Assurance And Advisory
Business Services

Health Sciences And
Advisory Services

Ernst & Young

Quality In Everything We Do

Straight Talk About Clinical Quality From Health Care CEOs

HEALTHCARE EXECUTIVE FORUM PARTICIPANTS

James D. Barber

President and CEO
Hospital Association of
Southern California

David L. Callender, M.D.

Executive Vice President and COO
University of Texas - M.D.
Anderson Cancer Center

Donald E. Casey, Jr., M.D.

Chief Medical Officer
Catholic Healthcare Partners

Denis A. Cortese, M.D.

President and CEO
Mayo Clinic

Michael A. Geheb, M.D.

Vice President for Institutional Advancement
Oregon Health & Science University

Walter W. Noce Jr.

President and CEO
Children's Hospital of Los Angeles

John G. O'Brien

President and CEO
UMass Memorial Healthcare, Inc.

G. Mark O'Bryant

President and CEO
Tallahassee Memorial HealthCare, Inc.

Paul H. O'Neill

Chief Executive Officer
Pittsburgh Regional Healthcare Initiative

Mary A. Pittman, Dr. P.H.

President
Health Research &
Educational Trust

Thomas C. Royer, M.D.

Chief Executive Officer
CHRISTUS Health

Gary S. Shorb

President and CEO
Methodist Healthcare
University Hospital

David P. Stevens, M.D.
Vice President for Clinical Care Improvement
Association of American
Medical Colleges, Washington, D.C.
and George W. Merck Senior Fellow, 2003-2004
Institute for Healthcare Improvement

Elliot J. Sussman, M.D.
President and CEO
Lehigh Valley Hospital
and Health Network

Bruce C. Vladeck
Professor of Health Policy & Geriatrics
Mt. Sinai School of Medicine
Formally Administrator, HCFA

Thomas F. Zenty III

President and CEO
UHHS University Hospitals
Health System

Welcome

Intensified public awareness and regulatory scrutiny have made clinical quality an urgent concern for the nation's health care leadership. Clinical quality is not a new issue, of course. Over many years and through numerous popular approaches, health care institutions have been working on quality and patient safety issues. However, permanent and replicable results have been elusive. From the Institute of Medicine's report on hospital errors to JCAHO surveys and investigations, improving health care quality is both a strategic and competitive issue that will only become more urgent in the years ahead.

Recognizing the growing emphasis on health care quality, Ernst & Young recently convened a group of health care leaders from major hospital and health care delivery systems nationwide for a candid discussion of the issues surrounding quality improvement. This health care forum represented a variety of industry perspectives and addressed questions such as:

- Do you see your commitment to quality as a competitive advantage, a compliance issue, or a moral commitment?
- Why does the gap between what we know should be done and what gets delivered still persist?
- With major changes in payment models, such as the new CMS/Premier program for hospitals and the Bridges to Excellence program for physicians, is the balance finally shifting to place quality at the center of the strategic agenda for health care CEOs?
- If quality is now a key strategic issue, how are health care leaders going about the task of making major improvements in their quality performance? What challenges are they encountering?

From our discussion, Ernst & Young has produced this white paper – *Straight Talk About Clinical Quality From Health Care CEOs*. It provides candid and thought-provoking insights into what the leaders of some of the nation's most prestigious health systems, academic medical centers, and other health care delivery organizations are thinking and doing about quality. The paper captures the collective insights surrounding the business case for quality.

I would like to thank the distinguished participants in our day-long discussion both for their generous time and for sharing their unique perspectives and experience. In particular, thanks to Paul O'Neil, former Secretary of the United States Treasury, retired CEO of Alcoa, Inc., and now CEO of the Pittsburgh Regional Healthcare Initiative for providing fresh insight from government, corporate, and public policy perspectives. I would also like to recognize my co-authors Jim Reinertsen, Senior Fellow at the Institute for Healthcare Improvement; and Mark Finucane, Principal in Ernst & Young's Health Sciences Advisory Services. Special thanks also goes to Jim Reinertsen for his guidance and help in facilitating the Executive Forum.

Rick Wallace
Ernst & Young LLP

Table of Contents

Introduction

For at least two decades, purchasers and payers have been taking steps to make clinical quality a true strategic priority for health care delivery system leaders. And for even longer than that, regulators have been pushing health care CEOs to improve the reliability, efficiency, and evidence-based quality of the care delivered by their organizations. A long list of acronyms and programs (PROs, JCAHO, Managed Care, NCQA, HEDIS, QIOs, QAPI, AHCPR…) bears witness to these efforts. Yet, despite this intense pressure from payers, purchasers, and regulators, Americans still experience a health care system that is:

- Marked with underuse of services that would benefit patients (55% of needed care gets delivered)[1]
- Plagued by overuse of expensive services (3x greater cost in some geographic areas versus others, with no apparent benefit to anyone except providers)[2]
- Scarred by misuse and harm (errors that cause tens of thousands of needless hospital deaths annually)[3]

Within the past two or three years, a new set of forces has come into play. (See Table 1) The Leapfrog Group has brought the purchasing pressure of 140 major employers and 35 million patients to bear on quality issues such as the staffing and organization of intensive care units, and computerized order entry systems.[4] Public awareness of safety problems in hospitals is at a far higher level than it was before the Institute of Medicine report on errors. An increasing number of report cards on broad quality measures are available to purchasers and consumers.[5] And perhaps most important, a number of new quality-driven models of how to pay hospitals and doctors have been developed and deployed in considerable scale. When these changes are added to the ongoing and intensifying pressures for quality brought about by JCAHO and other more traditional regulatory forces, it is clear that the quality environment within which hospital and health care system leaders are working is considerably changed today from what it was a few years ago.

[1] McGlynn et al., "The quality of health care delivered to adults in the United States," N Eng J Med 2003;548: 2635

[2] Fisher ES, Gottlieb DJ, Lucas FL, Pinder ÉL, Stukel TA, Wennberg DE. The implications of regional variations in Medicare spending: Health outcomes and satisfaction with care. Ann Int Med 2003;138: 288-298

[3] Committee on Quality of Health Care in America. To err is human: building a safer health care system. Washington, D.C.: National Academy Press, 2000.

[4] http://www.leapfroggroup.org

[5] http://www.healthgrades.com/

Sensing that these changes might be causing a major industry shift, from "clinical quality is a good thing but not a driver of organizational success" to "clinical quality is an essential element of organizational strategy," Ernst &Young brought together 16 health care leaders from major hospital and health care delivery systems in January 2004 to have a frank conversation about how they are thinking and acting about quality, and to address questions such as:

- Why does the gap between what we know should be done, and what gets delivered, persist?
- With the advent of major changes in payment models such as the new CMS/ Premier program for hospitals,[6] and the Bridges to Excellence program for physicians,[7] is the balance finally shifting to place quality squarely in the center of the strategic agenda for health care CEOs?
- If quality is now a real strategic issue, how are these leaders going about the task of making major improvements in their quality performance, and what challenges are they encountering?

This white paper is a report of that conversation, and provides a glimpse of how the leaders of some of the nation's most prestigious health systems, academic medical centers, and other health care delivery organizations are thinking about quality.

Health Care CEOs' New View of Quality

1. Quality of care has finally become an important strategic issue for health care CEOs
2. To respond, they must move from doing "boutique quality projects" to achieving system-level improvement
3. They haven't done this before, and they need help and support in dealing with a number of big challenges: leading cultural change (particularly system thinking), engaging physicians, solving business case issues (payment models, accounting systems), developing a common quality language, public transparency of quality information, …

[6] http://www.cms.hhs.gov/quality/hospital/PremierFactSheet.pdf

[7] http://www.bridgestoexcellence.org

Something Has Changed

"There used to be four ways for CEOs of hospitals to lose their jobs: Lose money, anger the doctors, fight with key board members, or get the hospital's name in the paper for something bad. Now there's a fifth: missing your clinical quality goals."

The health care leaders gathered by Ernst &Young were crystal clear on one point: ***clinical quality has moved to the forefront of their organizational strategic agendas.*** In many instances, these organizations have always had a significant focus on quality, but it has sharpened and intensified, at least as seen by the CEOs, during the past year or two. They framed this shift in a number of ways:

- "A couple of years ago, I would say that as long as we didn't have any quality disasters, our board really didn't pay much attention to quality. Now, my job is on the line if we don't hit our quality targets."
- "One marker of the change is that we've started disciplining or even removing physicians—even the big revenue-generators—if they are dragging down our measured quality performance."
- "Thirty percent of my salary is dependent on achievement of some fairly difficult quality goals."
- "We've adopted very difficult goals—such as the elimination of preventable deaths in the hospital by 2008. Such a goal would have been extremely unusual two or three years ago."
- "We regularly review a survey of what's on the minds of all the hospital CEOs in the U.S. Five years ago, 'Quality of Care' had perhaps half a page of CEOs who listed it as a big deal. The most recent list ran six pages."
- "There used to be four ways for CEOs of hospitals to lose their jobs: Lose money, anger the doctors, fight with key board members, or get the hospital's name in the paper for something bad. Now there's a fifth: missing your clinical quality goals."

The CEOs couldn't pinpoint any single cause for this shift. The IOM *Chasm* report and associated publicity has had a noticeable impact on public awareness, and the types of questions asked of CEOs by their boards. The recent advent of "pay for performance" models has clearly raised the level of attention to quality issues. Public and private report cards, in some instances, have brought about a new focus on quality. A number of CEOs described something of a personal transformation—usually related to an experience with a serious, heart-rending quality failure in their own hospital—that stimulated them to push quality to the forefront of the institution's agenda on professional and ethical grounds, without needing the addition of a business rationale.

They were also of the opinion that this change was just beginning, particularly at the governing board level. For example, in many instances, the CEOs are actively educating their boards to care about clinical quality, rather than the trustees bringing this issue to the CEOs.

In a sense, the CEOs are "calling in the quality fire on their own position," in an attempt to build good will and commitment from their boards and others to stay the course on quality improvement.

The CEOs and other leaders invited to this conference tended to be forward-thinking, and their organizations are among the top ranks of admired industry leaders. They acknowledged that their own shift in thinking about quality might not be mirrored throughout every hospital. For example, some reported that hospital trade associations feel considerable reluctance to get in front of this issue, recognizing that clinical quality represents a new focus for many of their CEOs and health systems, and that public reporting of clinical quality results would create winners and losers in any given region (always a difficult problem for membership organizations).

Further conversation about this problem surfaced several viewpoints about why the industry has been so slow to take quality forward as a major strategic initiative, and why some hospital and health system leaders continue to resist embracing the clinical quality agenda. (A similar list of reasons surfaced later in the meeting, when the CEOs discussed their challenges in achieving system-level improvements in quality within their own organizations.)

- ***"It's not really that big a problem."*** There remains a considerable reservoir of doubt among many in the industry about the data on error-caused deaths and other attention-grabbing headlines. Controversy over whether it is 32,000 or 98,000 or some other number of needless deaths has diverted attention from the realization that whatever the number, it's large, and it needs to be addressed.

- ***"It might be a problem, but it's not our problem."*** As one CEO expressed it, hospital leaders have been saying "Not guilty, not guilty" in response to quality allegations for so long that it has been difficult for them to face the real harm, and the overuse, underuse, and misuse that occurs every day in their own institutions.

- ***"We have a problem, but the doctors have to solve it, and we can't seem to get them engaged."*** There is no question but what hospital/medical staff relationships have been strained by any number of issues, from economic credentialing to compliance and regulatory barriers that actually punish those hospitals that engage their physicians in a shared quality and business agenda. Whatever the issues, the CEOs present were clear about one thing: if they are to succeed in achieving quality results, they will have to do more than simply credential individual physicians. And they were also clear about another issue: Hospital CEOs cannot wash their hands of this problem by saying "we can't do anything about the doctors." To many attendees, this stance sounds more like victimhood than leadership.

- ***"We resent having our organizational agendas being driven by outsiders such***

as Leapfrog." Many hospital leaders would rather direct capital toward facilities and programs than towards computerized order entry, hiring of intensivists to staff ICUs, and other new "requirements" being presented to them by purchasers.

- ***"We simply don't know how to do this yet."*** While no individual CEO expressed this thought in so many words, there was a strong sense that no one appears to have discovered a foolproof recipe for how a given hospital or health system can reliably achieve measured, system-wide high-quality performance across all quality dimensions for all major conditions and diseases. (Note: the Robert Wood Johnson Foundation Pursuing Perfection Grant Program is an attempt to learn what it will take to build and sustain such a health care organization. Seven U.S. hospitals and care systems have been working hard for almost three years to transform themselves into "the Toyotas of health care," but they would all agree that it will take much more time before the core elements of a transformational "recipe" are clearly spelled out.)[8], [9]

Perhaps the best framing of the nature of the shift emerged from the recognition that there have always been three reasons for CEOs to work on the quality agenda:

1. ***Moral responsibility.*** A fundamental tenet of the health professions is "First, do no harm." If CEOs know their care systems are harming patients, they have a moral responsibility to improve. The CEOs noted that they now feel a far more acute sense of the harm being done in their system, and a far higher sense of ***personal*** responsibility for that harm, than they had previously.

2. ***Strategic business reasons***. This has historically been the weakest reason to work on quality, particularly clinical quality. Other quality attributes such as patient satisfaction have always been important to growth in market share and other strategic business goals. But the advent of "pay for performance" markets, and the increasing public awareness of quality and safety issues, all focused on clinical quality, has moved this quality attribute—clinical performance—from the back to the front burner for many CEOs.

3. ***Regulatory compliance.*** Clearly, hospitals and health systems need to maintain accreditation, and comply with other regulations pertaining to clinical quality. This reason has always driven the quality agenda, and continues to do so to a significant extent.

[8] http://www.ihi.org/pursuingperfection/

[9] Reinertsen, JL. A Theory of Leadership for the Transformation of Health Care Organizations. White paper available at www.qualityhealthcare.org/improvementmethods/literature

But Our Performance Still Isn't What It Needs To Be

A marker of the relentless quest for improvement that characterized the leaders present at this conference, and the organizations they lead, was their forthright description of numerous opportunities for improvement within each of their institutions. These CEOs and other leaders were remarkably candid in their self-assessment. Examples include:

- "We are inconsistent and unpredictable. We have our *miracle moments* that make everyone feel great, and then we find ourselves in *cesspools* of quality failures the next day."

- "I think we get complacent when we look at our performance compared to benchmarks. Benchmark performance in health care is full of mistakes, costly failures, and harm. Should we really be satisfied with being the *cream of the crap*?"

Paul O'Neill, leader of the Pittsburgh Regional Health Initiative, challenged those present to harness their dissatisfaction with current performance to their personal ownership of their organizations' quality failures, in the following ways:

- To set their quality goals in relationship to the theoretical limits of performance, not in relationship to benchmarks.

- To take responsibility as leaders for everything that happens in their organizations, especially what goes wrong.

- To refuse to accept work-around solutions to tough problems—and to solve problems down to their roots.

- To look at safety failures (e.g., sentinel events) as the top of a pyramid of system-level problems, and to analyze the failures all the way to the base of the pyramid.

- In short, to lead quality, not preside over it.

"We are inconsistent and unpredictable. We have our miracle moments that make everyone feel great, and then we find ourselves in cesspools of quality failures the next day."

The New Business Case for Quality

How are hospital and health system leaders thinking about the new business case for quality brought about by pay-for-performance programs? Clearly, it has their attention. For instance, almost 300 hospitals have signed up to participate in the CMS/Premier program. And thousands of physicians are enthusiastically participating in various pay-for-performance programs. All of these programs are designed to have benefit for patients. But what are the implications for hospitals and doctors in terms of revenues, costs, and margins?

The CMS/Premier program focuses on 34 clinical quality measures clustered under five conditions and procedures: acute myocardial infarction, congestive heart failure, community-acquired pneumonia, coronary artery bypass grafting, and total hip/knee arthroplasty. The 280 hospitals in the program will be arrayed in deciles of performance according to their measures for each of the five conditions, and in the first year, the top 10% of hospitals in each condition will receive a 2% bonus over and above the total of CMS payments for that condition, and those in the 80th to 90th percentile will get a 1% bonus. The first year of performance sets an initial baseline range for all participating hospitals, and if a hospital's performance is still in the bottom tiers of that baseline level of performance after three years in the program, that hospital's payments will be *decreased* by similar amounts.

CMS expects a total payout of $7 million in the first round in bonus payments, divided among 56 hospitals (top 20% of 280 hospitals), so the average payment is likely to be a fairly small percentage of any hospital's revenues. In other words, the business impact of the program—at least as measured in revenues—is small. A minority of participants will realize small bonuses, (and some public recognition) and three years from now, a small number of laggards might realize small decreases in revenues. The actual strength of the business case of the CMS/Premier program must lie elsewhere than in the top line.

Physician versions of pay-for-performance have a taken variety of structures. In the Bridges to Excellence model, employers promise to pay fixed awards of $100 per patient to physicians who meet NCQA criteria for "excellence in diabetes," for all diabetic patients in that physician's practice. The criteria include documented delivery of evidence-based care practices such as eye and foot exams, and measurements of diabetic control. Other programs such as the Integrated Healthcare Association in California pay higher amounts (as much as $6.50 per member per month to capitated medical groups, for example) in return for performing in the top 20% of all physicians in the care network. The contractual basis and other implications of these payment models have been the subjects of recent reviews. [10], [11],[12]

[10] Epstein, AM et al. Paying Physicians for High Quality Care. N Engl J Med 2003; 350:406-410

[11] Gosfield AG. and Reinertsen JL. Doing Well by Doing Good: Improving the Business Case for Quality. White paper available at www.reinertsengroup.com

[12] Gosfield, AG: Contracting for Provider Quality: Then, Now and P4P. Health Law Handbook, 2004 Edition. Alice G. Gosfield, Editor. West Publishing.

These early pay-for-performance models have garnered a lot of attention, and those who have initiated them deserve to be applauded and encouraged.[13] But a careful examination of the business implications gives many health care CEOs (and perhaps more so, their CFOs) some pause. The following observations would seem to summarize the current state of understanding of pay-for-performance and the new business case for quality:

1. The early programs are a laudable effort to channel the attention of health care leaders to the quality agenda, and have been quite successful in achieving that aim.

2. The quality focus of virtually all of the early programs is on that subset of problems characterized by *underuse* (e.g., diabetic foot exams, use of helpful medications for congestive heart failure, and various preventive services.) The problems of *overuse* and *misuse* are going to be more difficult to deal with. In overuse, for instance, it's simply politically incorrect to pay a hospital or a physician a bonus for *not* delivering a service, even if the current practice of overuse is clearly harmful. For problems of misuse, our measurement methods for determining that a procedure or treatment was delivered *badly* are less developed than our methods (e.g., claims databases) for determining whether or not it was delivered *at all*. The net effect of the overuse focus is that these pay-for-performance models will likely have little influence on some of the biggest quality challenges we face (i.e., overuse and misuse.)

3. In few of the models has there been any significant net contribution into the provider payment pool from which any quality bonuses will be drawn. Therefore, as bonuses are paid out, the payments for all the rest of the services provided by hospitals and doctors will have to be reduced. If the CMS/Premier model is expanded from five conditions to 55, or 105 conditions, for example, at some point payment rates for all other conditions will have to be cut in order to fund the bonuses.

4. There are considerable costs associated with achieving the bonuses, ranging from investment in quality infrastructure (training, information systems, etc.) to the staffing and supply costs of actually delivering needed services that are not now being delivered (see overuse above), to the staff time to check the data on which bonuses are being paid. Many physicians have realized that while they might realize a modest increase in revenues from these programs, they will incur an even greater increase in costs.[14] The impact of many pay for performance models on ***margins*** is uncertain, at best.

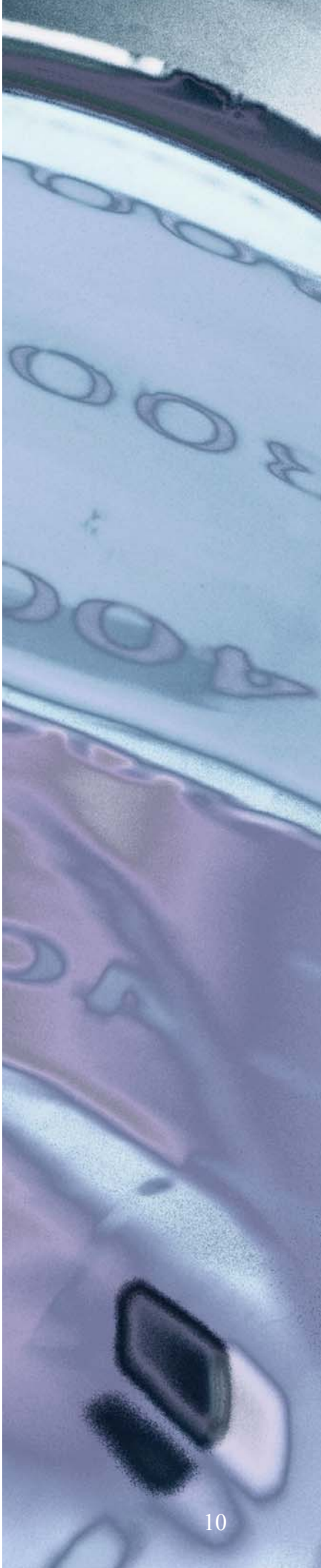
[13] Berwick, D, et al. Health Affairs 2003 (Nov/Dec) Volume 22: 8-10

[14] McGuire, "As They Struggle to Improve Quality, HMOs Try a New Incentive: Bonuses," Jun 2001 ACP-ASIM Observer. www.acponline.org/journals/news/juno1/bonuses.htm

5. For all of the above reasons, it seems reasonable to regard these pay for performance programs as transitional—a good start at trying to address the problem of the absence of a business case for high quality care, but not the final version of the payment models of the future.

6. These new pay-for-performance models are also a small part of the overall payment system, which still contains numerous perverse incentives, and which drives the business success or failure of hospitals and health care systems.[15] *CEOs and CFOs must therefore consider the business case for quality given the hodgepodge of payment models they already have, and not drive strategic decisions by the relatively small bonuses afforded under these pay-for-performance plans.*

7. Given the dominance of existing payment models, a number of CEOs at this conference sensed that the new focus on bonuses for quality might deflect attention from the real business opportunity related to quality—to reduce the costs of delivering *all* of our services—not just those eligible for a bonus—by making processes simpler, more standardized, with less rework and staff frustration. In other words, the business case revolves around 100% of an organization's costs, not around 1% or 2% of its revenues for a few conditions.



[15] New York Times December 5, 2003, page 1: " 'The health care system is perverse,' said a frustrated Dr. Brent C. James, who leads Intermountain's efforts to improve quality. 'The payments are perverse. It pays us to harm patients, and it punishes us when we don't.' "

How CEOs Are Planning To Hit System-Level Performance Targets

Connect quality, strategy, finance, and operations. The invasion of Normandy was one plan, with many integrated parts. The quality plan cannot exist independent of the financial, or strategic, or operational plans

With or without bonuses at stake, it is increasingly common for health care CEOs to find themselves being held accountable for achievement of quality performance goals such as reduction in harm from adverse drug events, reduction in preventable deaths, and reliable delivery of evidence-based care to diabetics, asthmatics, and other chronic disease patients—*across an entire hospital or health care system*. This is proving to be a daunting task, at least in the minds of the leading-edge CEOs present at this conference. Why?

The history of quality improvement in health care is replete with examples of project-level work—in which a team improves the delivery of evidence-based care in one department or office. Such projects form the vast majority of quality stories from the past 15 years of work applying industrial quality principles to health care. The teams are often celebrated, the CEO gets a photo-op or two for the annual report, and there might even be an award from a local or national organization for a particularly strong project.

But there are few examples of such project-level work which has been both sustained and continued over time, and scaled up and spread to all reaches of the organization—in such a way as to make a noticeable change in an overall measure of organizational quality performance. And it is vanishingly rare for a single organization to have been able to achieve performance improvement for multiple conditions, across the entire system, for multiple dimensions of quality simultaneously. (Note, in order to "win" at the Premier/CMS model, this is exactly what a hospital would need to do.)

In other words, the history of quality improvement looks as if we had spent 15 years proving, in project-level work, that we could land various types of boats carrying different kinds of soldiers and equipment onto different parts of the coast of France, but we had never learned how to mount a full scale attack—to invade Normandy—to achieve and sustain system-level quality results across many conditions, simultaneously.

These CEOs know that photo-ops and project awards aren't enough to keep them in their jobs going forward. How are they planning to achieve system-level results?

Approaches to system-level performance

This one-day conference did not allow each leader to describe a comprehensive plan by which his or her organization would "invade Normandy." But the CEOs and other leaders had a lively conversation that brought out a number of interesting ideas that are part of their current approaches to achieving measured system-level performance. They were specifically asked how they would reduce needless deaths, adverse drug reactions, and surgical wound infections—**sustainably, reliably, at the level of the whole system.** The following ideas surfaced:

1. **Learn rapidly, at the level of the whole organization**
   - Use quality failures to drive learning about the underlying system-level flaws that are causing the failures, and systematically correct the flaws.
   - Do "close call reviews" regularly—not just on actual failures—and share the learning immediately throughout the organization.
   - Make quality data far more transparent, to drive learning both within and across organizations.

2. **Channel leadership attention to quality**
   - Educate the board and invite them to hold you to account for quality.
   - Do "safety walk rounds" regularly, and do them well[16].
   - Assign specific groups of patients to each executive (including Human Resources, Finance…etc.) and engage them in working with the front line staff in understanding and solving the quality problems faced by "their" patient group.
   - Measure, report, and act on quality data at the same frequency and urgency with which your executive team deals with financial information. Note: this means that you will need measures and indicators of quality at every level: system, department, and local operating "unit."
   - Start asking every one of your reports for their quality performance data with the same frequency and intensity of grilling that you give them for their financial performance data.

3. **Organize for system-level quality**
   - Use the same models that work for other system-level goals such as financial performance. Specifically, make quality a *line* responsibility rather than a *staff* function assigned to the "department of quality."
   - Connect quality, strategy, finance, and operations. The invasion of Normandy was one plan, with many integrated parts. The quality plan cannot exist independent of the financial, or strategic, or operational plans.

[16] Strategies for Leadership: Hospital Executives and Their Role in Patient Safety (March 2001) This tool was developed by James B. Conway, chief operations officer at the Dana-Farber Cancer institute in Boston, MA. It was developed specifically for executives' personal use and reflection on their efforts to develop a culture of safety. It was mailed to all chief executive officers in early March 2001. Additional copies can be ordered through AHA Order Services (800-242-2626; #166924).

4. Put a human face on the quality problem

- When a problem surfaces, bring a leadership team immediately to the bedside and do your diagnostics while the patient is in front of you (not in a conference room, looking at monthly summaries, three months after the event).
- Start every board meeting with a story about an actual quality failure.

5. Build will to allocate the resources needed to address quality problems

- Develop a cost-accounting system that allows you to understand and track the financial implications of quality failures such as needless deaths, surgical infections, etc.
- Measure and track non-financial quality indicators of work, such as value-added time/total time (an example might be the percentage of each nurse's shift spent in "touch time" with patients and families as opposed to all other activities).

6. Engage physicians

- Start training a whole new cadre of physicians and physician leaders—modeled after the new ACGME requirements—so that in time our medical staffs will be populated with many MDs capable of driving system-level improvements. (Danger: over the next years, if your hospital *doesn't* change, but your medical staff signs on more and more of these young physicians, you are going to face a revolt!)
- Ask them to engage! (And then give them the opportunity and responsibility to contribute and perform. An example was described of an academic health center in which the chiefs were asked to take responsibility for key department-level and system-level quality performance measures. It took a year, but they are now fully engaged in the quality goals of the enterprise, rather than focused on their own silos.)
- Recognize that the reliability limits of the art of medicine (which by its very nature depends on individual custom-crafting) are very different from the reliability limits of the science of medicine (e.g., standardized care processes for common procedures and conditions such as "start heparin"). In other words, accept that there is a big difference between the science and the art of medicine, and manage the two aspects of care toward different reliability targets, using different methods. Physicians will truly appreciate this distinction.
- For those organizations attempting to hit multiple evidence-based care targets (e.g., Premier/CMS project), current levels of reliable performance on evidence-based medicine could potentially improve by at least an order of magnitude if physicians and nurses were to move to higher-reliability models of care, using

frameworks as described by Rene Amalberti and the IHI Innovation Group led by Tom Nolan (see table below.)

Levels of Reliability in Health Care

10^{-1}	10^{-2}	10^{-3}	10^{-4}	10^{-5}
Chaos	Defined, standard process; teamwork	Removal of discretion in high reliability culture	Loss of autonomy	Loss of identity
Each doctor writes individual orders, gives to RN	MD uses standing orders in system of reminders	External approval necessary for certain orders	All patients get EBM without order	Equivalent actor
Preventing treating acute and chronic disease	EBM practices for acute MI	ADEs per 1000 doses in best hospitals	Sterile technique in OR	Safety in anesthesia

- Create slack. Physicians (and nurses) are frustrated by lack of time to think, examine, listen to patients and feel that much of their time is wasted in non-value-added activities. If we're to achieve system-level results, a primary focus of quality improvement should be to remove wasted time—and therefore to create some "slack" for physicians.

- Standardize what is plainly standardizable. A key strategy for freeing up time is to standardize common processes so that physicians don't have to waste time custom-crafting orders each time they occur. Several organizations are working on expansion of "standing order sets" for common conditions and situations. In the best circumstances, these standing orders or "protocols" are developed in a multidisciplinary fashion, involving nursing, pharmacy, etc. Protocols appear to be farthest along in oncology and cardiovascular care, and in their infancy in many other specialties.

- Standardize *within*, not *to*, the evidence. A key concept is that the evidence based "goalposts" for standing order sets are very far apart—i.e., it's very likely that three physicians could come up with three different standing order sets and legitimately claim that each set is "evidence-based." But the variation among

the three different sets will produce complexity and error in the work of nurses, pharmacists, and others—not to mention confusion among referring physicians and other colleagues.

- Give physicians the time and space to process quality data—especially unfavorable performance reports on their department, for example—in "Kubler-Ross" sorts of phases: denial, anger, depression, bargaining, acceptance. Only then will they begin to own the problem.

- Don't let one loud negative physician voice paralyze improvement. One CEO described physicians in three categories: leaders, followers, and those who would rather die than change. The key, he claimed, is not to let the third group dominate the agenda. (Diagnostic label for this condition: *"monovoxoplegia"*)

It is noteworthy that the CEOs discussed their approaches to achieving system-level results in mortality, medication safety, and surgical infection rates for several hours without anyone mentioning investment in computerized order entry, or electronic patient records, as a key strategy for "invading Normandy." In some cases, their organizations have already implemented these types of systems. But the absence of any mention of information technology as part of the solution to this challenge was truly striking, and perhaps deserves further probing at a subsequent leadership conference.

Looking Forward: The Learning and Innovation Agenda

A one-day conference can at best provide a glimpse of what's on the mind of some of the health care industry's finest leaders, and this report is no exception. The focus of the conference was on three questions:

Question:

Has the quality agenda moved from "something professionally good to do, but not strategic" to "I'd better make sure we hit our quality targets, or my job is on the line?"

Answer:

Absolutely. Quality is now a strategic issue, not just a regulatory requirement, or a nice-sounding professional value.

Question:

If quality has moved onto the strategic agenda, what do new pay-for-performance models have to do with the shift?

Answer:

These new models have channeled more attention to quality than would be justified by a careful analysis of their business implications. They are at best transitional models. Their great value is that they have attracted a lot of attention to quality. Health care leaders should harness that attention to using quality methods to standardize, simplify, and make reliable all of their processes—thereby reducing operating costs—rather than focus on the small, transient bonuses that these pay-for-performance models promise on the revenue line.

Question:

If quality is now strategic, and CEOs of these leading health care systems need to hit tough quality targets as reliably as they hit financial targets, how are they planning to succeed?

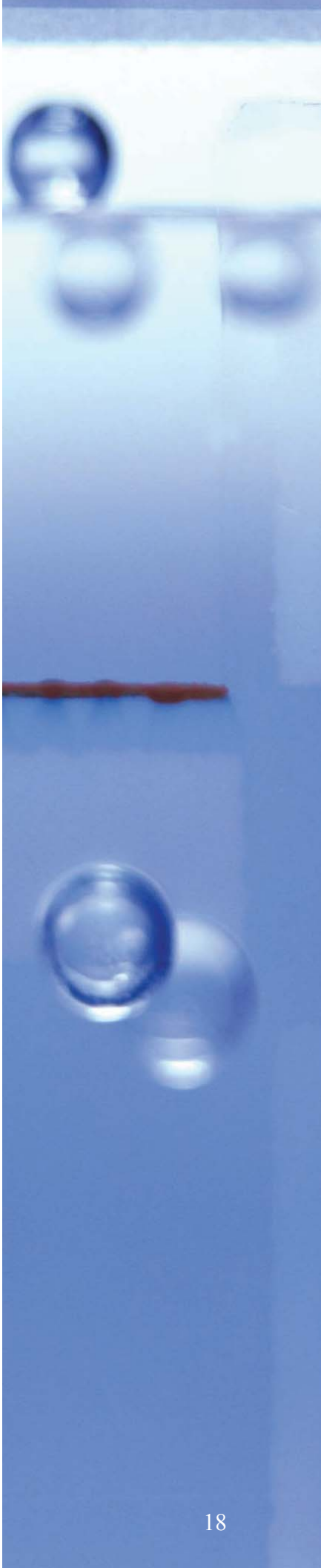
Answer:

No one can claim to have a foolproof recipe for success, because the sustained achievement of system-level, highly reliable, clinical quality results for the whole spectrum of diseases and conditions has not yet been demonstrated by any one organization. This group of industry leaders has a very good set of ideas that are worth sharing with their colleagues throughout health care. They are implementing these ideas with vigor, but much more learning and innovation is needed before a comprehensive model for winning at quality can be put forward.

In the meantime, we can all learn and share what's working in clinical quality, and what's not. Because ultimately, clinical care quality is about needless deaths and injuries to our patients, and it's about the unnecessary suffering brought about by poorly managed chronic disease, and the profound feelings of anger and helplessness in patients and professionals who are trying to deal with unnecessarily complex care systems. Quality may now have become strategic, but the competition in clinical quality is ultimately not the hospital across town. The competition is the oldest enemy of all: disease.

Table 1: Some Reasons Why Hospital and Health System CEOs Are Paying Attention to Quality

Initiative	Players	Mission	Strategies	Channeling CEO attention to...
Leapfrog Group	145 Large Employers, 35 million consumers	Use employer purchasing power to improve quality	• Inform employees about choices among providers • Develop comparative provider value ratings • Reward delivery systems with volume, pricing, and public recognition	• CPOE • Intensivist ICU care • Volume-based referrals for certain services
JCAHO	AHA, AMA, ANA,	Use accreditation as driver of quality improvement	• Mandatory implementation of all goals and recommendations • Evaluations of actual performance, not just intent • Increased rigor of assessments' • Unannounced surveys	National Patient Safety Goals • Patient ID • Communication • High-alert meds • Wrong-site surgery • Infusion pumps • Clinical alarm systems
Institute of Medicine	National experts in quality and safety	Advance and disseminate scientific knowledge to improve health	White papers, books, public dissemination of quality information e.g., "To Err is Human" and "Crossing the Quality Chasm"	• Public awareness of harm and errors • Evidence-based care • Patient-centeredness • Cooperation across the care system • Nursing issues and safety
NCQA	Health Plans	Improve quality of health care delivery	Measurement and comparative reporting on quality performance of plans	• HEDIS measures



Initiative	Players	Mission	Strategies	Channeling CEO attention to...
HR1 (Medicare Modernization Act)	Federal Government, CMS	Improve Medicare, add drug benefit	Add penalty for not reporting on hospital quality performance in 2005 (0.4% reduction in update rates)	Previously "voluntary" quality measurements and reports
CMS/Premier Initiative	CMS, Hospital Purchasing Cooperative, 280 Hospitals	Improve quality and safety of care delivered in hospitals	Medicare Bonuses of 1%-2% for achievement of 80th and 90th percentile for six conditions	Reliable delivery of evidence-based care and measured quality results for • Acute MI • CHF • Community acquired pneumonia • CABG • Total hip • Total knee
Bridges to Excellence	Large employers	Improve quality of office-based care for chronic disease	Bonuses to physicians who achieve high scores on evidence-based care for chronic diseases	• Organization and delivery of chronic disease care • Diabetes • CHF
Various "Pay-for-Performance" programs	Providers and plans e.g., Integrated Healthcare Assn.	Improve quality of physician-delivered care	Bonuses (up to $6.50 pmpm) to providers who hit top tiers of performance on quality measures	Varies–includes • Preventive services • Diabetes care • Asthma
Institute for Health Care Improvement, Boston	• 100's of hospitals, academic medical centers, physician groups • CMS • WHO • Philanthropic organizations	To accelerate the improve-ment of health care systems worldwide	• Use quality methods, leadership support, and innovation to help hospitals and physician practices produce breakthrough results • Public advocacy on quality	• The gap between current and possible performance • Evidence-based care • Patient-centeredness • Cooperation as a system

Source: E&Y Global Health Sciences Center for Industry Change

About Ernst & Young's Health Sciences Advisory Services

Ernst & Young Health Sciences Advisory Services

Ernst & Young Health Sciences Advisory Services practice has a special focus on reimbursement services for health care providers. We have the experience and resources to help clients achieve appropriate reimbursement levels from government, managed care and other third-party payers. In addition to our strengths in the reimbursement area, Ernst & Young provides a wide range of services supporting providers' needs for capital resources in today's environment. Through these services, we can help clients assess their capital needs and financing alternatives, as well as assist their compliance with reporting requirements for new and existing financing alternatives.

Ernst & Young

Ernst & Young, a global leader in professional services, is committed to restoring the public's trust in professional services firms and in the quality of financial reporting. Its 103,000 people in more than 140 countries around the globe pursue the highest levels of integrity, quality, and professionalism to provide clients with solutions based on financial, transactional, and risk-management knowledge in Ernst & Young's core services of audit, tax, and corporate finance. Further information about Ernst & Young and its approach to a variety of business issues can be found at www.ey.com/perspectives. Ernst & Young refers to all the members of the global Ernst & Young organization.

For more information please contact Rick Wallace at 317- 681-7205 or e-mail Rick at rick.wallace@ey.com.

ERNST & YOUNG LLP

www.ey.com

SCORE Retrieval File
No. AY0005