



Deloitte.

Pay for Quality: A Strategic Perspective

Produced by the
Deloitte Center for
Health Solutions

Audit • Tax • Consulting • Financial Advisory.

Forward: The Quest for Excellence in Health Care Quality



The quest for quality in U.S. health care is an active pursuit of policymakers, hospitals and physicians. At the same time, health plans and employers have played key roles in stimulating debate on the subject and spotlighting gaps.

Transparency, pay for performance, provider profiling and utilization management are but a few of the manifestations of this emerging emphasis on quality. Are they enough? Will increased attention lead to systemic improvements in the U.S. health system's clinical performance?

In this report by the Deloitte Center for Health Solutions, (the "Center"), part of Deloitte & Touche USA LLP, we examine the potential for quality in a narrow context: What if the care provided in a community was the safest and most effective care achievable? What if errors were reduced to nil and adherence to evidence-based guidelines took inappropriate variation completely out of the system? In the community of Topeka, Kansas, where most public report cards show that the hospitals perform well above average and physician performance appears good, there is still room for improvement. Topeka has a gap between good and excellent.

Why? Is it because doctors and hospitals do not wish to pursue safe and effective care? No. Is it because health plans, employers and consumers refuse to ask or pay for excellent care? No. The gap reflects a systemic challenge: The goal of achieving safe and effective care at the highest level is not being met, although all stakeholders acknowledge the need.

Pay for Quality: A Strategic Perspective offers one viewpoint on how safe and effective care is achievable if key stakeholders approach the process openly and with trust. With the assistance of HealthGrades, a leading independent health care ratings company, we examine a community in which the gap between good and excellent is relatively narrow but nonetheless significant in terms of lives lost and dollars spent. It is not our goal to assign blame; it is our purpose to simply illustrate that the gap exists and to raise consciousness among all key stakeholders that it can only be narrowed if a concerted effort is pursued by all working collaboratively.

We believe that health care services in the U.S. can be more safe and effective. We believe excellent care is achievable. It is a moral mandate for this nation's health care, which is by far the world's most expensive and technologically advanced.

A handwritten signature in black ink that reads "Paul H. Keckley". The signature is fluid and cursive, with a long, sweeping underline that extends to the right.

Paul H. Keckley, Ph.D.
Executive Director
Deloitte Center for Health Solutions

Pay for Quality: A Strategic Perspective

In 1998, an American bubble burst when journalists reported a startling finding: More than 98,000 needless deaths occur each year as a result of avoidable mistakes in hospitals due to complications from the wrong medication, injuries to patients from falls or neglect, missed diagnoses and poorly coordinated care. Pundits were quick to note the equivalence of these 98,000 deaths to a daily 737 plane crash.

That clarion call was the Institute of Medicine's report, *To Err is Human: Building a Safer Health System*. In academic and public policy circles, a flurry of scholarship followed. Among the most notable are those in Figure 1.

Thus began the public discussion about health care safety and quality. These efforts were accompanied by a move toward transparency – report cards and profiles that compared hospitals and physicians on measures of safety and quality.

Providers found themselves pulled into an uneasy public debate: How can the U.S. health care system be so costly and yet fall short in safety and quality? How can differences between patient populations be accounted for when comparing hospitals and practices? And how can “quality” be a basis for payments when outcomes often are out of providers’ control?

Health plans, employers, policy makers and the public liked the idea of ratings; hospitals and physicians bristled. The longstanding cold war between providers and health plans heated up. And while hospitals and physicians voiced legitimate concerns about validating measures of quality and demonstrating caution when report cards are disseminated, it was clear momentum had created a strong public appetite for transparency built around comparisons of hospitals and physician performance.

Figure 1: Landmark Publications that Called Attention to Gaps in Safe and Effective Health Care

Publication	Findings
<i>Crossing the Quality Chasm: A New Health System for the 21st Century</i> (Institute of Medicine, 2001)	The health delivery system falls short in delivering high-quality, evidence-based care.
“The Quality of Health Care Delivered to Adults in the United States” (McGlynn et al, <i>New England Journal of Medicine</i> , 2003)	Physicians adhere to evidence-based guidelines only 55 percent of the time.
“The Implications of Regional Variations in Medicare Spending” (Fisher, Wennberg, et al, <i>Annals of Internal Medicine</i> , 2003)	Where a Medicare enrollee lives correlates closely to the quality of care one receives; variation among communities is significant.
<i>The State of Healthcare Quality</i> (National Committee for Quality Assurance, 2003, 2004, 2005)	Quality of care varies from health plan to health plan: Tightly managed networks achieve better clinical performance than loosely organized networks.
<i>Paying for Quality: Health Plans try Carrots instead of Sticks</i> (Strunk et al, Center for Studying Health System Change, 2004)	Carrots and sticks are necessary but the jury is still out on best practices for rewarding providers for care that otherwise should be routine.
“The Unintended Consequences of Publicly Reported Quality Information” (Werner, <i>Journal of the American Medical Association</i> , 2005)	Publicly available information about the quality of hospitals and physicians has unintended results: confusion.

Source: Deloitte Center for Health Solutions, 2007

Meanwhile, three scholarly efforts raised the bar even higher. Don Berwick’s work was chronicled in the Institute for Healthcare Improvement’s series of papers quantifying error rates in hospital care resulting from falls, infections, medication errors and other causes. Liz McGlynn and her Rand colleagues measured physician adherence to evidence-based best practices for 30 conditions using 439 measures and concluded that physicians in the U.S. adhere only 55 percent of the time. Jack Wennberg and his Dartmouth colleagues quantified the prevalence of “inappropriate variation” in treatment patterns, showing huge differences in care standards between communities only explainable by significant differences in practice patterns. From these three landmark efforts, two conclusions became clear:

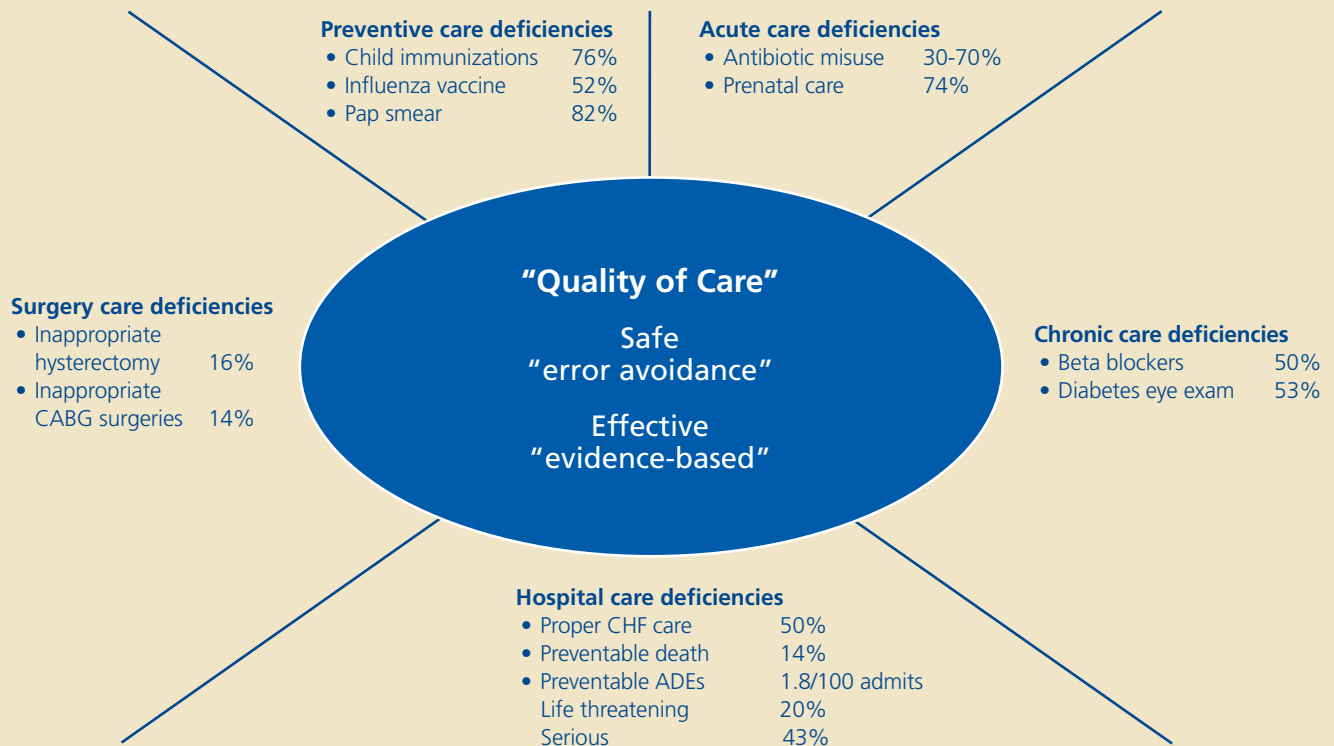
- The U.S. health care system falls short in the delivery of safe care – avoidable errors are a major problem.

- The health care system falls short in the delivery of effective care – care based on evidence that improves the likelihood of an accurate diagnosis or optimal treatment plan.

Across the continuum of the system of care there are noticeable gaps in quality (Figure 2). For example, only 76 percent of children receive immunizations. As a result, policymaker discussion about the gap between the care we get and the care we should be getting became a fixture in legislative circles. And these gaps were quantified in settings beyond the hospital: Trade organizations, health plans, large employer coalitions, accrediting agencies, professional societies and even public watchdog groups became stewards of measurement, resulting in the identification of quantifiable gaps across the entire continuum of care. In the late 1990s, the most significant transformative theme in health care was the recognition that, across the board, improvements were needed in the system to deliver safer, more effective care.

Figure 2: Health Care Quality Gap

The gap between the care we get and the care we could be getting



Source: Vanderbilt Center for Evidence Based Medicine¹

For physicians and hospitals, the spotlight on safe and effective care posed a dilemma. How could the gap between knowledge and practice be bridged? How might differences between practice patterns for which there should be less variation be explained? How could hospitals be held accountable for decisions about admitted patients made by physicians over whom the hospital had no control?

For health plans and large employers, in contrast, the quality issue provided impetus to develop report cards and link payments to performance. It spawned more than 200 pay for performance projects and birthed an entire industry devoted to producing report cards about hospitals and doctors. Today, report card and provider rating services is a growing niche in health care. (Figure 3):

Figure 3: Leading Organizations that Provide Report Cards Comparing Hospital and Physician Performance on Quality

Major Reporting Organization	Description
CMS Hospital Compare	21 major measures of hospital clinical process performance for 4,200 hospitals.
HealthGrades	Provides quality ratings for hospitals, home health agencies, nursing homes and medical practices; uses a five-star system for evaluating hospital quality performance that adjusts for severity (case mix); developing similar scheme for medical practices; counsels provider organizations seeking improvement in safety and quality.
Leapfrog	Initiative driven by organizations that purchase healthcare who are working to develop improvements in the safety, quality, and affordability in healthcare for Americans.
NCQA	Non-profit organization that accredits and certifies healthcare organizations and provides healthcare quality information to consumers. NCQA collects and reports on statistics that track the quality of care of the nation's health plans. Also, NCQA sponsors three physician recognition programs.
NQF	A private, not-for-profit membership organization created to develop and implement a national strategy for healthcare quality measurement and reporting.
Pacific Business Group on Health	A West Coast business coalition leading efforts in value-based purchasing (www.pbgh.org)
Pennsylvania Health Cost Containment Council	A notable state-led initiative to profile hospital and physician performance (www.phc4.org)
Premier Inc.	Clinical Advisor™ is the leading clinical efficiency and quality performance benchmarking application in the healthcare industry. Clinical Advisor allows performance tracking against benchmarks in the Perspective™ database, including comparative clinical quality measures, comparative utilization, and cost data down to the individual transaction level.
Subimo	Provides information about dozens of specific procedures – information such as questions to ask your doctor and the types of risks you face, as well as your surgical and non-surgical alternatives – that you can review prior to having surgery.
Solucient (now Healthcare Advisor)	Information products company serving the healthcare industry. Solucient maintains the nation's largest healthcare database, with comparative measurements of cost, quality, and market performance for providers and pharmaceutical companies.

Source: Deloitte Center for Health Solutions

At this point, the potential impact of these efforts is generally unknown. Will report cards prompt hospitals and physicians to deliver more safe and effective care? Will performance-based payments be necessary?

Peer-reviewed studies about pay for performance and provider profiling currently are not readily available so the industry lacks a systemic assessment. However, a recent study in the June 6, 2007 issue of *JAMA, The Journal of American Medical Association*, offers a glimpse into the situation. The Duke research team compared 54 hospitals that received higher payments for improved quality to 446 that did not get higher payments but received equal recognition via CMS Hospital Compare. The team found that “the pay-for-performance was not associated with a significant incremental improvement in quality of care or outcomes for acute myocardial infarction.” In other words, transparency might be the stimulus for improvements; performance-based payments might not be required.²

In scholarly circles, analyses of market dynamics around transparency and performance-based payments are expected to be plentiful. Certainly, the subject is ripe for investigation. Meanwhile, the health care system must wrestle with an acknowledged gap between the safe and effective care we get and the safest and most effective care we could get.

Safe and Effective Care: It’s What the Public Assumes and Expects

At its most basic, high-quality health care should not hurt people (it is safe) and it should be based on what works best according to the latest scientific studies (effective care).

Safe care is readily understood by most consumers; effective care is more difficult to comprehend. Most Americans assume that the standard of care among communities and practitioners is essentially the same. They also conceptually understand the notion that clinical decisions in diagnosing and treating patients have a basis in scientific studies (evidence) and that some approaches work better than others (benefit-risk analysis) but the complexity of medicine is overwhelming to most people, who prefer to leave clinical judgments to physicians. This concept, referred to as evidence-based medicine, is the basis for effective care: Effective care minimizes risks, optimizes benefits, and is based on the most reliable, relevant scientific studies about what works best.

Definition: Evidence-based Medicine

“Evidence-based Medicine is the conscientious, consistent use of relevant scientific studies to patient decision making that includes patient values and input in the process.”

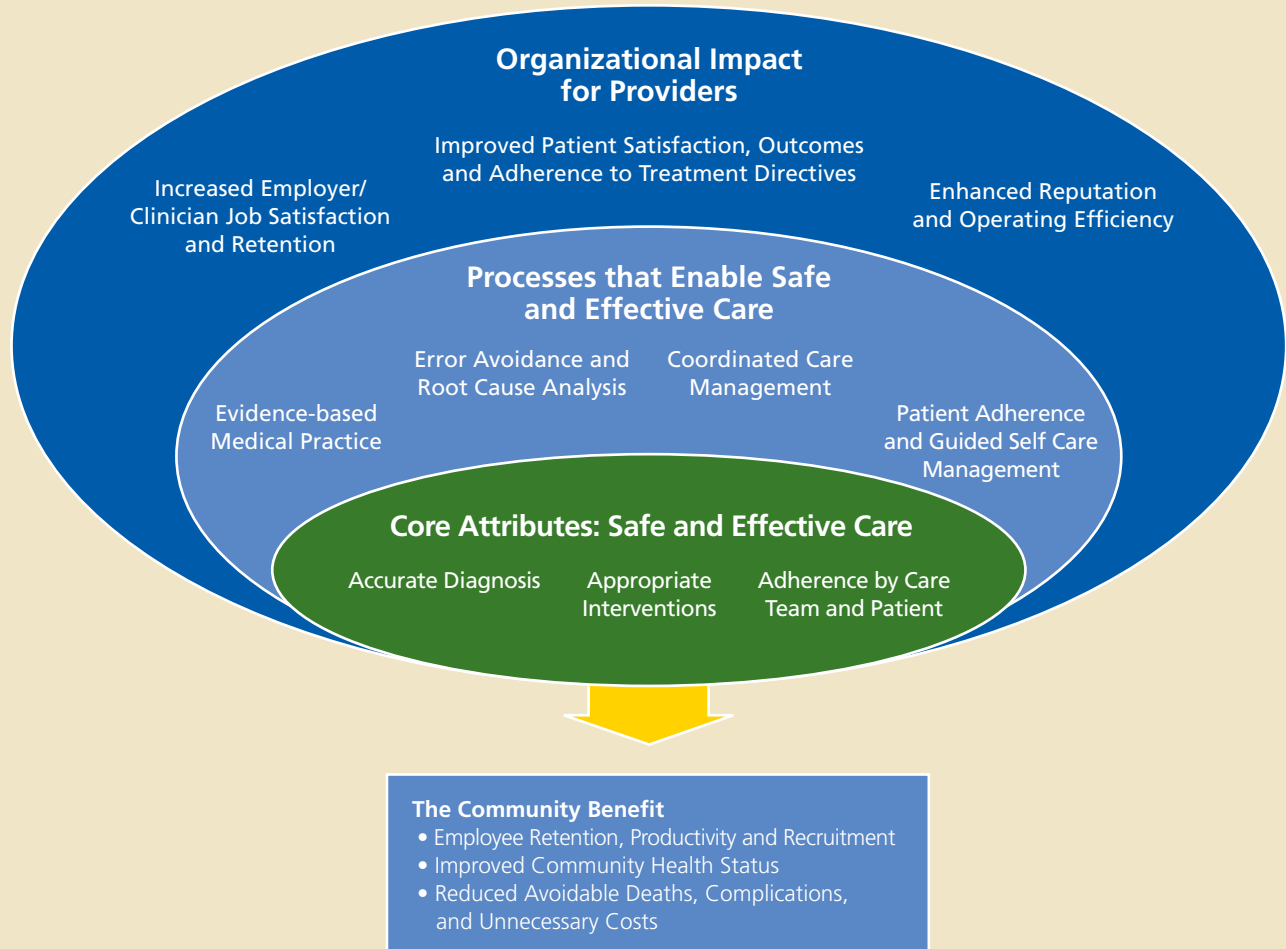
Source: Vanderbilt Center for Evidence-based Medicine³.



In the medical community, the concept of evidence-based medicine as the basis for effective care is widely debated. The notion that clinicians should adhere to a scientific standard in diagnosing and treating patients is troublesome to many who decry it as cookbook medicine. Their concerns are justified if the evidence supporting a particular intervention is weak; but when it is evident that one treatment works measurably better than another, it is reasonable to conclude that physicians should follow that course.

Just as there are valid and reliable measures for safe care, there are increasingly valid metrics associated with effective care – care that is provided based on evidence-based medicine. (Understandably, physicians and hospitals are uneasy when their practices show a gap in either category.) However, achieving and measuring safe and effective care can be challenging. It is much easier to focus on patient satisfaction and perceptions of quality than the reality that safe and effective care is about a myriad of decisions and processes that require the engagement of teams that work well together. It’s also easier to operate a system of care based on a simplistic notion that physicians *alone* are responsible for clinical decisions than to build systems of care involving physicians, care teams and patients in collaborative decision making. Yet, safe and effective care is the essential hub of the delivery system.

Figure 4: Quality of Care: A Community Perspective



Source: Deloitte Center for Health Solutions

As reflected in Figure 4, the essence of quality is safe and effective care. When properly engineered into systems of care, it has the dual impact of improving outcomes and reducing cost. The process, however, must be built around timely, patient-centered coordination of care by a dedicated team of professionals. Indeed, patient satisfaction can be deemed superior but unless the care that is delivered is safe and effective, the system fails its patients and its community.

More Measures, More Attention to Safe and Effective Care

As more measures of safe and effective care are validated and transparency efforts accelerate, key stakeholders including health plans, large employers, state health agencies and Medicare (CMS) will aggressively expose differences between hospitals and physicians who perform better than others. The varied approaches each of these stakeholders takes to stimulate safe and effective care can be instructive: (Figure 5):

Figure 5: Stakeholder Approaches to Stimulate Safe and Effective Care

Stakeholder	Core Strategy to Advance Safe and Effective Care
Health Plans and Large Employers	<ul style="list-style-type: none"> • Tiered networks that reflect differences in performance of doctors and hospitals • Pay-for-performance programs to reward better-performing providers • Public report cards (transparency) to spotlight variation • Differential fee schedules that reward high-quality providers more for better performance
State Health Agencies	<ul style="list-style-type: none"> • Transparency efforts showing price and quality comparisons • Aggressive implementation of safe and effective care standards in reimbursement for Medicaid, workers compensation and SCHIP programs • Promotion of tiered networks reflecting variations to state and municipal employees and dependents
CMS and Federal Health Agencies (Medicare)	<ul style="list-style-type: none"> • Transparency in demonstrating local differences in doctor and hospital results for safe and effective care • Differential payments to hospitals for improved results (CMS Hospital Compare)

Source: Deloitte Center for Health Solutions



Health plans and large employers prefer pay-for-performance programs and tiered networks to direct referrals away from doctors and hospitals that under-perform. By contrast, state health agencies responsible for managing programs such as Medicaid focus on transparency but shy away from tiered networks, fearing lack of adequate provider participation in their programs.

Medicare is unusually influential since its fee schedule and administrative policies are mirrored by private health plans. It appears to be following a path paralleling plans by using performance-based payments and transparency as its levers.

State leaders demonstrate perhaps the greatest variability in their initiatives, ranging from aggressive transparency and performance-based payment efforts to virtual absence. While it is reasonable to conclude that state-led health reform efforts are more focused on cost reductions, efforts paralleling health plans, employers and Medicare to link payments to improvements in safe and effective care are likely.

What does this increasing focus on safe and effective care mean to the care we receive in our hometowns? Does it matter? Who is paying attention? Perhaps its relevance is best framed in the context of a city like Topeka, Kansas, which, in most respects, could be "Anytown, USA."

Topeka, Kansas: “Anytown, USA”

Topeka, Kansas is in the heartland of America. The five-county area of more than 227,820 boasts a stable workforce, modest population growth and a hearty appreciation for family values.⁴ Demographically, the only major distinction between the region and the U.S. as a whole is its ethnicity. Otherwise, it could be “Anytown, USA.”

Demographics 2005 ⁵	Topeka MSA	USA
Male	48.9 %	49.0 %
Female	51.1 %	51.0 %
Median Age	37.9 yrs	36.4 yrs
White	84.7 %	74.7 %
Black	6.2 %	12.1 %
Other Race	9.1 %	13.2 %
Median Household Income	\$44,464	\$46,242

Topeka is a regional hub of health care activity. It is served by two major hospital systems, five specialty facilities and more than 400 physicians. Notably, local physicians serve a large number of patients outside the five-county MSA, and when compared to national statistics, physicians appear to be in short supply. It has a slight oversupply of beds but an under-supply of physicians, contributing to an understandably competitive climate between the two hospital systems.

Supply of Health Care Providers, Beds	Topeka MSA	USA
Beds per 100,000 population	298 ⁶	280 ⁷
Physicians per 100,000 population (2004)	171 ⁸	281 ⁹
% Primary Care Physicians per 100,000 population	36% ¹⁰	40% ¹¹

Topeka is primarily a discounted fee-for-service market where Preferred Provider Organizations (PPOs) provide citizens with access to all doctors and hospitals. Only 12 percent of the Topeka population is uninsured, considerably lower than the national average of 16 percent.

Topeka Health Insurance Market Breakdown* ¹²	% of Population 2006
Managed Care Fully Insured	18%
Non Medicare Advantage	17%
Non Managed Medicaid	2%
Other Private Insurance	54%
Uninsured	12%

*Adds to more than 100% due to dual-eligibility.

Payment rates to Topeka doctors and hospitals are relatively modest compared to the U.S. in general: Medicare pays local physicians and hospitals 11 percent less than its national averages, based on its calculation of lower costs associated with the delivery of care in the community.

Reimbursements Per Enrollee 2003 ¹³	Topeka HSA	USA
Total Medicare reimbursements (Part A and B)	\$5,803	\$6,611
Total Part A Medicare reimbursements	\$3,431	\$3,875
Total Part B Medicare reimbursements	\$2,372	\$2,737

In sum, the Topeka health care landscape is relatively stable. With perhaps the shortage of physicians as an exception, all signs point to a community that enjoys a high degree of stability in its health services.

Medical Care in Topeka: Efficient, Safe and Effective

Efficiency: Discharge and length-of-stay data suggest that Topeka health care providers – doctors and hospitals – tend to use resources sparingly. For the most part, discharge rates are below U.S. averages; only discharge rates for knee replacements were significantly higher than the U.S. average.

Discharge Condition (per 1,000 Medicare Enrollees 2003) ¹⁴	Topeka HSA	USA
Bacterial Pneumonia	16.15	19.33
Congestive Heart Failure (CHF)	14.58	22.90
Hypertension	1.08	1.30
Diabetes	1.54	2.34
Acute Myocardial Infarction (AMI)	4.21	8.44
Back Surgery	4.49	4.02
Coronary Artery Bypass Grafting (CABG)	3.53	5.18
Hip Replacement	3.83	3.18
Knee Replacement	9.32	6.88

Average length of stay, adjusted for severity, for the two major non-federal hospitals in Topeka is relatively low compared to the U.S. average, suggesting providers in the market are effective in managing patients and avoiding protracted hospital stays.

Average Lengths of Stay	Topeka MSA	USA
Total Acute Care ALOS	4.05 ¹⁵	4.68 ¹⁶

Safety: Death rates and other dimensions of health status usually associated with a community's health system also point to services that are safe. Topeka's age-adjusted death rate and incidence of low birth weight babies are below national averages, although the infant mortality rate is slightly above.

Public Health Measures	Shawnee County	USA
Death Rate 2003 (Age-adjusted death rate per 100,000 US population)	816.9 ¹⁷	832.7 ¹⁸
Infant Mortality Rate 2000-2004 (Rate per 1,000 live births)	8.0 ¹⁹	6.9 ²⁰
Low Birth Weight 20045 [Less than 2,500 grams (5 pounds and 8 ounces)]	7.6% ²¹	7.9% ²²

In fact, local hospitals have emphasized patient safety in their core acute operations. For example:

- Both hospitals participated in the Institute for Healthcare Improvement's 100K Lives Campaign.
- In 2006, one of Topeka's hospital systems was selected as one of three hospitals recognized by HealthGrades for patient safety and was one of 260 that participated in the CMS Hospital Compare Pilot Project.^{23, 24}

Effectiveness: From all external indicators, hospital care in Topeka also is effective. In each of the four categories judged by CMS Hospital Compare data, the two Topeka hospitals outperform the U.S. average.

% Patients Receiving Appropriate Care ²⁵ (CMS Hospital Compare)		
Quality Categories	Topeka Avg of 2 Systems	USA
Heart Attack	92.9%	83.1%
Heart Failure	83.3%	73.0%
Pneumonia	85.7%	78.2%
Surgical Infection	80.5%	71.5%

Both hospitals score favorably in HealthGrades' assessments as well, as seen in Figure 6, the Observed to Expected (O/E) Mortality and Complications Ratio of selected common conditions. The Observed to Expected Ratio is an important quality measure because it considers the probability of a person's death given the severity of their condition and then weighs the numbers actually saved (observed) versus those who otherwise would have been expected to die. An O/E ratio of

less than 1 means that the procedure/diagnosis measured had fewer deaths or complications than expected given its patient populations. An O/E of greater than 1 means that the procedure/diagnosis measured had more deaths or complications than expected given its patient populations. A ratio of 0.55 is considered to be the best. The average ratio for hospitals across the U.S. is .99, which, in most cases, Topeka hospitals exceed.

Figure 6: HealthGrades Observed to Expected Mortality Ratio for all U.S. Hospitals

HealthGrades Rated Cohorts	U.S. Observed to Expected Ratio (3-year aggregate 2003-2005) ²⁶	O_E_Top 5% Hospitals Benchmark ²⁷ All U.S. Hospitals	O_E_Top 10% Hospitals Benchmarks ²⁸ All U.S.	Observed to Expected Ratio Hospital Outcome (Mortality) ²⁹ Average of Topeka Hospitals
Mortality				
CABG	.999	.4687154	.4837001	.7922759
Valve Replacement Surgery	.989	.4529320	.5077644	.9627233
PCI	.999	.5284852	.5489865	1.0613361
AMI	.998	.6995918	.7204426	.8840910
HF	.999	.5792093	.6114304	.9613756
Atrial Fib	.995	.2827010	.3186726	1.2259692
COPD	.997	.4508544	.4805222	.4911053
Community Acquired Pneumonia	1.00	.5525658	.5918425	.5671153
Stroke	.997	.6483725	.6752712	.8867805
AAA Repair	.916	.3949716	.4152554	1.3080079
Bowel Obstruction	.999	.5409338	.5559819	.7766617
GI bleed	.999	.5124566	.5439203	.7718193
Acute & Chronic Pancreatitis	.981	.2342754	.2459240	.3976021
Pulmonary Embolism	.943	.2751259	.3140436	.6399751
Diabetic Acidosis & Coma	.986	.1604662	.1944340	.8724498
Sepsis	.995	.6511767	.6842198	1.0461077
Complications				
Primary Total Knee Replacement		.4619908	.4815326	1.0298597
Primary Total Hip Replacement		.4607533	.4683067	.7758821
Hip Fracture Repair		.4607068	.4837457	.7924311
Partial Hip Replacement		.4082792	.4387346	1.0393573
Spine Surgery without Fusion		.4476078	.4825724	.8524603
Spinal Fusion		.5147471	.5296067	.6705888
Carotid Surgery		.5054797	.5413899	1.0710781
Peripheral Vascular Bypass		.3796356	.4116848	1.2663302
Prostatectomy		.4255185	.4319737	1.7922041
Cholecystectomy		.5022644	.5424324	.8914722

© Copyright 2007, Health Grades, Inc. All Rights Reserved.

From these data, it would appear that health care in Topeka is safe and effective. *But is it as safe and effective as it could be?*

Consider severity-adjusted mortality rates for the 17 conditions HealthGrades tracks: The two Topeka hospitals fall short of the top 10 percent and top five percent thresholds by a significant margin. A similar gap exists for the 10 measures related to severity-adjusted complication rates. What do these gaps mean? They certainly do not mean that doctors and hospitals are reckless or willfully neglectful. They simply mean that the standard of care falls short of what it could be.

What would it mean if care in Topeka was more safe and effective?

- If Topeka hospitals performed in the top 5 percent nationally, 152 lives could be saved every year³⁰ and 189 complications could be avoided³¹.
- If every hospital in the U.S. performed in the top 5 percent, 221,778 lives could be saved every year.
- If every treatment decision was evidence-based, outcomes would be better and costs would be reduced by almost \$600 billion.

There could be more. In Topeka, are unnecessary diagnostic tests done? Are surgeries performed for which the symptoms suggest a different, safer intervention might be a better option? Are prescriptions written that result in drug complications or simply don't work? Nationally, inappropriate variation resulting in these avoidable problems is widespread: It leads to suboptimal outcomes and avoidable costs approaching \$2,000 per capita per year.³²

In human terms, the gap is about lives that could be saved, care that could be better, and communities that could be healthier. Is it a fault of the hospitals and the physicians? Not at all. It is a systemic issue in health care. It is about all stakeholders in a community like Topeka coming together to bridge the gap to provide safer, more effective care to residents.



It Takes a Community... and a Plan

The vigilant, relentless pursuit of safe and effective care requires an ongoing commitment from each key stakeholder in the local health care system. Everyone plays a vital role in this endeavor.

What would be required to achieve safe and effective care in a community like Topeka? What roadblocks might stand in the way in a community where safe and effective care is not already being achieved?

- **Denial.** Key stakeholders – physicians, hospitals, health plans, employers, elected officials and policymakers choose to disregard the problem. While espousing “high quality of care” in the community, there is lack of a coherent understanding about the depth and gravity of the problem.

- **Lack of a community-based plan.** The path to safe and effective care requires a clear plan, dedicated resources, and community-wide vision for its implementation. It is not about finger-pointing; it’s about system-wide process improvement.

- **Lack of Tools.** Access to information technologies that facilitate coordination of care, personal health records, e-prescribing, prompts and reminders to clinicians and patients is imperative.

Assuming these roadblocks are removed, the roles that key stakeholders play are complimentary and each is essential (Figure 7). In most communities, there is little effort to collaboratively pursue safe and effective care. The results speak for themselves.

Figure 7: Community Stakeholder Roles in Pursuit of Safe and Effective Care

Navigators	Key Responsibility	Key Compass Tools
Hospital Leaders	Organize processes to assure safe and effective care delivery (chronic, acute, long-term) and reduce inappropriate variation and avoidable errors	<ul style="list-style-type: none"> • Develop evidence-based pathways to standardize care and reduce inappropriate variation • Develop coaching platform to enhance patient compliance • Develop quality dashboard for community transparency • Develop coordinated care management models to facilitate improved adherence to evidence-based pathways
Physicians	Organize medical community efforts to achieve safe and effective care	<ul style="list-style-type: none"> • Develop evidence-based pathways and coordination of care (coaching) policies and procedures • Adopt standardized electronic medical records for practices and personal health records for patients • Develop data repository for effective measurement of adherence • Develop policies and procedures to reduce inappropriate variation by providers
Employers	Facilitate adherence to safe and effective care standards by local providers and consumers	<ul style="list-style-type: none"> • Structure benefits to reward selection of adherent providers and consumers • Collaborate with local employers in development of Health Information Exchanges to facilitate reduced errors, improved coordination of care, and quality and safety measurement • Select health plans that “hard wire” adherence to safe and effective care in their coverage decisions, network configuration and benefits design options
Health Plans	Lead market evolution from employer-sponsored care to guided self-care management using safe and effective care as the focus	<ul style="list-style-type: none"> • Establish transparency in coverage decisions so providers and consumers understand the evidence considered in decision-making • Develop tiered networks that encourage use of providers that demonstrate adherence to safe and effective care • Structure reports to employers that profile measures of safe and effective care in addition to financial and utilization metrics
State and Local Government	Enact public policies that reward safe and effective care and structure state health care programs to use those that perform best	<ul style="list-style-type: none"> • Adopt transparency programs that spotlight physician and hospital performance in safe and effective care • Facilitate development of local Health Information Exchanges to assist providers and consumers to avoid errors and adhere to evidence-based practices
Consultants	Encourage, promote and hold stakeholders accountable for results	<ul style="list-style-type: none"> • Web-based tools to monitor local milestones and provider performance • Personal health records (PHRs) to increase adherence to evidence-based treatments

Source: Deloitte Center for Health Solutions

The vigilant, relentless pursuit of safe and effective care requires an ongoing commitment from each key stakeholder in the local health care system. Everyone plays a vital role in this endeavor.

While bridging the gap between good and best care is an admirable end goal, it is not for the faint of heart. There are serious challenges to its implementation:

- If a hospital CEO becomes an advocate for safe and effective care, he/she is at risk of friction with the medical staff. (Conflict with physicians is the number-one reason that hospital CEOs are terminated; often, the conflict is around standards for care that challenge physicians to practice differently than they have been.) Also, adherence to evidence-based medicine is, in some communities, a major source of tension between doctors and hospitals, and between health plans and providers.
- If a large employer structures its health benefits to reward use of hospitals and doctors who are more effective in the delivery of safe and effective care, employees could criticize the company because their “trusted” physician is not among that group or in a preferred tier. What happens if a well-liked physician’s performance lags another and an employee complains of having to pay a higher co-pay to see the under-performer?
- If a physician challenges a patient who wants a test or prescription for which there is no evidence of need, the patient is likely to be less satisfied. Or, what if a physician suggests a course of treatment based on solid evidence and the patient disagrees?
- If a health insurer structures doctors and hospitals in tiers with incentives to direct enrollees to a select subset of the community’s providers, employers might cry foul because the network is too restrictive. What happens if one hospital performs better than another in certain programs but not all programs? What if a health plan creates tiers around specific clinical programs such as heart disease instead of around the overall institution? What if a plan allows patients to see an orthopedic surgeon with great results for knee replacement but encourages use of another for hip replacement because results are better?

These are tough questions, to say the least. The journey to safe and effective care is not without risk or controversy; however, it is necessary. Safe and effective care is not motivated by increased payments nor dismissed because it is not important. It is the right thing to do. It is about saving lives and improving outcomes.



Pay for Quality? Our Viewpoint

Will employers and health plans pay more for the best care? Is it plausible to anticipate higher payments as doctors and hospitals achieve higher levels of safe and effective care?

From the perspective of health plans, employers and consumers, there is pushback around paying for quality. They reason that financial rewards for doing the right things seem inconsistent with the mission and purpose of the health care system. They bristle at the notion of paying more for a level of care that is already expected.

From the perspective of physicians and hospitals, there is readiness to change. Physicians and hospital leaders know that variation exists and incentives reward doing more rather than sometimes doing less. They understandably err on the side of caution: A lawsuit is always a near and present danger and the plaintiff bar is always lurking. They know that electronic medical records are essential tools and they’re embracing IT methodically. They know that patients expect safe and effective care and they are committed to that above all else. Often, however, their efforts stall due to lack of local leadership or, regrettably, sheer neglect.

We believe the pursuit of safe and effective care is an essential mandate for communities. And while we believe current efforts to promote quality via pay for performance offers a temporary stimulus, we do not anticipate more pay for higher quality.

Closing Thoughts

In Topeka, citizens receive good care. But the care they receive could be safer and more effective. Closing that gap could mean 152 saved lives. It could mean better care and lower costs.

The pursuit of safe and effective health care will continue to generate considerable debate and strong emotion among all key stakeholders in the system. Doctors and hospitals share the same desire for safe and effective care as health plans, employers, policymakers and the general public. The path to get there is what separates these groups.

We believe that performance-based payments and transparency are keys to safe and effective care but the development of these programs must be built on a level playing field in which all stakeholders have substantive design input.

We believe that information technologies that assist physicians and consumers in making clinical decisions are essential and that these tools must be shared community-wide via health information exchanges with unique identifiers for each citizen.

We believe that physicians and hospitals must find ways to work together to coordinate care, reduce inappropriate variation and increase adherence to evidence-based practices.

We believe that health plans, employers and government health programs should construct payment methods that reward safe and effective care and call attention to differences in performance among local, regional and national best practices.

We believe that patients should become engaged consumers, discarding passivity for activism in shaping the health of their community.

The U.S. health care industry has a moral obligation to pursue safe and effective care. When it is achieved, everybody wins...particularly patients. Topeka already gets good care. What will it take to get the best? It's a critical question for Topeka's most important stakeholder: the citizens it serves.

Acknowledgements

Special appreciation to Kerry Hicks, CEO, and Samantha Collier, MD, Chief Medical Officer, HealthGrades, Golden, Colorado.

The following individuals from Deloitte Consulting LLP and Deloitte & Touche LLP provided extensive research, analysis, and writing assistance: Ann Scott Blouin, RN, Ph.D., Robert Williams, MD, Patrick Voight and Kelly Kuzak.

Contact Information

To learn more about the Deloitte Center for Health Solutions, its projects and events, please visit www.deloitte.com/us/healthsolutions.

Deloitte Center for Health Solutions

555 12th Street N.W.
Washington, DC 20004
Phone 202-220-2177
Fax 202-220-2178
Toll free 888-233-6169
Email healthsolutions@deloitte.com
Web <http://www.deloitte.com/us/healthsolutions>

Endnotes

- 1 Keckley, Paul Executive Director, Vanderbilt Center for Evidence Based Medicine, Vanderbilt School of Medicine (used with permission)
- 2 "Pay for Performance, Quality of Care, and Outcomes in Acute Myocardial Infarction," Seth W. Glickman; Fang-Shu Ou; Elizabeth R. DeLong; Matthew T. Roe; Barbara L. Lytle; Jyotsna Mulgund; John S. Rumsfeld; W. Brian Gibler; E. Magnus Ohman; Kevin A. Schulman; Eric D. Peterson, JAMA. 2007;297:2373-2380
- 3 Vanderbilt Center for Evidence Based Medicine
- 4 U.S. Census Bureau and K.U. Policy Research Institute, 2004
- 5 All Demographics for Topeka MSA and USA: U.S. Census 2005 American Community Survey
- 6 American Hospital Association, rates based on 2004 Population: Topeka MSA = 227,820 taken from US News & World Report Hospital Directory, updated May 2006. Beds for Topeka MSA include all community hospital beds in the 5 counties.
- 7 Kaiser Foundation State Health Facts 2004, rates based on 2004 Population US = 296,410,404 Notes: Data are for community hospitals, which represent 85% of all hospitals. Federal hospitals, long term care hospitals, psychiatric hospitals, institutions for the mentally retarded, and alcoholism and other chemical dependency hospitals are not included.
- 8 Kansas State Board of Healing Arts as of July 1 2005, MDs and DOs with active licenses in the 5 county MSA were added together to get total number of physicians. Rate per 100,000 population based on 2004 population: Topeka MSA = 227,820.
- 9 Kaiser Foundation State Health Facts, Calculation based on American Medical Association, Physicians Professional Data, data as of 2004, copyright 2005: Special Data Request; resident population; Annual Population Estimates by State, July 1, 2004 Population Notes: Nonfederal physicians are not employed by the federal government and include medical doctors and osteopaths. They represent 98 PERCENT of total physicians.
- 10 Office of Health Care Information and Office of Rural Health, Kansas Department of Health and Environment (1996-1999) Primary Care Access, Shawnee County, Weighted Average of the 5 counties was used to calculate Topeka MSA.
- 11 Kaiser Foundation State Health Facts 2004, American Medical Association, Physicians Professional Data, year of data 2004, copyright 2005: Special Data Request Notes: Primary care physician specialties include Internal Medicine, Family Practice, Pediatrics, Obstetrics/ Gynecology, and General Practice Dartmouth Atlas of Health Care
- 12 HealthLeaders-Interstudy, Topeka MSA, as of January 2006
- 13 The Dartmouth Atlas of Health Care, 2005 Notes: Hospital service areas (HSAs) are local health care markets for hospital care. An HSA is a collection of ZIP codes whose residents receive most of their hospitalizations from the hospitals in that area. HSAs were defined by assigning ZIP codes to the hospital area where the greatest proportion of their Medicare residents were hospitalized. Minor adjustments were made to ensure geographic contiguity. Most hospital service areas contain only one hospital. The process resulted in 3,436 HSAs, ranging in total 1996 population from 604 to 3,067,356.
- 14 The Dartmouth Atlas of Health Care, 2005 Notes: Hospital service areas (HSAs) are local health care markets for hospital care. An HSA is a collection of ZIP codes whose residents receive most of their hospitalizations from the hospitals in that area. HSAs were defined by assigning ZIP codes to the hospital area where the greatest proportion of their Medicare residents were hospitalized. Minor adjustments were made to ensure geographic contiguity. Most hospital service areas contain only one hospital. The process resulted in 3,436 HSAs, ranging in total 1996 population from 604 to 3,067,356
- 15 Solucient ProviderView, Average of Topeka community hospitals used to calculate ALOS, 2006.
- 16 Solucient ActionOI – USA ALOS based on the 50th percentile in a Standard Compare Group of Hospitals with 200-400 beds.
- 17 Age Adjusted Death Rate Per 100,000 US Population Shawnee County: The Kansas Department of Health and Environment 2004

- 18 Age Adjusted Death Rate Per 100,000 US Population USA: Centers for Disease Control and Prevention National Vital Statistics Report
- 19 Infant Mortality Rate Per 1,000 Live Births Shawnee County: The Kansas Department of Health and Environment
- 20 Infant Mortality Rate Per 1,000 Live Births USA: Centers for Disease Control and Prevention Health, United States, 2005
- 21 Low Birth Rate is less than 2500 grams Shawnee County: The Kansas Department of Health and Environment 2004
- 22 Low Birth Rate is less than 2500 grams USA: Centers for Disease Control and Prevention Health, United States, 2005
- 23 Health Grades accessed Dec. 5, 2006. See the following website for selection methodology. <http://www.healthgrades.com/media/dms/pdf/DHAPatientSafetyMethodology.pdf>
- 24 Premier Inc. accessed Dec. 5, 2006 from <http://www.premierinc.com/quality-safety/tools-services/p4p/hqi/index.jsp> For a complete list of participating hospitals see <http://www.cms.hhs.gov/HospitalQualityInits/downloads/HospitalParticipate200601.pdf>
- 25 CMS Hospital Compare, Data Last updated Sept. 8, 2006, retrieved Nov. 28, 2006. Averages results of the two major non-federal hospitals were calculated for each indicator in all 4 categories. Averages of all the indicators in each section were then calculated. USA based on average of all reporting hospitals.
- 26 The Ninth Annual HealthGrades Hospital Quality in America Study October 2006, <http://www.healthgrades.com/media/dms/pdf/HealthGradesNinthAnnualHospitalQualityinAmericaStudy.pdf> retrieved January 9, 2007
- 27 HealthGrades: O_E_5PCT is the observed to expected ratio averaged across hospitals in the top 5% by z-score
- 28 HealthGrades: O_E_10PCT is the observed to expected ratio, averaged across hospitals in the top 10% by z-score
- 29 HealthGrades: Based on 2003-2005 MEDPAR data. Weighted averages by case count were used for the two major non-federal hospitals in Topeka.
- 30 HealthGrades: Deaths avoided if Topeka hospitals perform at the level of the comparative benchmark (e.g., 5STAR, Top 5%, Top 10%) is calculated as OBSERVED – (PREDICTED * O_E of the comparative benchmark)
- 31 HealthGrades: Complications avoided if Topeka hospital perform at the level of the comparative benchmark (e.g., 5STAR, Top 5%, Top 10%) is calculated as OBSERVED – (PREDICTED * O_E of the comparative benchmark)
- 32 The Dartmouth Atlas of Health Care, <http://www.dartmouthatlas.org>

These materials and the information contained herein are provided by Deloitte & Touche USA LLP and are intended to provide general information on a particular subject or subjects and are not an exhaustive treatment of such subject(s). Accordingly, the information in these materials is not intended to constitute accounting, tax, legal, investment, consulting or other professional advice or services. Before making any decision or taking any action that might affect your personal finances or business, you should consult a qualified professional advisor.

These materials and the information contained therein are provided as-is, and Deloitte & Touche USA LLP makes no express or implied representations or warranties regarding these materials or the information contained therein. Without limiting the foregoing, Deloitte & Touche USA LLP does not warrant that the materials or information contained therein will be error-free or will meet any particular criteria of performance or quality. Deloitte & Touche USA LLP expressly disclaims all implied warranties, including, without limitation, warranties of merchantability, title, fitness for a particular purpose, noninfringement, compatibility, security and accuracy.

Your use of these materials and information contained therein is at your own risk, and you assume full responsibility and risk of loss resulting from the use thereof. Deloitte & Touche USA LLP will not be liable for any special, indirect, incidental, consequential, or punitive damages or any other damages whatsoever, whether in an action of contract, statute, tort (including, without limitation, negligence), or otherwise, relating to the use of these materials or the information contained therein.

If any of the foregoing is not fully enforceable for any reason, the remainder shall nonetheless continue to apply.

About Deloitte

Deloitte refers to one or more of Deloitte Touche Tohmatsu, a Swiss Verein, its member firms, and their respective subsidiaries and affiliates. Deloitte Touche Tohmatsu is an organization of member firms around the world devoted to excellence in providing professional services and advice, focused on client service through a global strategy executed locally in nearly 140 countries. With access to the deep intellectual capital of approximately 150,000 people worldwide, Deloitte delivers services in four professional areas — audit, tax, consulting, and financial advisory services — and serves more than 80 percent of the world's largest companies, as well as large national enterprises, public institutions, locally important clients, and successful, fast-growing global companies. Services are not provided by the Deloitte Touche Tohmatsu Verein, and, for regulatory and other reasons, certain member firms do not provide services in all four professional areas.

As a Swiss Verein (association), neither Deloitte Touche Tohmatsu nor any of its member firms has any liability for each other's acts or omissions. Each of the member firms is a separate and independent legal entity operating under the names "Deloitte," "Deloitte & Touche," "Deloitte Touche Tohmatsu," or other related names.

In the United States, Deloitte & Touche USA LLP is the U.S. member firm of Deloitte Touche Tohmatsu and services are provided by the subsidiaries of Deloitte & Touche USA LLP (Deloitte & Touche LLP, Deloitte Consulting LLP, Deloitte Financial Advisory Services LLP, Deloitte Tax LLP, and their subsidiaries), and not by Deloitte & Touche USA LLP. The subsidiaries of the U.S. member firm are among the nation's leading professional services firms, providing audit, tax, consulting, and financial advisory services through nearly 40,000 people in more than 90 cities. Known as employers of choice for innovative human resources programs, they are dedicated to helping their clients and their people excel. For more information, please visit the U.S. member firm's Web site at www.deloitte.com

Deloitte. Center for Health Solutions

About the Center

The Deloitte Center for Health Solutions (the "Center"), located in Washington, D.C., is part of Deloitte & Touche USA LLP and was formed to further research on and develop solutions to some of our nation's most pressing health care and public health-related challenges. Tommy G. Thompson, former Secretary of Health and Human Services and former Governor of Wisconsin, is a senior advisor and Independent Chairman of the Center.