.

Measure	Avoidable deaths	Avoidable hospital costs
Beta-blocker treatment after a heart attack	800 - 1700	\$9.7 million - \$15.2 million
Breast cancer screening	100 - 700	\$41.9 million - \$94.2 million
Controlling high blood pressure	10,600 - 29,600	\$333 million - \$922 million
Cervical cancer screening	800 - 1,200	N/A
Diabetes care—HbA1c control	7,400 - 15,000	\$1.35 billion - \$1.62 billion
Smoking cessation	7,300 - 11,100	\$848 million - \$872 million
Prenatal care	1,300 - 2,200	N/A
Colorectal cancer screening	5,700 - 11,900	\$267 million - \$374 million
Flu shots for adults (65+)	3,600 - 7,600	N/A
Osteoporosis management	N/A	\$8.3 million - \$8.7 million
Total	37,600 - 81,000	\$2.9 billion - \$3.9 billion

Source: National Committee for Quality Assurance, 2005

in order to make bundled payments work. That gives organizations that are really trying to work toward greater efficiency real motivation to do it, while at the same time staying out of the trap of micro-managing the processes of care in addition to payment systems. That said, we really don't want the government, NCQA, or any other outside party to be dictating this, because we're in a time when we need more innovation, and we want people to be figuring out ways to deliver effective care at a lower cost. As it stands, the current payment system really doesn't encourage efficient, effective care; in fact, it punishes it.

MOLPUS: *Is the discussion in the coming years going to shift to one on value? Will having more consumers paying attention to the cost of their care play into this?*

O'KANE: Well, it's really to make the cost agenda more explicit. The big political challenge lies in helping the public to understand that it's in their interest to have a value agenda, that the alternative to a value agenda is basically an unraveling of the insurance system. Even from a narrow quality perspective, a value agenda can exert tremendous discipline. When patients are getting procedures they don't need, they're not getting good value—they're not getting good care, either. There's a lot of new technology being put forward, but there's not enough discipline in the current structure of things to keep technologies that are really marginal from being deployed. I think we are on the right track with hospitals to eliminate some of the waste and harm there, which should help. We need to figure out a way to activate the patients and make the patients more of a partner in their own health, but I don't think we have an evidence base for this. A lot of people sort of roll their eyes when you bring this up because we really haven't funded the kind of research about what makes people engage in wellness behaviors or comply with what their physician is trying to get them to do.

Six Evidence-Based Interventions Recommended by the 100,000 Lives Campaign

Deployment of rapid response teams ... at the first sign of patient decline

Delivery of reliable, evidence-based care for acute myocardial infarction ... to prevent deaths from heart attack

Prevention of adverse drug events ... by implementing medication reconciliation

Prevention of central line infections ... by implementing a series of interdependent, scientifically grounded steps called the "Central Line Bundle"

Prevention of surgical site infections ... by reliably delivering the correct perioperative antibiotics at the proper time

Prevention of ventilator-associated pneumonia ... by implementing a series of interdependent, scientifically grounded steps called the "Ventilator Bundle"

Source: Institute for Healthcare Improvement

MOLPUS: *What are the things the industry has to do from that perspective to get them more involved in the leadership of quality? In particular, getting them usable information that they can use to make their decisions.*

O'KANE: The IOM did a great report last year on how millions of Americans have a problem understanding and communicating with their doctors. While it highlights the health literacy problem we have in this country, the healthspeak jargon we often use doesn't do much to help the problem. So it seems to me that we need to find a common ground, and we're not there yet.

BERWICK: The positioning of the consumer in a powerful role with respect to design, evaluation and configuration of the services we give is crucial to me, as is complete transparency. Everything should be known. I do not believe a national agenda of shifting cost to patients in any form whatsoever is based in good data or is likely to work. In fact it'll probably hurt since ill health and low income go together so closely. I don't think we should be using shifting cost or payments as a tool. Nor do I think we should be naive about expecting patients at the point they are very ill to be picking up *Consumer*

Reports and deciding where to go. If CalPERS can't make wise choices about where to contract, Mrs. Jones can't either, certainly not when she is suffering from pain or illness. A combination of transparency and real listening to consumers is great. Transparency will do its work mostly through the super-egos of the providers of care, not through the choices that consumers are going to hope to have. It's not what I think even consumers want.

ROPER: One of the most challenging things across the past 20 years has been the business case for quality; that is, how will the business community and payers more generally be interested in quality? Even more difficult than that is what we're here talking about, which is the consumer case for quality and whether the average American will get interested and make transforming decisions about quality. The National Quality Forum, which I'm involved with, and Peggy and Don are as well, has as one of our guiding principles the notion of bringing all the sectors together, including consumers. I think we've made some real progress in that regard, but still it's hard to get average Americans interested in this issue, because it's arcane and technical. But to

say that it's hard is not to say let's not do it—it's to say we need to find better ways of engaging average Americans in this important issue and getting their shoulder to the plow, so to speak.

Uniting stakeholders

MOLPUS: *There are many groups that are players in quality, and NQF was chartered as a common ground, so to speak, to bring all the various stakeholders together. Talk a little bit about how difficult that's been and some of the progress that it's made. Has it really been possible to bring all these stakeholders together in a unified way?*

ROPER: NQF was founded in the summer of 1999, and we've made some progress, but by no means as much as I had hoped back at that point. We've now redoubled our efforts, and we have a new CEO and are looking intently right now about changing the way we are organized. A number of other groups have come into being, most notably the Hospital Quality Alliance and the Ambulatory Quality Alliance. And organizations like Peggy's and Dennis O'Leary's Joint Commission have major agendas of their own. One of the challenges we face is we've got a lot of efforts under way out there—all of them well-intentioned, many of them headed in the same direction. But one of the things I have been hoping for is that we would have some sort of governmental action clarifying by the Congress what the landscape is here. Absent that, it's up to us to persuade each other to work together, and on a good day I'm encouraged that we're making progress in that regard. But it's a challenge.

O'KANE: It's a real challenge, and I think we have a responsibility to exercise some collective leadership. But having said that, it really does become very complicated when you're trying to manage your own complicated agenda and also align with others.

MOLPUS: *Do we really think the industry is going to be able to make the progress on its own without the government stepping in?*

Can all the healthcare stakeholders within themselves in the industry really move forward without more aggressive push?

ROPER: No.

BERWICK: Sufficient will doesn't appear to lie within the industry to make the changes we need. The one sector, the one stakeholder group, that's a wildcard to me is the employers. As I said earlier, I sometimes wish I could get every Fortune 500 CEO to come with me to Sweden, just to Sweden, for one week. And have me walk them through that system and just show what's going on and show them the bill and see if they can return without demanding a fundamental restructuring in this country. I don't understand why that coalition of interests hasn't formed, but maybe it can.


The industry's future

MOLPUS: *I just want to know from all the participants your thoughts relative to being optimistic or pessimistic about the healthcare industry and system's ability to really close these gaps in quality?*

PICKRELL: On the issue of hospital CEOs and other provider executives and their leadership, on both the for-profit and the nonprofit side, there is great interest in the development of superior quality delivery of care. The incentives are all aligned to try to improve quality, but again it starts out where I started my discussion, which is that we have a very good system by any historical or global perspective. And if that's true, I'm optimistic that we can continue to improve the quality of care that we have, whether it's Congress or CMS or large employers or small employers or hospital executives or nonprofit hospital executives—everyone involved in healthcare wants to improve the quality of care. The questions always are at what cost, do we have systems where we avoid perverse incentives, and do we have systems where we encourage good behavior. I think that's what everyone is working toward. Personally, I'm quite optimistic.

BERWICK: There's just too much good knowledge out there, too much potential for effectiveness, and too much pride and joy in getting to what we want, for me to believe that, in the end, we're not going to get there. Maybe not immediately, but the future healthcare that is pretty easy to imagine is just plain better in so many ways. My problem is pace. It's like being in a taxi and watching the meter click away, and the meter keeps clicking and I just wish we'd get off the dime. What I currently think is we are probably going to have to pass through a period of failure. The policy canon right now around all the things we've been talking about—pay for performance, shifting cost to consumers, the failure to control capital and supply, the failure to plan care, the rejection of managed care—all of these are mistakes in policy at the moment, and we apparently need to make them first. Isn't there another Winston Churchill quote about that—we always do the right thing after we've tried everything else?

O'KANE: I think Herb Stein said that unsustainable trends can't continue. But it would be great if we could avoid having to live out some of the things that it feels like we're headed for if we don't take action. Having to live through poorly thought-out policy directions is more painful than having what seems like a good policy direction on its face and then discovering that it's not quite working. So I feel a great impatience myself.

ROPER: I would just say I am similarly optimistic. There's a growing set of forces and organizations and individuals who are pushing us in the right direction. I, too, am very impatient. This has taken a whole lot longer than I thought to get us even to this point. So we need to pick up the pace—and I don't know what else to say except we have to do this, there needs to be a real imperative about it. 

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