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Healthcare Leadership Strategies in Times of Economic Crisis and Political Opportunity

EXECUTIVE SUMMARY

The United States may be mired in its worst economic crisis since the Great Depression, but that does not obviate the need for healthcare reform. If anything, it intensifies it. Thus, President Obama and leaders in Congress have made it clear that healthcare reform is the top domestic priority in 2009.

Although healthcare remains central to the U.S. economy, its poor value proposition—that is, the relatively low quality of care accompanied by its high cost—paradoxically makes the industry an economic drain. Unnecessary or low-value expenditures on healthcare deprive the nation of investing in other worthwhile needs.

Federal legislation is only one element of system transformation. Healthcare reform is not merely a matter of moving dollars around or increasing access. Instead, federal policymakers are considering ways to transform the system in which the government encourages behavior through incentives with an eye toward spearheading long-term quality improvement.

In the meantime, quality improvement initiatives are happening all over the country. Many health insurance programs are national, but the delivery enterprise is local. Yet even though innovations are increasing, they often occur in silos and are not easily replicable. Replicating or "scaling up" such innovations so that they become part of a national transformation effort may be the biggest challenge of reform.

Any true reform effort must ensure that patients are at the center and are its focus. Yet consumers are skeptical, because they do not trust many stakeholders. To restore that trust, all stakeholders in the healthcare industry must, as a part of healthcare reform, ensure that all of their dealings are fully transparent.

The economic crisis presents an opportunity to fashion the healthcare system in a way that is economically viable, scientifically innovative, and patient-centric. With concerted reform, there is a promising trajectory for significant improvements in healthcare for all Americans.

Introduction: The Current Climate

The nation's two top domestic policy issues, the economy and healthcare, are not as separate as they might initially appear. To the contrary, they are tightly intertwined. The United States may be mired in its worst economic crisis since the Great Depression, but that does not obviate the need for healthcare reform. If anything, it intensifies it. The healthcare sector is a pillar of the U.S. economy, representing more than 16 percent of GDP;[1] yet despite this investment, quality of care in the United States is lacking, and a sizable proportion of healthcare services represent waste.

In light of this, President Obama and leaders in Congress have made it clear that healthcare reform is a very high priority in 2009. Legislation already has been introduced and likely will be voted on by the end of the year, if not sooner. Serious disagreement remains about elements of reform,

➲ *Continued on page 2*

and some of these disagreements could derail reform altogether. But most major stakeholder groups have publicly acknowledged the need for reform and have at least tacitly endorsed it conceptually. "Although the economic crisis continues to cause a great deal of pain for our country, there is an atmosphere of hopefulness and collaboration to forge a solution about healthcare," says Janet M. Corrigan, PhD, MBA, president and CEO of the National Quality Forum.

In a June 2009 report, President Obama's Council of Economic Advisers spelled out large economic impacts of genuine healthcare reform. They include:

- slowing the annual growth rate of healthcare costs by 1.5 percentage points would increase real gross domestic product, relative to the no-reform baseline, by more than 2 percent in 2020 and nearly 8 percent in 2030;
- for a family of four, this implies that income in 2020 would be approximately $2,600 higher than it would have been without reform (in 2009 dollars), and that in 2030 it would be almost $10,000 higher;
- slowing the growth rate of healthcare costs will prevent disastrous increases in the federal budget deficit;
- slowing cost growth would lower the unemployment rate consistent with steady inflation by approximately one-quarter of a percentage point for a number of years;
- expanding health insurance coverage to the uninsured would increase net economic well-being by roughly $100 billion a year, which is roughly two-thirds of 1 percent of gross domestic product; and
- reform likely would increase labor supply by removing unnecessary barriers to job mobility.[2]

However, although healthcare remains central to the U.S. economy, its poor value proposition (i.e., the relatively low quality of care accompanied by its high cost) makes the industry an economic drain. Unnecessary or low-value expenditures on healthcare, particularly but not exclusively public expenditures, deprive the nation of investing in other worthwhile societal needs. Like the financial sector before its collapse, the U.S. healthcare system is burdened by perverse incentives and archaic infrastructure. The root of the problem is not so much the total dollars but the way they are spent. Thus, healthcare reform that solidifies and enhances the role of the industry within the U.S. economy is of even greater importance.

Much of what is currently being debated about healthcare reform focuses on expanding access. But true reform, as a component of total systemic transformation into a patient-centric, high-value enterprise, means more than simply granting greater access to the system. Healthcare reform in 2009 is expected to address extending health insurance to all Americans, eliminating unnecessary services to reduce costs, implementing quality improvement initiatives (including but not limited to performance measurement and public reporting), and changing key features of the delivery system to improve outcomes and boost overall value. This will require substantial investments and substantial reform to improve access, quality, and costs. And it will require extraordinary leadership both from public policy leaders and from healthcare leaders. Ultimately, the question of "Can we afford to reform healthcare?" must be answered, "Can we afford not to?"

The Case for Federal Action

Most Americans support healthcare reform.[3,4] The system's problems with safety (e.g., 98,000 deaths per year because of medical error),[5] access (e.g., approximately 45 million Americans lacking insurance),[6] and efficiency (e.g., overuse amounting to an estimated $700 billion per year)[7] are well documented, making clear the social justice case for healthcare reform. Americans have long considered healthcare the nation's top domestic policy priority, and sizeable majorities support key elements of reform currently being debated, such as employer mandates, individual mandates, and a public plan option.[8]

Despite the current economic crisis—and in many ways because of it—the President and Congress are pursuing comprehensive healthcare reform in 2009. First steps already have been taken in the form of the American Recovery and Reinvestment Act of 2009, which includes investments in health information technology and comparative effectiveness research. Other current federal efforts include expanded funding of community health centers and investments in prevention, nurse education, and the State Children's Health Insurance Program. And the President's Fiscal Year 2010 budget blueprint includes a reserve fund for healthcare reform. These efforts are paving the way for a comprehensive effort in which "everything is on the table."

Senator Sheldon Whitehouse (D-RI), who has been working on healthcare reform legislation, describes the current environment as dire but also full of opportunity. "Our bad news is also our good news," Whitehouse says. "We see so many problems with our current system, and we just can't tolerate more of it. The only way to fix it is through delivery system reform."

However, federal legislation is only one element of system transformation. "Reform means more than improving access to care," says Reed V. Tuckson, MD, executive vice president and chief of medical affairs for UnitedHealth Group. "We need to get at the quality and appropriateness questions." This time, policymakers truly understand that healthcare reform is not merely a matter of moving dollars around or increasing access but spearheading long-term quality improvement. "We believe that we cannot pursue reform without simultaneously talking about reducing costs and improving quality and preserving choice," says Robert Kocher, MD, National Economic Council, Special Assistant to the President. "It does not make sense to focus solely on covering everybody first, at whatever

cost and uncertain quality, and then fix the system. We are optimistic that reform will have a transformative impact that improves the quality of our healthcare delivery system and expands access to virtually all Americans."

Instead, federal policymakers are considering ways to transform the system in which the government encourages behavior through incentives and are looking to states and delivery systems for models of reform. State governments, as "laboratories of reform," have enacted pockets of highly progressive action in both access and quality, such as the individual mandate for universal coverage in Massachusetts.

Proposals at the federal level include financial incentives to build infrastructure (e.g., health information technology and community health centers); new payment initiatives to improve coordination of care and outcomes and to reduce waste; and investments to support evidence-based decisions through comparative effectiveness research. And, of course, there are proposals to expand coverage and access. "There are really two fights in Washington," Whitehouse says. "The access fight, everyone knows what that looks like. It's a mature piece of political terrain. But the delivery system reform portion is much newer. We've got some inventing to do. This part isn't just about political pie-cutting."

Health System Transformation Starts at Home

Although federal action is critical to stimulate system transformation, quality improvement initiatives are happening all over the country.

Health insurance may be administered at the national level, but the delivery system enterprise is essentially local. This matters because what succeeds in one geographic area may not succeed in another. "While so much of the current public discussion focuses on the negative, it is important to remember that there are also extraordinary successes. Examples of cutting-edge innovations are everywhere," says Michael J. Dowling, president and CEO of North Shore-Long Island Jewish Health System. "Despite that, however, we must all do better to improve quality—there is a huge gap between where we are and what we can become. It gets tiring only to hear about all the good things that go on at Geisinger Health System or Intermountain Healthcare or Kaiser Permanente. They do wonderful work in their markets but their models are not easily or quickly replicable. Each local market is different."

At the local level, there are success stories. For example, Memorial Hermann Healthcare System in Houston, Texas, has undergone a rapid shift in institutional culture to integrate its vast system of disparate parts across the nation's fourth-largest city, while Denver Health,

Case Study: Memorial Hermann Healthcare System

As the U.S. healthcare system undergoes the sometimes painful process of self-examination that comes with reform, providers can look to examples of hospital systems that have demonstrated dramatic improvement on their own. Houston-based Memorial Hermann Healthcare System offers one such example.

Six years ago, Memorial Hermann—a vast collection of 14 hospitals, 70 outpatient facilities, and dozens of other facilities and services—was suffering. Quality scores were mediocre, as were patient satisfaction scores. It was losing $50 million each year. As the largest provider of care in a county in which one of every three residents lacked health insurance, Memorial Hermann lacked focus—which may have been the system's greatest weakness.

"This system had come together through a series of mergers and acquisitions, and it had no real culture of its own," recalls Dan Wolterman, the system's president and CEO. "Until we could change the culture of the system, from the boardroom to the bedside, we could not make any sustained progress in quality or in any other area."

Memorial Hermann started by devising a "brand pyramid," with its vision statement—"to be the best of the best"—at the top, followed by a brand promise, then its culture (composed of operating principles and behaviors), then strategies and major initiatives. Foundational to it all were its mission and its values. The purpose of the brand pyramid was to instill cultural change across the system. "All 20,000 of our employees had to own this," Wolterman says.

Some of the change was easy, but not all of it. This became evident in August 2006, when the system committed two blood transfusion errors within one week. "We thought we had it nailed—but we hadn't taken the time to truly change the culture," Wolterman says. Thus, the system embarked on an $18 million safety culture training, starting with the board and extending to the entire staff.

Today, the results are in. Memorial Hermann has gone more than two and a half years without a transfusion error. The number of healthcare-associated infections has plummeted to almost zero—just 6 in the past year out of 1.4 million patient encounters. The "door-to-PCI" time—the amount of time it takes from a patient presenting with acute myocardial infarction until an emergency percutaneous coronary intervention—has been sliced nearly in half since 2005. And the system is achieving this efficiently; it is now operating at a 13 percent positive margin annually. This turnaround has led to Memorial Hermann winning several awards, including the National Quality Forum's 2009 National Quality Healthcare Award.

"We just started by making a promise to our community—that if you come to a Memorial Hermann facility, you would get the best outcome possible, with an exceptional experience," Wolterman says. "Everything we've done has been to try to fulfill that promise."

Leadership Strategies

Michael J. Dowling, president and CEO of North Shore-Long Island Jewish Health System, offers the following strategic advice for leadership in healthcare:

- Be a leader, not a manager.
- Understand your local market.
- Embrace transparency.
- Make sure the patient is central to every decision you make.
- Align physician incentives with hospital incentives.
- Don't shift blame, and don't confuse a "blameless" system with lack of accountability.

Lessons Learned at Memorial Hermann

- Share best practices.
- Make sure all incentives are aligned.
- Implement and maintain a good electronic health record.
- Make sure all endeavors, both on the clinical and management side, are evidence based.
- Hold everyone accountable.
- Be transparent to your community.

Colorado's largest safety net institution, has integrated a variety of public health components while improving clinical quality through the Toyota Production System.

Integration to reduce readmissions and costs is the theme behind another strategy that has shown promising results: the Transitional Care Model, a project that provides comprehensive in-hospital planning and home follow-up for chronically ill high-risk older adults hospitalized for common medical and surgical conditions.

The Transitional Care Model, developed by University of Pennsylvania researchers, emphasizes coordination and continuity of care, prevention and avoidance of complications, and close clinical treatment and management. Under the model, at hospital admission, eligible patients are assigned a transitional care nurse, who conducts a comprehensive

Case Study: Denver Health

Nothing symbolizes the healthcare crisis quite as much as the urban safety net provider. Safety net institutions tend to provide mostly uncompensated care and suffer from overcrowding, aging facilities, and poor funding. But Denver Health, Colorado's largest safety net provider, demonstrates that the integrated public health model can serve as a model for reform.

Denver Health faces significant financial challenges: Last year, approximately 40 percent of the care it provided was to uninsured patients. Yet the system remained financially solvent by aggressively moving from a fragmented to an integrated delivery model.

Denver Health is composed of a broad set of components. It includes a 500-bed main hospital in downtown Denver, 8 family health clinics, and 12 clinics in the city's public schools, as well as a set of health plans. It operates the city's 911 medical response system, its public health department, its poison and drug control center, and its correctional health facility.

As the city's safety net provider, Denver Health provides $360 million in uncompensated care each year. The city contributes $27 million to the system—a figure that has not changed in 18 years. Yet Denver Health consistently returns positive margins and meets or exceeds standard quality metrics; 92 percent of one-year-olds treated in the system are fully immunized, and it meets 100 percent of all five components of the acute myocardial infarction "care bundle."

The secret: integration. The system's components and its employed physicians are linked by a single electronic health record system, in which patients are assigned a unique patient identification number, ensuring that records are not lost and tests are not duplicated unnecessarily. The multiple points of access to care—such as school clinics and community health centers—mean that more primary care is delivered, lessening the need to follow up with more expensive and dangerous acute care later.

"Health reform addresses access, cost, and quality. If you move from a fragmented to an integrated system, you can do all three of those at once," says Patricia A. Gabow, MD, the system's CEO. "The integrated model of care can provide a starting point, especially for extremely vulnerable populations."

As it created an integrated system, Denver Health adopted the Toyota Production System for institutional quality improvement, using its "Lean" method to identify and eliminate $21 million in wasteful spending. "We don't manufacture cars, but Lean is ultimately about respect," Gabow says. "The idea behind the Lean method is that it is disrespectful to humanity to waste resources. So Toyota is not a tool of the day; it's a real way to change culture forever."

assessment of patient and family caregiver needs, coordinates the patient's discharge plan with the family and hospital provider team, implements the plan in the patient's home, assists the patient with management of his or her care needs, and facilitates communication and the transition to community providers and services.

The results are promising. Readmissions are cut in half within 24 weeks, and total healthcare costs are cut by nearly 50 percent within 6 months, researchers have found.[9] "This model directly responds to the most threatening healthcare problems facing this nation: the rapidly growing number of chronically ill patients and the disproportionate rate of healthcare expenditures among these patients," says Mary D. Naylor, PhD, RN, director, New Courtland Center for Transitions and Health at the University of Pennsylvania School of Nursing.

This model holds promise because it is built to apply broadly. Yet, although similar innovations are occurring all over the country, they often occur in silos and are not easily replicable. Replicating or "scaling up" such innovations so that they become part of a national transformation effort may be the biggest challenge of reform. "You can go across the United States and pick a place and see extraordinary innovation," Dowling says. "But it's a mixed bag. We have to do a better job than we do currently, irrespective of federal legislation."

The Patient at the Center of Reform

Consumers are understandably skeptical about healthcare reform.

The Institute of Medicine (IOM) defines "patient-centeredness" as one of the six aims of healthcare quality, and thus it has long been a goal to place patients at the center of every healthcare encounter. But this stakeholder group remains marginalized in most settings, IOM's definition of quality notwithstanding. "We've been talking for years—for decades—about getting better information to consumers so they can engage in their own healthcare," says James A. Guest, president and CEO of Consumers Union. "We've made some progress, but we still have a long way to go. So I hope that health reform brings real breakthroughs in getting information to consumers in terms they can understand."

Any true reform effort *must* ensure that patients are at the center and are the focus of the effort. Yet consumers are skeptical because they do not trust many stakeholders, including the pharmaceutical industry, organized medicine, health plans, or the government. To restore that trust, Guest says, all stakeholders in the healthcare industry must, as a part of healthcare reform, ensure that all of their dealings are fully transparent. "There are all kinds of conflicts of interest today within the system, so it's important to avoid or minimize conflicts and, where they exist, to manage those conflicts by disclosing them," Guest says.

But disclosing conflicts of interest does not mean keeping industry out of the mix altogether. Industry and other stakeholder groups can be of assistance by ensuring that their efforts are transparent, but they must engage in the endeavor with the explicit understanding that these endeavors are *always* for the benefit of the patient.

"The supplier community, in particular, is beginning to focus research beyond that required for registration purposes to better developing products and services that provide increased value to the healthcare system," says David Domann, MS, RPh, director, Future Market Strategies for Johnson & Johnson Health Care Systems. "The culture in the industry is changing," Domann says. "We're not totally there yet, but industry can be a catalyst for change if we work in collaboration with other stakeholders. We have to concentrate on how our products and services bring value to healthcare though improved and measurable outcomes."

Ultimately, the reform effort demands transparency, trust, and full participation from all stakeholders. Goals must be aligned, and resources allocated, to improve the health of communities. "The community level is a great place for this to happen," says Bruce Siegel, MD, MPH, director of Aligning Forces for Quality. Siegel's reasons:

1. **A sense of urgency.** Although healthcare reform can become an arcane policy debate in Washington, it is of urgent interest to communities, where economic insecurity merges with health insecurity.
2. **Communities can prioritize.** When resources are limited, it is easier to settle on a finite set of priorities. "It's harder at the community level to be all things to all people, but instead you find yourself choosing a few things and working to be really good at those," Siegel says.
3. **A focus on the common good.** Communities have equity as a core value, which is often lost in high-level policy debates, according to Siegel. "When you have to look your neighbor in the eye, it concentrates the mind," he says.

With this understanding, community-focused and consumer-focused reform are two sides of the same coin. Large national entities (e.g., the Centers for Medicare & Medicaid Services or large national health plans) may not mean much to consumers, but local hospitals and physician groups do.

Conclusion

The success of reform ultimately will be measured by the significance and sustainability of change in the thousands of delivery systems across the country.

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NQF's mission is to improve the quality of American healthcare by setting national priorities and goals for performance improvement, endorsing national consensus standards for measuring and publicly reporting on performance, and promoting the attainment of national goals through education and outreach programs.

NQF Issue Briefs provide insight into payer, policy, and industry efforts to promote quality healthcare. The 2009 Leadership Colloquium was support by a grant from Bristol-Meyers Squibb. Sustaining support is provided by the Cardinal Health Foundation.

NATIONAL QUALITY FORUM

601 13th Street NW
Suite 500 North
Washington, DC 20005
202-783-1300 Tel
202-783-3434 Fax
www.qualityforum.org

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In communities and healthcare institutions across the United States, pockets of innovation and excellence have been identified. However, spreading these practices across the country has been slow. Federal reform can modify the underlying barriers to change through its various policies for federal health programs, which collectively amount to more than half of the nation's total healthcare spending.

Unfortunately, health systems today are burdened by lower revenues—because of the recession—precisely as they need to shore up their investments to be competitive and provide better care for patients. In such a challenging environment, it takes leadership to grasp the vision and embrace the challenge. Part of that vision needs to be an intentional and constant focus on the needs of patients, families, and communities.

The economic crisis presents an opportunity to fashion the healthcare system in a way that is economically viable, scientifically innovative, and patient-centric. Although much of the hot-button controversy surrounds payment issues, improving quality and re-establishing the value proposition are just as important. Keys to change will be public-private partnerships, payment reform that encourages quality, and multiple-stakeholder initiatives. With concerted reform at the federal level, along with state and community implementation actions, and with continued successes in public-private partnerships at the delivery system level, there is a promising trajectory for significant improvements in healthcare for all Americans.

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Notes

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