Rewarding Quality Performance:
The Multidisciplinary Approach
Alliance for Health Reform
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ED HOWARD: On behalf of our chairman, Jay Rockefeller, and our vice chairman, Bill Frist, I want to welcome you to this program on the connection between the developing pay-for-performance phenomenon and the nursing workforce that has such a dramatic impact on the quality and the efficiency that the pay-for-performance initiatives are supposed to reward in the first place. Our partner is today's program is the Robert Wood Johnson Foundation, the country's largest philanthropy devoted exclusively to health and healthcare. We're very happy to have Sue Hassmiller of the Foundation here today. Actually, we had John Lumpkin here for a second.

I guess pay-for-performance is the next big thing that US healthcare is coping with or blessed with. There are more than 100 P-for-P initiatives already operating in both the public and private sectors, aiming to do in healthcare what we do in every other part of our economy, and that is that we reward superior performance in the marketplace more than we reward mediocre performance in the marketplace. Entities like hospitals and physician practices and other healthcare institutions are going to have a hard time performing well in this P-for-P era without strong input from their nursing staff. Is that happening in some places? Can it happen in most places? Are there policies we need to put

in place to help that along? Those are a few of the

questions that we hope to explore today, and what better way

to mark National Nurses Week than to have this kind of

discussion?

          Let me just do a quick logistics review for those of

you who haven't been to a lot of these briefings. In your

packets there is a lot of good background information,

including the slides from the speakers from whom we got them

in advance. The bios that are not more extensive, I'll have

time to give them. By tomorrow morning you'll be able to

watch a webcast of this session on KaiserNetwork.org, and in

a few days there'll be, on that web site and on ours at

AllHealth.org, a transcript of the discussions, along with

electronic copies of the materials that are in the kits that

you have before you. You'll also find a green question card

and a blue evaluation form way at the back on the right-hand

side of your kits; we hope that you will make use of both of

them at the appropriate time.

          As I noted, we have Sue Hassmiller of the Robert Wood

Johnson Foundation with us today. She is senior program

officer there and the team leader for their nursing team.

RWJ, most of you know, has been extremely active in helping

to shape nursing policy in this country, and Sue has been

instrumental in shaping RWJ's role, so we're very pleased

that she is able to join us. She is actually in town for

another meeting, but managed to free herself for

participation here and we wouldn't have had this briefing if

she hadn't pushed the folks up there very hard to put it

together. Sue thanks for being here.

    SUE HASSMILLER, Ph.D., R.N.: Thank you, Ed. I'm

absolutely delighted to be here today and so happy that it's

a nice day our and you were able to walk over here to be with

us. To the nurses in the audience and non-nurses alike, I do

want to wish you a happy Nurses Week. It is Florence

Nightingale's birthday today, so this is a very nice event

today.

    I just wanted to let you know where the Robert Wood

Johnson Foundation is coming from and why we are so happy to

co-sponsor this event. As you know, we pay a great deal of

attention to the important health issues that are shaping

today's society, and we're very interested in whatever we can

do, whatever policies, whatever strategies, whatever

programs, that we can promote to improve the quality of

patient care. As our president, Risa Lavizzo-Mourey, is so

fond of saying, "We absolutely want to improve the quality of

patient care, but you just ain't gonna get there if you don't

have the nursing policies and the nursing workforce in place

along the way." We noticed, obviously, that pay-for-

performance was a very, very important issue being talked

about in many corners and auditoriums around the country and

even at our own Foundation. We really did notice as well

that many great administrators, physicians, and others are

being involved in some of the decision making in pay-for-

performance. At that point, we simply made the decision to

help co-sponsor this panel today to see what we could do to

ensure a multidisciplinary approach to pay-for-performance.

We simply believe that if all voices aren't heard at the

quality table, the pay-for-performance table, that it would

indeed be a missed opportunity for our patients and America

today. With that I will ask you to introduce the panel Ed.

ED HOWARD: Great, thank very much. In case you

thought this was a flash-in-the-pan phenomenon, some of you

may have seen the story in yesterday's *Boston Globe* that Blue

Cross and Blue Shield of Massachusetts has doubled the amount

of money that it is putting into a pay-for-performance

initiative to something like $189 million for the coming

year. There is a real financial stake that is being

developed in places all around the county in, as I said,

private and public payers to be able make this phenomenon

actually work to improve the quality of our healthcare

system. That goal is one that is the primary goal of our

first speaker. We're going to hear first from Dr. Barry

Straube from the Centers on Medicare and Medicaid Services

where he is the director—note, no longer acting director;

congratulations Barry—of the Office of Clinical Standards and

Quality and the chief medical officer at CMS. He is, in

other words, the quality go-to guy at that agency, both

internally and in relationships with outside groups like the

Joint Commission and the National Quality Forum. In his

spare time, he draws on his background as a nephrologist to

chair CMS's end-stage renal disease activities and advise the

agency on ESRD and transplantation issues. So the fact that

he is here with us is great. We're very pleased to have him

lead off the discussion today. Barry?

     BARRY STRAUBE, M.D.: Ed thanks very much, and Sue

thank you also. Good afternoon to all of you. I'm seeing a

lot of familiar faces and for those of you that I haven't met

yet, I hope to get to know each and every one of you at some

point here over the next few years at least. What I wanted

to do is to lead off the session here.   I have far more

slides than we could possibly cover in the entire session,

let alone the 8 or 10 minutes that I have, but let me try to

paint for you the imperative that I think is there for us to

progress with pay-for-performance. As Ed mentioned, in terms

of the some of the commercial payers putting large numbers of

money on the table, I think a lot of people jumped to the

conclusion that we're doing pay-for-performance to save

money. I'd like to make a case that, although we do have an

imperative as a nation to address the growing healthcare

costs, we also have imperatives from the quality and

efficiency standpoint that we have to address irrespective of

the need to control costs. So I'm going to whiz through

these.

First of all, we at CMS are operating more and more

not just as a regulatory agency, but as what Mark McClellan,

our administrator, likes to refer to as a public health

agency. This is not functioning as an agency that sets up

flu clinics and immunizations clinics and other preventive

services, those are important, we are trying to use our

influence with revenue spending with other activities that we

do to join in partnership with Congress, with the

Administration, and with other stakeholders in healthcare

industry to try to improve quality of care. I've put for you

some bullet points here. We intend to try and align beyond

the Medicaid and Medicare programs, go beyond that, and

address the entire healthcare system in terms of making our

policies consistent with improving quality of care across the

United States. We're focusing on quality first and foremost,

but increasingly we all need to talk about other terms such

as value, efficiency and eventually, cost effectiveness,

although that's not our charge at CMS right now. I have a

whole bunch of slides here we can't go individually through,

but let me take you to the summary slide on these. That is

these are the imperatives, I think, that are driving the

discussions we'll be having here this afternoon.

First of all, in the United States, we as a

healthcare system spend more per capita on healthcare than

any other country of the world. In spite of these

expenditures, the quality of care, as measured by quality

measures and outcomes here in the United States, is often

inferior to those of other industrialized nations that spend

far less money per capita than we do. Often the quality of

care that we deliver does not meet national consensus-driven

broad-based guidelines. In Beth McGlynn's study, published

in *The New England Journal of Medicine* three-and-a-half or

four years ago, only 1 out of 2 patients coming to a

physician's offices gets the care that they should be getting

according to national guidelines. In some conditions, it's

only 1 out of 4 or 1 out of 3. This is not acceptable and we

have to improve on that. We definitely see nationally gross

and market variations both in the quality of care that's

delivered in different parts of the country and even on a

regional basis from city to city, from neighborhood to

neighborhood. At the same time, we see market variation in

the amount of expenditures that are being expended to get

that care. To some extent, there is increasing evidence that

there may be an inverse relationship between the amount of

money we spend on healthcare and the quality outcomes. By

that I mean in areas where we spend the greatest number of

dollars on healthcare, we see the worst quality of care.

Conversely, the best quality of care is often associated with

lower expenditures, as you'll see today from the Premier

hospitals as an example.

We're responsible for the healthcare of a growing

number of people; the Medicare program is growing

exponentially now as Baby Boomers hit us, and so we feel that

the imperative is that CMS, working in collaboration with

other stakeholders, has to address these issues going

forward. We're going to do this through our quality roadmap;

The Right Care for Every Person, Every Time is our vision.

We can't go into our strategies in much detail here, but the

quality initiatives that CMS and the Department of Health and

Human Services has initially chosen to focus on are in these

regions, or these domains, or these silos: hospitals,

nursing homes, home health agencies, dialysis facilities, and

we've just embarked upon a focus on physician offices.

Clearly, there are many, many other healthcare settings that

we'll be focusing on first and foremost in Medicare and

Medicaid, but in concert with private sector commercial

payers of healthcare in other areas also. This slide though,

there is something important to see here. We have focuses as

a nation on the silos of settings of care. We focus when

people go into the hospital, but we forget that patients

don't live their lives in just one of these silos. We have

to increasingly focus on what happens when a patient leaves

the hospital, whether they go home, to a nursing home, to a

home health agency, and so forth. We have to measuring the

quality of care and improving the quality of care across the

continuum in each and every one of these settings and as

patients navigate the different settings.

We have, in our Quality Initiative, several broad

themes, I've listed them here. First of all, we're first and

foremost working through broad national quality alliances.

We've been very heavily focused on the Hospital Quality

Alliance and on the Ambulatory Quality Alliance, but there

are many, many other quality alliances that are forming,

including one we've just announced in the past several weeks,

the Pharmacy Quality Alliance. I'm involved with an End-

Stage Renal Disease Quality Alliance that's been forming and

we will be involved with others, but we feel it's very

important for broad-based, multiple-stakeholders to talk

about how we approach pay-for-performance and other quality

information. We also believe very firmly on the principle of

using quality data; if you can't measure quality, you can't

improve it. So we are heavily invested in developing quality

measures and publishing that data and allowing it to be very

transparent in alignment with the White House's and the

secretary of HHS's initiatives on transparency and using that information for quality improvement and performance.

And last but not least, we take all of these principles and we take the quality measures et cetera and we believe that what we've done so far, in terms of quality improvement efforts, have largely not been effective. We have too many gains that we need to make and the methods that we've been using up until now have not succeeded, so we have to think outside the box with new methods. At the moment, whether you think it's a good idea or bad, the only one on the table really in pay-for-performance right now. We believe that it has great promise and merit if done properly, and you'll be hearing about that during this panel discussion on ways that we think we can go forward.

We have a number of incentive initiatives, or pay-for-performance initiatives; we don't have time to talk about all of these. By the way, we'll make this available for you, too, after this presentation, for those of you who are rapidly writing notes, or you can E-mail me.

ED HOWARD: Barry, I should say also that we'll make sure that it's on our web site with the materials that are already there.

    BARRY STRAUBE, M.D.: Thank you, Ed. But you'll see

here a great number of demonstrations, and these are only a

partial listing, and they all have different tweaks,

different approaches in terms of how we're trying to approach

so-called pay-for-performance. I think that the standard

things that we're doing in these initiatives are that the

initiatives all are involved with development and

implementation of standard performance measures in every

setting and measures that can measure quality of care across

these various settings. We're increasingly focused not just

on quality of care, but because of the expenditures that I

mentioned earlier, on efficiency of care. So we want first

and foremost for people to achieve a very high level of care,

but once we can define what that level is, we want to reward

people who are more efficient and can deliver that high level

of care more efficiently than other providers can. We are

developing pay-for-performance initiatives in all the areas

that I mentioned. We just recently announced six pilot sites

through the Ambulatory Care and Quality Alliance that will be

doing collection, integration, and reporting of data along

with pricing and cost reporting across the United States.

They'll be based in California, Arizona, Minnesota,

Wisconsin, Indiana, and Massachusetts to start. The

secretary of HHS is extremely interested in these pilots, and

we hope to be able to very quickly expand the number of sites

and expand the concept not just the physician offices, which

we're starting off in, but to include hospitals, to include

cost and pricing performance measures also, more to come

about that. But the themes that we use have to do with

physician/patient partnerships; they have to do with the

benefits of group practice and integrated practices; they do

have to do with efficiency and value through coordinated

care, through care management, through health information

technology adoption and the use of evidence-based medicine.

We're focused on chronic illness. We're focused on the

benefits of prevention. We're clearly looking, as I

mentioned, at evidence-based guidelines being used. And last

but not least, we clearly think the entire process should be

very transparent, especially to the payers and consumers so

that they can choose where they get their care and have some

effect on the economic structure of how they get their care.

What I'd like to quickly do in the remaining minute

or two here is tell you about three things. First of all,

the Hospital Quality Initiative; we initially, four years

ago, in concert with the other hospital organizations I

listed here, announced a voluntary system where we hoped

hospitals would voluntary report up to 10 quality metrics in

the hospital arena through the Hospital Quality Alliance.

After a year-and-a-half or two of a voluntary effort, only

30-percent of hospitals had agreed to voluntarily report. In

fact, only 10-percent were reporting 1 or more of those 10

measures. Congress enacted Medicare Modernization Act,

Section 501b giving a 0.4-percent incentive to report this

data. Within six months, we went from 10-percent reporting 1

or more to 98-percent of hospitals reporting all 10 measures

or more. So for those of you working up on the Hill, money

does talk and does give incentive to people to report and, I

think you'll find here in some of the example, to do better.

These are the Hospital Quality Measures we used. We had the

Premier Hospital Quality Demonstration, I won't go into great

detail on that because you'll be hearing from other people

participating in it, but basically this demonstration looks

at 34 quality metrics in the hospital setting, voluntary

participation, they'll talk about the scoring system

somewhat, but what I wanted to show to you was these five

metrics. You'll see the baseline in the blue-colored slide,

the improvement or the second year of performance after

interventions were made, and in all five areas of heart

attack, congestive heart failure, pneumonia, coronary artery

bypass grafting, and hip and knee surgery, there was

significant improvement after one year of pay-for-performance

models.

The final thing I'd like to do with you is something

called PVRP, which is the Physician Voluntary Reporting

Program. We just started this in January of this year.

We're encouraging voluntarily again, although we anticipate

to go the same route as the hospitals where we may have to

pay for reporting, for physician offices to report quality

measures by appending a G code to their normal claims

submission for Medicare services. We will measure a whole

series of quality metrics that I've listed here on these

slides, a whole series of them, 16 basic core quality

metrics, and we will be able to take that information,

calculate results by individual physician offices, give them

back to physician offices, and work with them to try to

improve the quality of care. You'll see here a potential

timeline for physician offices where we may go. This year

voluntary reporting; next year perhaps Congress will assist

us in apportioning or appropriating some money to actual pay-

for-reporting; in 2008 perhaps actual pay-for-performance in

physician offices and so on, on the timeline.

Finally, I'll end with those of you, again, on the

Hill. The Deficit Reduction Act of 2005 has a number of pay-

for-performance components. We're responsible for delivering

to Congress a plan for the hospital setting for a pay-for-

performance program that might be implemented nationally by

Congress, and we're also charged with delivering to Congress

a play for home health agencies. I would anticipate that,

for the other three arenas that I mentioned to you earlier,

we will also be charged with doing that in the very near

future. In addition, Congress have very wisely, I think,

charged us with implementing a gain-sharing demonstration

where hospitals, doctors, and other providers working all

together in the hospital setting will be able to share in

cost savings after they have delivered very high-level care,

something that has not been allowed under the law previously.

I think this will be a major contribution, pro or con, to

determining where we go with pay-for-performance.

Last but no least, I'll end on my focus of Care

Across the Continuum. There's an acute post-care payment

reform demonstration that we will be enacting. We will

develop a single, post-acute care assessment tool, which at

the time of discharge from the hospital, patients will be

able to be assess and be assessed, be determined what setting

of care they should go to for their next level of care, and

then continue to have quality measurement, regardless of the

setting they're in, probably linked to reimbursement at that

point, too. So this, again, is a very, very quick overview.

Here's my contact information. Ed, I will turn it back over

to you and I'll be here to answer more detailed questions

once we get into it.

ED HOWARD: Terrific; thanks very much Barry. That's

quite a lot of ground that you covered and quite a lot that's

going on within the agency. If I can ask our folks in the

audience, if you have not already done it, could you put your

pagers and cell phones on vibrate or whatever it is you can

do, that will be very helpful to the continuity of our

conversation.

Next we're going to here from Jack Needleman who is

on the faculty at UCLA School of Public Health. When we felt

the train rumble in below, he said he thought it was just

another Southern California phenomenon [laughter] and wasn't

worried at all. Jack is also one of the country's top health

services researchers. He's won, as David Helm pointed out to

me, the AcademyHealth Health Services Impact Award. He leads

the Robert Wood Johnson Foundation's evaluation of

Transforming Care at the Bedside initiative. His *Health*

Affairs article on the business case for better nurse

staffing is in your packets and I commend it to you. Jack,

thanks for coming all this way and for being part of this

discussion.

JACK NEEDLEMAN, Ph.D.: It is a pleasure to be here

and a delight to talk to you. I'm going to try to keep my

comments brief, which those who know me, know will be

difficult, because I think the most important things we can

get out of today are out of the Q&A.

There are really three points I want to make in this

introductory presentation. The first is simple that nursing

matters for patients. I'm going to focus principally on

hospitals, but research suggests in many other settings as

well. The second is there is a business and social case for

enhancing hospital nursing, and that may cost us a little bit

more, but one can make a very strong argument that it is

worth it. The third point is that the current pay-for-

performance systems do a very poor job of targeting

improvements in hospitals in the core work that nurses do.

Let me start with the first point that nursing

matters. Over the last decade, there has been a growing body

of evidence that nurse staffing and hospitals makes a

difference in patient outcomes in very significant ways.

Lots of different ways of measuring nurse staffing in

hospitals, the who measures that have been most commonly used

in the literature are some measure of nursing hours per

patient day and the skill mix of the nurses, the proportion o

the nursing staff that are registered nurses. When you look

at either of those and you look at the research that is

there, outcome after outcome after outcome is sensitive to

those measures in hospitals. Mortality is probably the one

that has been least demonstrated to be related to nursing,

the one with the most mixed evidence. But mortality in

hospitals happens for many, many reasons and it was simply

trying to capture a very noisy phenomenon looking at only one

of the things that might affect it. When we actually look at

a narrower range of deaths, which are in the literature

characterized as "failure to rescue," patients who begin

developing complications that need to be treated in a timely

and appropriate fashion, things that nurses are critical and

central to, we see more evidence for nurses' impact on

mortality. When we look at other measures, length of stay

and overall measure of the efficiency with which care is

delivered and the reduction in complications that keep people

in the hospital longer, nursing is very clearly associated

with reducing length of stay. Pneumonia, urinary tract

infections, other kinds of hospital-acquired infections,

pressure ulcers, deep vein thromboses, bleeding, shock,

cardiac arrest, medication errors, falls, the whole list of

evidence that we have as study after study comes in shows

that the quality of the nursing staff and the amount of time

that staff has to work with patients make a difference in

patient outcomes and patient experience in the hospitals. So

nursing clearly matters.

         Nurses' work is at the core of what hospitals do. We

have outpatient surgery, outpatient physician visits,

outpatient imaging; God knows if you go into the Virginia

suburbs you can't go more than two or three blocks without

seeing and MRI center. We have outpatient imaging,

outpatient therapy, outpatient lab testing. There is only

one reason for a patient to spend a night in a hospital, and

that is because they need nursing care. The range of

outcomes that we see influenced by nurse staffing reflects

the range of work nurses do. Yes, the standard image is of

the nurses taking the doctors' orders and doing what they've

been asked to do is certainly part of that work, but so is

the assessment and monitoring of patients, so is the

development and the identification of the need for and the

beginning of timely and appropriate intervention and pain

management, so are patient education activities, discharge

planning; there is a whole range of things that represent

some of the core functions that nurses do. The whole list

shows that the amount of the nursing staff, the quality of

the nursing staff, and the way the nursing staff is organized

in hospitals makes a difference in the ability of the

hospital to carry out that work. We tried estimating, in the

Health Affairs article that Ed alluded to, how much it would

cost hospitals to increase nurse staffing and whether the

improvements in the care, the reduced number of days, the

reduced adverse consequences, the reduced deaths would

basically pay for themselves. Clearly, the impact of

improving nursing is substantial. We estimated, if the

three-quarters of the hospitals that were below the top

quarter of hospitals just raised their nurse staffing up to

that level that we see in the top quarter, how much it would

cost, how care would change, and how much would be saved.

These are the numbers from that estimate in terms of the

impact. If you raise both of the both of the staffing

measures that I mentioned before, there would be 4 million

fewer days in the hospital or roughly 1-percent; 70,000

avoided events of those events we looked at, and we did not

look at all the things that nurses affect; 6,700 fewer

deaths. Would the savings from these things pay for

themselves? Well, probably increasing the skill mix in

nursing, increasing the proportion of registered nurses in

the hospital staff would pay for itself, which was one of our

conclusions. However, increasing the hours, which have major

consequences on days and deaths, would not pay for itself;

you would have to pay more for that. But we have an estimate

of how much and depending on how you dealt with the fixed

cost in hospitals, whether you think that in the long run

that those can get adjusted as the other care changes. The

estimated cost of getting those full sets of improvements

that we modeled were somewhere between 0.5-percent of what we

spend on hospitals today and 1.5-percent. To put that number

in context, hospital costs have been increasing every year by

about 5-percent. So we're talking about one-tenth to one-

third of one year's increase to get those benefits. The

business case is iffy in the sense of relying upon the

savings to pay for themselves. The social case, that this is

care worth paying for and is affordable, I think, is much

stronger. If we're talking about pay-for-performance, we

might be talking about creating incentive for hospitals to

actually spend that additional money to bring the nurse

staffing up with the value it brings to patients. One of the

problems we see, however, is that current pay-for-performance

systems do a poor job of targeting improvements in the core

work of nursing. Pay-for-performance usually looks at

processes, with a focus on whether specific processes have

been completed. On the list that Barry Straube pointed out

before on heart attacks, a patient coming into the hospital

with a heart attack, did they get an aspirin when they came

in? Did they get beta blockers when they went out? If they

needed catheterization, did they get it within two hours of

the time that they came in the door? If you're looking at

diabetes, did they get appropriate blood tests, eye tests,

and foot exams? But nursing processes are hard to measure;

nurses are everywhere doing everything and they are

multitasking as they go from patient to patient. They are

tailoring the care that they do to specific patients, so

quite appropriately, every patient does not get the same

process of care. To understand a lot of what nurses do, say

with pain management, you need to look at the documentation

not for a one-time event, but for things that are happening

over and over again through the whole admission process.

Keeping track of that kind of documentation is very, very

hard to do and very expensive to pull together in the kinds

of systems that pay-for-performance relies upon.

I went to the CMS hospital compare site, which

contains many of the metrics for hospitals that Barry Straube

mentioned, looking for some of the measures that seem most

closely related to nurses' work. I happened to miss the

falls measure; I'm not sure it's actually on the hospital

compare site. But here are the ones I came up with that were

nursing related. The PCI within 120 minutes, not because

nurses are core to that, because that's a team effort and

nurses are certainly parts of those teams. Whether of not

patients leave the hospital having been assessed for their

needs for pneumococcal vaccine and whether they got it is the

second measure. The third measure is smoking cessation

counseling for patients that come in with conditions that

suggest it ought to be looked at; heart attacks, pneumonia,

and heart failure. Finally, discharge instructions after

heart failure. These were the five measures that I could

find that were nursing related. As you look at this chart, I

think one should draw two conclusions from it. The first is

that our hospitals are doing a crummy job; they're doing a

mediocre job at best. We're looking at rates here between

50-percent and 78 or 79-percent. So that's the first thing

one should conclude. Of the things we can measure about the

functions that nurses do in hospitals, hospitals aren't doing

so well. The second conclusion one should draw from this

chart is that these don't look like the core functions of

hospital nursing. They don't involve the pain management;

they don't involve the assessment of patients for risk of

complications, for risk of dying, for the various and

important things that nurses do. This is not core activity

to nursing. The problems that you have creating these are

not unique to CMS; this is actually the state-of-the-art.

When the National Quality Forum went to develop a set of

nursing performance measures for hospitals, after looking at

scores of measures, well over 100 and I think I'm

underestimating substantially, they came up with 15 measures

that they thought were documented and in the public domain.

Eight of them were outcome measures; four of them were

structural measures like how many staff and what their

turnover was; only three were process measures. The problem

for finding good measures for process is not unique to CMS.

The three process measures that came are in the CMS compare

data that I just showed you. So this is not a problem that

is unique to nursing. I mentioned diabetes before and all

the process stuff; did you get this test or that test, did

you get that exam? But other activities that are central to

actually helping diabetics actually live with their disease

and improve their functioning, things like education and

other kinds of dietary interventions are also not in these

systems. It's not a unique problem to nursing. It is,
however, a problem for nursing. If we want hospitals to
improve their core functions, in terms of delivering higher-
quality to patients, nursing is central to that and we are
going to need to find better ways to measure the core
activities that nurses do and bring them into these systems.

     ED HOWARD: Thank you so much, Jack, that was very
helpful in moving this discussion along. Now that you have
the policy background that you need, we're going to look at
the view from the front lines. I think we have gathered
representatives of two hospitals who are definitely not, as
Jack used the term, crummy. [Laughter] In fact, they are
exemplars of high quality. First up in that category is Rob
Colones who is the president and CEO of McLeod Health, which
is a non-profit health system in Northeast South Carolina.
He has been a member of the McLeod management team for many
years; he has been president and CEO for the last four. He
is a winner himself of the Milliken Medal of Quality, one of
several South Carolina-specific rewards based on the Malcolm
Quality Aware Criteria. The McLeod system, four hospitals
and associated units, has been one of the top performers in
what you've been hearing a little bit about, the CMS Premier
Quality Demonstration. So we're very pleased to have a non-
crummy, non-mediocre [laughter].

ROB COLONES: Thank you. And thank you, Sue, for

inviting us to be here today; we appreciate the opportunity.

I'm just going to talk for a minute about the hospital and

the organization that I work in. You'll probably note some

institutional pride in my conversation, but my reason for

mentioning it to you and the work that you do is that we are

a hospital in average America. In fact, we're in a poor and

rural part of South Carolina. If we can take knowledge that

is readily available in the literature and apply it in a

reliable and consistent manner, dramatic improvement can

occur both in the quality for patients and in cost. So our

effort in the demonstration project, I think, proves that

this can happen anywhere in America at any of the 5,000

hospitals that are functioning today.

Let me talk just for a minute about McLeod. McLeod

serves a 12-county area in Northeastern South Carolina.

We're four hospitals in that particular area of South

Carolina. We serve, with our tertiary services, about a

million people. The mission of McLeod is to improve the

health and well-being of people living in this region. It is

our goal to reduce the burdens that are associated with

illness and injury to people who need our services. We are a

non-for-profit private organization and last year we provided

$135 million in uncompensated care to patients who needed the

specialized services of McLeod Health.

It is a privilege to be here today for several

reasons. One, this marks our 100 years of service to our

community; this is our centennial celebration all year long

at McLeod and today we're celebrating Nurses Week, and it's

good to be here with you on that as well. McLeod was founded

in 1906 by Dr. F.H. McLeod to be a general hospital and a

training school for nursing. We've had nursing education as

part of our mission for a number of years. Later today, at

2 o'clock in Florence, about 150 former graduates of our

nursing school will have a reunion this afternoon as part of

both in celebration of our 100 years and in celebration of

Nurses Week. The tradition, the richness and the history

that's there in our organization has allowed us to achieve

recently some success. I'll just mention a couple of things.

Two of our four hospitals in our system have received the

South Carolina Governor's Quality Award. That is an award

given in South Carolina to any corporation that achieves that

status based on the Malcolm Baldrige Criteria. So we

competed with manufacturing and other service organizations

to receive that distinction. We received a Nation Award in

2003 with Premier; we received their quality award and a

variety of their other awards that are listed there. One

that we're very proud of that really leveraged our work much

more than the previous year's was the Pursuing Perfection

Grant. We were one of seven organizations selected by the

Robert Wood Johnson Foundation to try to raise the bar in

performance in healthcare. The work that we did during those

two or three years with the other hospitals and health

organizations dramatically improved our organization.

We are also participants in the CMS demonstration

project, and let me just share with you some results. As

noted in the earlier presentation, there are certain

evidence-based standards that hospitals have difficulty

meeting; 50 or 60-percent of the time on a given night,

evidence-based standards are able to be delivered. It has to

do with complexity; it has to do with specialization; it has

to do with a lot of different issues. But the scorecard

across America is not very good. The CMS demonstration

project picks five clinical focus areas, and there are 4 to 7

evidence-based standards within each of those 5 categories.

So if you can't score a 100 in all 7, you don't get credit

for 5 out of 7 or 6 out of 7; you only get credit when you

can deliver all evidence-based standards for every patient

within those particular clinical areas of focus. Nationwide

that number would be 60-percent or less. In our work in the

demonstration project, we were top decile in the four of the

clinical focus areas and second decile in one of them, and we

missed that one by only two-tenths of a percent. So the

demonstration project and the work that we've done based on

our quality effort is something that can be achieved

throughout the country. This shows our mortality declining

by 25 to 30-percent over that time period as well. Our key

design principles in our quality work are physician

leadership, data-driven decisions, and evidence-based

medicine; we use that to direct us in our work.

I to pick out several core successive actors for our

quality work; I'd like to walk you through these six just

briefly. I also want to highlight for you the role that

nursing plays in our organization in helping us achieve this

quality work that physician-led, data-driven, and evidence-

based.

At the top right, quality is a core value of our

organization. We have four values, and quality is a core

value that we teach, train, and remind ourselves about

consistently throughout the organization. Next May I need to

be a better president than I was this May. I need to

understand my weaknesses, I need to get education, and I need

to improve as an individual. We expect that of our radiology

department and our emergency room.   We expect not only

individuals, but departments in the hospital to honestly look

at their data, their comparative data, and then work using

our methodology to improve as an organization. So quality is

a key value of our organization and is one of our core

success factors. Prioritization and data-driven decisions,

we are a partner with Premier; we've used the Perspective

Plus Data System for a number of years. It gives us

information in several key areas to find gaps such as how we

performed taking care of pediatric asthma patients this year

and links the stay and mortality, complications, cost,

readmissions compared to other hospitals in that database.

Where there's a gap, we put a team of our people together to

work on that and apply the evidence-based measures.

Improvement methodology; in 1994 Jack Welch visited

Florence, South Carolina. He brought the board of General

Electric to Florence; not to visit us, but to visit the GE

plant in Florence where 51-percent of the world's magnets for

MR machines are shipped off the loading dock in Florence,

South Carolina. He came to recognize that plant for their

quality improvement efforts and their teamwork. We took note

of that, went out and understood what they were doing, used

their trainers and training materials, and adopted that

methodology into our organization. We have a methodology

that's based on Deming's [ph] work that helps us improve the

organization that we use each and every time we find areas of

opportunity to work on.

We've worked on change theory; many of you may have

read Cotter's *Model of Change*. But in other words, we have a

methodology we use to help people cope and understand the

various steps in change and how to go about changing a very

complicated and specialized environment. We have physician

and executive engagement. We have over 200 physicians who

have participated in three-month quality improvement

projects, not only receiving education, but helping to lead

that effort. We have senior leadership engaged in that as

well. Every morning at all of our hospitals, the first 30

minutes are spent visiting patients to try to understand

what's going on with them and what quality opportunities

there would be available to us. Many of our senior leaders

are nurses by training. Our chief information officer is a

master's nurse. Our vice presidents of patient services,

several of them are master's prepared nurses. Our chief

quality officer is a master's prepared nurse, as is our vice

president of human resources in training. So we have allowed

nurses to come in to the board room table and lead the effort

within the organization.

     The reliability theory, all of these are a mile deep;

we could take a week on each one of them. Learning how to

prevent errors before they occur, learning how to identify

and mitigate errors as they are occurring so there isn't

harm, and learning how to redesign whole systems so that

they're more reliable and consistent. This is just a close-

up example of one of our teams. It lists the number of

people who were involved in an ICU redesign project; you

certainly can see the physicians who are listed there. There

are several key nursing positions that are listed there. We

have learned to put an implementer on every team so that

during the three months of their work, they hear the various

solutions that are generated and they can help people

understand what might be implemented and what might not work.

We have a nurse educator on those teams, we have a nurse

champion on those teams, and we have a nurse implementer

working on those teams. This is a graphic of our Medication

Safety Project, which was one of our Robert Wood Johnson

Pursing Perfection grants, and it shows a significant

reduction in medication errors over the term of that project

and we continue to maintain less than a 0.5 per 1,000 rate of

harm for medication errors.

Ventilated-required pneumonia is recent work out of

the 100,000 Lives Campaign with the IHI. We've now gone 22

months without any patient developing pneumonia on a

ventilator in our intensive care units, and all of that is

based on quality work from those committees for that redesign

team that I shared with you.

Does it work? It certainly works for us in the

demonstration project. This is a listing of the top most

expensive hospitals in the state of South Carolina. There

are about 65 hospitals in the state of South Carolina. We're

the fourth largest in terms of budget, people, programs, and

services; yet we're number 38 on that list with regard to

cost. So we believe our quality efforts over the last couple

of years have had dramatic improvement. We have been able to

reduce costs. Just for example, the ventilator-acquired

pneumonia adds $40,000 to the cost of taking care of that

patient. So if you can prevent that patient who is on a

ventilator from developing pneumonia, you have the

opportunity to reduce length of stay, reduce costs, and

improve the mortality opportunity for that patient. Thank

you.

   ED HOWARD: Thank you so much, Rob. Our last, but

not least speaker, as they say, is Regina Berman who heads up

Performance Improvement Services for the Hackensack, New

Jersey University Medical Center. She is a nurse by

profession and training herself. She has been at the Medical

Center for seven years and has steered it to Quality New

Jersey Governor's Awards, also based on the Baldrige criteria

and, like McLeod, an award for RWJ for the Pursuing

Perfection initiative. Hackensack, with Regina's leadership,

is another big winner; in fact, maybe the biggest winner in

the CMS Premier Demonstration Project, so we're very pleased

to heave her with us.

REGINA BERMAN, R.N.: Thank you very much. I'd love

to just piggyback on some of Rob's comment, because I think

that a lot of the outcomes that we have both been able to

enjoy really did start with an early work and commitment

through the Pursuing Perfection grant and the Robert Wood

Johnson Foundation's capability there. Thank you.

The underlying concept as part of that grant was to

transform healthcare, which was quite a large order, but also

to look at really making the commitment to defect-free care.

I think when we do that in the environment of applying

evidence consistently, which Rob so nicely described, you

start to lay the foundation for your stability in your

publically reported outcomes and those things that have been

selected for pay-for-performance. So I think the link of

those activities is very important, and the trajectory of how

that occurred is very important.

For Hackensack, there are just a couple of items I'd

like to tell you about us. We're currently a 781-bed

facility that grew from a 12-bed facility. So we all have

our origins and most of them are very humble. Right now

we're the largest provider of healthcare services in Bergen

County, New Jersey. We're just 10 miles outside of New York

City, so our largest competitor groups, if you will, from a

market share standpoint are the large academic medical

centers in New York City: Columbia, New York, Cornell, Mount

Sinai, NYU, et cetera. So we are not the only player in town, if you will, so our CEO, John Ferguson, who has been at Hackensack for 20 years, made a commitment many, many years ago that quality would be a distinguishing factor for the organization, and I think every decision made throughout those 20 years has really looked at service and quality as a distinguishing factor. The point I'm trying to make is that it's not something you start when you're forced to do it, but its part of your leadership model, and I think that's a very important distinction. I think, very consistent with a lot of the Baldrige work, that we make reference to the Malcolm Baldrige program which is, as you know, a government-based program. Leadership, development of leadership strategy is the primary initiative of those developments. If you live with them, you then go down to the impact on the workforce and ultimately on your results. They cannot be separated. We do enjoy 90-percent of our medial staff being board certified. I think that is a very important and compelling piece of our success. We're the second organization in the country to be provided with the Magnet Distinction for Nursing and have been re-certified three times since. That, we think, has been a long-standing success factor in our retention efforts for nursing and some of the autonomy that nursing has had in Hackensack for a long period of time.

Rob showed you the CMS Demo results for the first year; I thought I would add for you the second-year preliminary results that we have. Again, based on the preliminary results, we have achieved top decile in 4 out of 5 case types, hip and knee being a little bit of our nemesis, but I think the important piece of this slide is to see, if you would just look at hip and knee, the first year second-decile performance was achievement of a rate of 93.85; that was our rate. We did not make top. That's a pretty good number. Most people would be happy with 90 or better, but that in now way was top decile performance. For year two, we're once again second decile, and I think we missed it by about 0.1-percent or something. But at a rate of 98.09-percent we are still second decile. When you talk about moving the bar and raising the bar, this is what's happening in this project; everyone is getting better. That's the good news. I think the bad news is that you become obsessed with defect. That may not be bad news totally, but sometimes you can get distracted by them also. We just need to realize that this is not a fixed number that you try to achieve and once you arrive, you've been there; this is a moving scenario. I think improvement across the nation needs to include some type of moving scenario and the bar always being raised. The other numbers we have on here, Rob mentioned reliability, I think both organizations are very committed to

looking at reliable systems and processes and 10 to the -2

basically is about 2 defects per 100; 10 to the -3 would be 2

defects per 1000. It's sort of a modified Six Sigma. In all

the reports that we give to our staff, to our board or

anyone, we include those numbers so we can say, "Yes, we have

a high grade, but our process still is not highly reliable."

Or, "It is getting highly reliable." I think that's a very

important distinction to consider because it's not only the

number. What we've tried to avoid as part of our approach is

chasing the number, but instead really understanding where we

are at any point in time and keeping in mind that defect-free

care is our overriding principle. It's very important for

the workforce to understand that you're not chasing a number

for the money, and you're not chasing a number for the wrong

reason, and that you're not chasing the number, but that

you're trying to do what's appropriate. There are times when

withholding an intervention might be more appropriate than

providing it and there needs to always be a balance in that

regard.

        I have here for you a couple of slides about

different paradigms in quality because I think it gets

confusing when people talk about the concepts of misuse,

overuse or underuse verus outcome process structure. I think

we've heard references to each of them today. Then of course

with the IOM reports the dimensions of care: safety,

efficacy, patient centered, and timely. What I think you
need to do is look across those and horizontally take the
most important components of them. I will go quickly, but I
think that's an important foundation. I don't think there is
cookie-cutter approach that you can apply; we have to see
what works. We began with structure and creating a very
important infrastructure in the organization that supported
quality initiatives. It began with the use of small
multidisciplinary expert teams, a rapid-cycle approach, which
was a baseline Deming. But I think the most important piece
that was a breakthrough for us was creating multidisciplinary
rounds where you really had partnerships at the unit level
among all caregivers, be they physicians, nurses, or
ancillary providers. You have to have a common lexicon and a
common way to align your care on any given day that then
includes the patient's component of that care.

     Moving along, one of the things that we found was
important was developing unit-based score cards and having
line-of-sight for the staff so that they knew at any
particular point in time where they were. I think the
constant learning from failures and allowing an environment—
Oh, I'm sorry this slide did get it. We thought this was the
one that was absent. That's just an example of as you do
your interventions; the staff gets to see each intervention,
what the plan to check that cycle was, and what impact it

had. I'll show you some examples later of those tools.

Learning from failures, I think from this slide the most

important piece is that we do expect the staff to constantly

use tools and methods that help to promote quality and that

you need to have an environment of safety briefing and safe

ability to say what did not go right so that you can then

correct it. I think that has been a major breakthrough.

The next slide, basically you'll all recognize this

from *Crossing the Quality Chasm* and the *Simple Rules Through*

the 21st Century, I put in because under the new rules, those

highlighted areas are some of the aspects that we focused on

in order to get started. Customizing care, which I think

Jack referenced, is a double-edged sword because it takes

tremendous resources to do that, but it's also an important

pivotal component for the social aspects, as well as the

efficacy.

The next couple of slides show you examples of how we

integrated in those IOM dimensions, our aim or promise to the

patient and then how we planned to try to focus across the

continuum of care. Just to go to some of the previous

comments made, on this particular example, access to care for

chronic conditions and ensuring that patients understand what

happens post hence and self empowerment so that they know

what to do when they leave the hospital, who to call, and how

to have easy access; those are very important components. So

while we are an acute care facility, the rest of the aspects

are really that much more important. The MDR rounds, to go

back to that for a second, I listed for you the goals.

Basically, again, our model was to integrate in the IOM

dimensions, thinking that those are the components for the

21st century and that we really have to find models to live

with through them. We did a little bit of an internal study.

As we deployed MDR rounds, we did find there was variability

at the round level and we found that there was variability in

the outcomes, and we tried to study that to find out what the

difference was because the model was the same. What we found

based on the CMS Demo measures and the unit-based score cards

where we were looking at where defects occurred and why the

occurred was that those units that were really the best

performers and had the lowest levels of variances were mostly

clustered units where they had a homogenous patient type,

such as cardiac, they constantly saw cardiac patients,

therefore they were able to take care of them very

efficiently as a second nature, and intuitive sense was

applied very quickly. A failure-to-rescue scenario was

rarely occurring because you could see a problem coming and

intervene very quickly. So early recognition and early

intervention was what was promoted in those clusters. When

we got down to the mixed Medicaid-surg units, we found that

because there was an infrequency of any particular case type,

the workforce was unable to organize around all case types so

they needed additional and different tools and techniques.

We actually created tool kits for those units. If you have a

patient with an MI, here's your order set and here's what you

need to do. You have to do different things in different

places, and I think that was some of the learning.

The elephant in the room, if you'll indulge me for

this next room, is a very important concept. I think it's

greatly misunderstood. You hear it chronically referenced

that the documentation wasn't there, or the documentation

wasn't good, or it's not a quality issue, it's a

documentation issue. I think there is a lot of confusion and

a lot of concern. I think the point that we have to

understand is that since almost all of this reporting is

based on clinical documentation and often on abstracted data

and administrative data sets, you have to realize that the

physicians and the nurses write in clinical terms and they

have an algorithm in their mind that they are describing and

writing to. The coding staff, who are working with a set of

principles, but not necessarily the same, are really

extracting that information in diagnostic terms; they don't

always match. The algorithms, the mental models don't always

match, so what you do wind up with are sometimes elements

that are just disconnected. As we expand for pay-for-

performance, we do have to work on the lexicon and bridging

some of those gaps if we're going to stay with some of these

rankings. If we're going to look instead at individual

thresholds, I think we can get someplace else. So one of the

approaches we committed to was accurate capture and exchange

of information at all portals. Regardless of what your job

is, it became everyone's accountable situation to make sure

that we had the most complete and accurate information.

We've put forth a lot of alignment programs according to

documentation and coding.

The next one, and I know we're just about out of

time, is the data distinctions. I think this is an important

one for policy going forward. If you look at the right lower

corner, if you really want to improve, you really need

prospective information or information that is readily

available to you so that you can act and react to it,

especially the staff. But the price of getting that is high.

If you want to have real-time information available to you,

it's a high price; however, the upside is that you have a lot

of accuracy and reliability and you can tend to deal with

disconnects is a more real-time manner and avoid a lot of the

back-end rework that usually occurs. I think this is

important because many of the models that we've been told

have failed in the past tended to use either the completely

retrospective model, post-hoc analysis where you're really

trying to understand something that happened a long time ago,

and it just doesn't necessarily have the analytics or the

relevance that one would need. So I just offer that as a

concept. The next slide, of course, just basically

reinforces that if you want to improve, you need to have

real-time notion of where you are at any given point in time.

Horizontal integration, I think, is very important.

This is mortality, referred to earlier as the ultimate

clinical outcomes, and I just want you all to have access to

this to realize that we use the AHRQ indicators for patient

safety to monitor much of this, and I think if you are not

looking across scenarios for those multiple tasks that Jack

referenced that the nurses have to look at, you have to have

some sort of visual model or context for them to work within;

otherwise it's just one more number, one more topic, one more

scenario. I think if we furnish the appropriate tools and

analytic capability at the front end, we have found most of

our success is that the staff has what they need in order to

make the next right decisions.

The next few slides are just examples for you about

what those analytical tools look like. Finally, the most

important one from my standpoint is these, which are the

current public reporting initiatives that we are involved in.

One of the dilemmas we have is that the board will say,

because they all have different comparators and different

pools of data, "Well, are we good or not?" Because in some

we're the top decile, in some we're the top quartile, and in

some we might be at the mean or the median. It's very

dependent on the comparative group you're using. In the

state, for example, the more local you get when you're

dealing with low volume, high volume, et cetera, we might be

in the median of a particular therapy, as opposed to like

hospitals. So I think there are just some cautions that have

to be understood about what we select, how we compare it, and

then what we're reporting because if we want the boards fully

engaged, we need to give them something to react to in a

simplified manner. I think we can end with that. Thank you.

   ED HOWARD: Thank you, Regina. We are now in Q&A

mode. I would invite any of our panelists, if have a comment

in response to something they've heard since they spoke, to

throw in at this point. They'd be welcome to do that. I

want to make sure that Sue is involved in this as well. You,

of course, have access to microphones in either half of the

room and the green question cards that you can use to write

the question and hold it up, and someone from the staff will

grab it from you and bring it forward. We have somebody at a

microphone that is prepared to ask a question. I'd ask you

to identify yourself, and I'd ask all of our questioners to

be as brief as possible so that we can get as many questions

covered as we can.

BEVERLY COLEMAN-MILLER, M.D.: My name is Dr. Beverly
Coleman-Miller. I am an internal medicine physician and a
bachelor's degree nurse. I am curious about Six Sigma; I
heard it mentioned in passing and I'm just wondering, as I
look at them transform their quality assurance from the Jack
Welsh [inaudible] into the healthcare arena, whether any of
you have approached it or whether you've approached it and
negated it as quality assurance that's not appropriate? I
have a real quick second question. It sounds like Medicare
and Medicaid just kind of thought about nurses after the
fact; we've been multitasking for 1,000 years and I'm
wondering whether that can't be part of our measurements.
Multitasking is the natural order for nurses.

ROB COLONES: About GE's methodology, which was the
precursor to Six Sigma, many of the statistical tools that
are in Six Sigma are also in what we use currently. It
worked for us, so we stuck with it. We are also using lean
principles and learning more about that as well. So I think
its several tools in the toolkit that broadens our
understanding of what to apply, whether we're working to
prevent an error, whether we're working to identify and
mitigate, or whether we're working to totally redesign a
system. I think, in my opinion, neither one of them is more

important. They're all important as tools to use in the

toolkit.

ED HOWARD: Jack, do you have a comment?

JACK NEEDLEMAN, Ph.D.: Yes. When we looked at the

hospitals and the Transforming Care at the Bedside

initiative, which is a funded project by Robert Wood Johnson

Foundation to try to improve the performance of med-surg

nursing units and improve the work environment for the staff

including nurses in those units. We've got a number of

different hospitals, and they're using a variety of different

methods, Six Sigma and some lean methodology. I think the

critical thing here goes back to something that Regina

alluded to, people need to have a common way of talking about

their common problems and whatever methodology people adopt

is a vehicle for giving them a common way of talking about

what problem we're trying to solve and what our tools are for

achieving that. It's a teamwork-building component and has

been very valuable in terms of allowing for the

multidisciplinary work that nurses, physicians, the unit

clerks, and the housekeeping staff together are trying to do

on these units.

BARRY STRAUBE, M.D.: My reaction, too, is in prior

lives I've been involved with Six Sigma as one of multiple

parts of the toolkit, as Rob was alluding to. I think at CMS

we're not so focused quite yet on the methods in the toolkit.

We are involved with that through our Quality Improvement

Organization Program where we're trying to bring different

methodologies to various providers that they can use. I

still think our main problem is that the healthcare industry

is still not used to measuring quality of care. So before we

jump into how we fix it, we still have to answer some very

basic questions about how we measure the quality of care, how

we do it with the least amount of burden and the least amount

of resource use in order to get that information. How valid

is it and to whom does it apply? There is a long, long list

of questions that we still haven't fully answered, but the

biggest hurdle that we've started to jump, I think, is that

people are finally starting to collect, analyze, and report

data. That's the most important thing to us. It's been a

pet peeve, I suppose, of mine that in any setting that I've

been at, hospital or physician level, health plan, I was a

vice president for quality improvement for a large national

HMO, and now at the federal level for the major federal payer

of healthcare, nursing gets kind of forgotten and put off to

the side. Yet, it's key and core to all of the settings that

I mentioned up there just as much as physicians, if not more

so. Part of this gets back to the payments systems we have

and how we're going to develop these pay-for-performance

programs given the payment systems we have. Right now we, in

Medicare, recognize that our payment system is one of the

most perverse, if you will, in terms of alignment of payment

for reward. We reward a doctor or a nurse or whoever who

does very, very good care and keeps people out of the

hospital, yet the patient who comes in who has a very, very

long hospital stay with many complication, premature

discharge, readmission to the hospital, we pay for all of

that in spades. The people who work in those settings don't

always share in the cost savings. So as we reform the

payments system in each of the settings, we also have to

figure out how we can incent people who are on the cutting-

edge line but aren't getting the payments that we're getting;

we have to maybe insist that it be passed onto other people.

So a lot of questions to answer.

        SUE HASSMILLER, Ph.D., R.N.: We have some questions

from the audience with the nursing themes. I think, Barry,

you answered one of the questions that has to do with CMS and

nursing integration.

        BARRY STRAUBE, M.D.: Sue, if I could just add on

nursing and this supplements what Jack said; we're very

concerned about staffing, particularly in the nursing

staffing area. We haven't really gotten our arms around that

or addressed it adequately, but we do have a number of

special projects that are being done through the QIO program

looking at staffing turnover at hospital and nursing homes in

particular. I think we need to increasingly look at that.

SUE HASSMILLER, Ph.D., R.N.: Okay, and that's what

the cards would indicate. So this question is for Rob. It's

probably a two-part, and I'm going to try to integrate a

couple of these questions here. I think in the diagram that

you showed, your key principles, if nursing is so important

to the multidisciplinary team and leadership, why isn't

nursing leadership one of those key design principles? What

changes, if any, were made in regard to nurse staffing as you

addressed quality in your own organization?

ROB COLONES: Each of those six core processes that

we think are important are a mile deep, and you could take a

week on each one. When we talk about improvement

methodology, when we talk about prioritization, when we talk

about executive leadership, nursing is at the table with us

making those decisions. Each Tuesday, we spend about four

hours with a variety of people. Most of the room is nursing

helping us look at the data, analyze the data, and pick the

opportunities for improvement. It's just hard in just a few minutes to explain that; but if you were in our shop, you would see a significant amount of nursing involvement in that whole prioritization and project selection. And then in the actual three-month cycles that we run, we have a care manager, a master's prepared clinical nurse specialist, who is our black belt, our content expert, in our quality methodology and he or she, as a nurse, helps that physician leader drive that three-month cycle all the way through.

SUE HASSMILLER, Ph.D., R.N.: And what kind of retention efforts are going on inside your hospital that you might relate to quality improvement?

ROB COLONES: In South Carolina, we have about a 13 or 14-percent nurse vacancy rate. At McLeod we're about 2-percent. So we're doing much better than the state average. Nursing retention was one of our quality efforts in our ways that we worked on and made some significant improvements in keeping it [inaudible].

JOSH SEIDMAN, PH.D.: Mine falls onto this question, so it fits right in. I'm Josh Seidman from the Center for Information Therapy. Given Dr. Needleman's comments for the third point that current pay-for-performance systems do a

poor job of targeting improvements in the core work of

nursing and also the work that RWJ sponsored at Wagner in the

chronic care model that demonstrates the critical importance

of engaging patients as partners in care, I'm wondering what

measures you think pay-for-performance systems should use to

reward nursing impact on patient engagement? And sort of as

a followup to that, what are the data sources that we need

for that, which I think is a question about the use of

patient-reported data?

     JACK NEEDLEMAN, Ph.D.: I was afraid I was going to

get that question. It's easy to criticize; it's hard to

design. I think there are a couple of basic principles. One

is as I noted, a lot of measures that we have that we

associate with measures of nursing performance are outcome

measures. For a variety of reasons, we might want to think

about including some of those in the measurement set. The

big challenge for doing that is risk adjustment. The

advantage of process measures is that the patient who needed

it either go it didn't, and there is no risk adjustment

involved. So we have to think about what kind of mix of

outcome and process measures we want to use in adjusting our

payment systems. In terms of nursing process, clearly there

are other measures that we need. When I mentioned the

National Quality Forum Initiative, one of the big missing

gaps that the NQF committee felt was there was pain

management. I think if we could develop a good process

measure for pain management, which would require looking day

after day at the needs of patients about whether it's

assessed and whether it's controlled, we would get a long way

to measuring how much time and attention nurses are able to

deliver to patients not just for pain, but across the variety

of tasks that nurses have to do for individual patients. If

we take that as an example, one of the real challenges is the

ability to access the day-after-day records from processes.

I think one of the things that's going to make a big

improvement in our ability to measure what has to be measured

is the development and extension of electronic health

records, electronic medical records, in hospitals where we

can begin using them as databases to compile detailed

information on the whole process of care, not just fixed

endpoints.

        REGINA BERMAN, R.N.: I'd like to just add to that.

I referenced the AHRQ patient safety indicators, for which

there are very, very clear technical specifications, and we

are able to get them out of our clinical data systems, so we

look at decubiti, nosocomial decubiti, falls, failure to

rescue, some of those things that Jack referred to in his

research that really are directly related and nursing teams,

as well as the multidisciplinary teams, respond to that data

constantly.

JACK NEEDLEMAN, Ph.D.: Regina's comment just

reminded me of something. She noted that she and other

people in her hospital were putting together flow sheets and

check sheets around specific conditions. Those check sheets

become the vehicle for monitoring what care was needed and

what care was delivered. You can integrate both whether care

was delivered with a common order set of what care might be

appropriate for this patient. So I think in the short run,

we have some paper-based systems that will allow us both to

improve care and can serve as a vehicle for monitoring

whether or not care is at the level where we want it.

BARRY STRAUBE, M.D.: From the federal perspective to

your question, I have already alluded a little bit, on

nursing incentives, since we don't pay nurses directly under

Medicaid or Medicare, nor do commercial payers generally,

except in some circumstances, we probably have less impact

right now. But that's something that I think people who pay

salaries and bonuses to nursing staff ought to be thinking

about. I think, however, to address this from the patient

perspective, this is a very important area. A couple of

things, you may remember that on the slides that I put up

earlier one of the key components of many of our

demonstrations has to do with trying to reenergize the

concept of doctors, nurses, and clinicians working with

patients as a partnership and as a team. As an extension of

that, there are ways that we can potentially incent or

involve patients with this whole pay-for-performance process.

One is, first of all, in our development of the structure of

premiums, deductibles and co-payments. I know this is

happening in the private sector, and we've talked a little

bit about ways we might do it in the Medicare and Medicaid

programs. But there are some private payers and PPO programs

in particular who are waiving co-payments or reducing co-

payments or deductibles for those patients who actually

adhere to certain treatment regimens and other advice that

their clinicians are giving to them. That's one way of doing

it. Another indirect way, and again, this is all emanating

from the White House, the secretary of HHS and Mark

McClellan, our administer, is this transparency approach.

We're making all of this information on quality and cost and

pricing available to all of us and then able to use that

information. One example would be where we go to get our

care. So if you have a bad-quality provider and patients

know about it, they don't go there; they go to somebody else.

Volume and the revenue stream can indirectly drive or promote

quality in that way. Of course there are other things; all

of you who are involved with statute development and policy

development, which is going to be debated and discussed very

much this year, is the Administration's proposal to promote

health savings accounts. Whether you agree or disagree with

the general concept, the general concept would be trying to

put money in consumers' hands, give them information to make

choices about how that money is spent on healthcare, and

empower those people to change healthcare by putting their

dollars where they think the best care is given. So those

are three examples.

        SUE HASSMILLER, Ph.D., R.N.: This question is from a

member of news organization and I guess it's for the panel.

If more expensive, more well-trained nurses and more of them

curtail adverse outcomes, that is, cut business, why would a

for-profit hospital even invest in more and better nursing?

[Laughter] For the news media.

        BARRY STRAUBE, M.D.: It all depends on how you're

paid. If you're paid per admission, as CMS does, and those

better-trained nurses are shortening length of stay and the

payers don't come back and try to recapture the savings of

the shortened lengths of stay by cutting the rates, than the

hospital has gained the funds. If you're paid per day, as

many smaller insurance plans are still paying hospitals, and

you cut the length of stay, than the insurer gains that money

and the hospital has to go negotiate back with the insurer on

why they should get paid more per day since they have been

instituting plans that save money. This issue of incentive

alignment is a central one in any of these systems and it

needs to be examined and kept in mind closely.

     REGINA BERMAN, R.N.: I will say that that's the

business case for quality; do you, by putting more resources

and a rigorous program in place, give yourself the yield you

need? When we looked at that, we tend to run a very, very

high census. We have in the past month been at 99-percent,

which is almost impossible to manage. But one of things we

did is we know that we replace those patients; we're not out

recruiting them, but people come. More people come so

efficiency has not hurt us in any way. Efficiency has helped

us. We applied APN, Advanced Practice Nurses, as part of

this work to work with disease-specific categories of

patients such as cardiac, heart failure, pneumonia and some

of these issues where we actually had people looking across

the organization, licensed independent practitioners who

either had a collaborative agreement with physicians or

functioned as an augmented resource to the nursing staff with

the idea of helping to spread the knowledge. What we found

is that it's an expensive part of the workforce; they're

highly skilled, licensed practitioners. Some of them can

bill for their work. We mostly did not take that tact

because we used them as part of the workforce instead, and we

did not want the physicians feeling as though they were

competing with their payment options, so we just kept it as

part of the salary expense. But what we found was that the

efficiencies were 10-fold, that the return on that investment

was great, that we were able to get into some of those

patient-centered approaches, we were able to work on the self

empowerment pieces for the patients so that when they got

outside, they knew much more about self management,

readmissions went down dramatically in heart failure, and the

length of stay and cost per case went down dramatically. So

I think there is a business case that's supportive. It tends

to be very clear in the chronic care model, but I'm not sure

we have the answer across the board.

     BARRY STRAUBE, M.D.: I was just going to take this

one step further. We've talked an awful lot about the

measure that we will reward in pay-for-performance and

whether or not they're nursing sensitive, but Jack's

observation about the need for payment alignment would lead

one to examine what kind of payment mechanisms there are in

these various initiatives, including the ones at CMS and

Premier, and how they're structured in a way that does or

does not make them sensitive to the criteria that you're

developing that would be sensitive to nursing inputs.

ED HOWARD: Here's what you're measuring and

rewarding and how you can structure the reward. Med PAC says

that 2-percent should be a pretty good incentive for

hospitals to change their behavior. The National Health

System in Great Britain has followed a reward for general

practitioners of 30-percent total compensation. Somewhere in

that range there is a mechanism that would be ideal for

helping us target the nurse-sensitive measures.

BARRY STRAUBE, M.D.: I'll take a stab at that. To

be honest, we have not focused on nursing up front. I've

listed the five areas we've focused on at CMS in the Medicare

and Medicaid programs, and I think to a large extent for the

commercial payers it's been the same way. So I think we have

to address that and there are many other clinicians involved

including physician's assistants, technicians and all sorts

of other people who are part of this system that we probably

ought to be thinking about. I think your question, though,

does raise some other things we haven't talked about in pay-

for-performance considerations. First of all, do you pay for

the top performers as we're doing currently in Premier

Hospital Demonstration? Or do you pay for anybody who makes

a significant improvement over their baseline? The argument,

if we just do the top performers, is that there may be some

people because of geographic location, their own business

case situation in a local area, or commitment to their

administration, who will never be to get in the top 1 or 2 or

10 or even 20-percent of performers. But they may go from

being in the bottom decile to the fifth decile; that's a

significant improvement. Should that be rewarded or not? I

think that's important. I think the other thing has to do

with amount. But I've already mentioned that in the hospital

setting 0.4-percent took us from 10-percent to 98-percent, at

least in terms of reporting, so small amounts do make a

difference. In the Premier Hospital Demonstration $8.85

million in the first year was paid out. That may be a lot of

money, but when spread out over a lot of hospitals, it's not

such a large amount. So what's the right incentive amount?

Some people do say numbers, particularly for physician

offices, you might have to get up in the 20-percent range in

terms of an incentive to make a change. I think we have to

struggle with all of these issues.

Finally, in terms of the methods, regardless of the

amount, in our demonstrations we have a variety of methods.

It can be a straightforward bonus, as in the Premier

Demonstration, where if you get in a certain range, we will

pay you a bonus on top of your base payment. Other ones are

set to a capitation method where you pay a flat fee and if

you have savings, you get to keep those savings. Other

methods where there'll be populations treated, there are cost

savings, and the people involved may be able to share a

percentage of the cost savings. So there are many, many ways

to structure this. I think we still don't know how to

distribute it to all of the people involved, what the

appropriate amount of incentive should be and what the

vehicle is to do that, and how much it should be.

 ROB COLONES: I think this is more about a beginning

to the line incentives of different providers to come

together to create standardization of care. This is not

really about money. The raises next year in our system will

be $9 to $12 million dollars; this is a 3 to 4-percent raise

for people. The $200,000 to $500,000 from the Demonstration

Project doesn't make it available to distribute and even put

a dent in that $9 to $12 million raise, but what it does

begin to do is it begins to allow us to standardize. We're

talking about 13 orthopedic surgeons who trained in 13

different places and have 13 different ways of doing

something and trained across 30 different years; it's

maddening for the nurse to implement 13 different protocols

to take care of her patients. Standardization would help

greatly. There are many benefits beyond just the actual

funds received. The issues with flow and the peaks and

valleys in demand are big stressors on nurses. If we can

attack that issue through performance improvement, we can

make a big difference. The goal is to begin to align

incentives and get people to make the real changes that are

needed. I don't think any of us think that a lot of money is

going to be coming from Washington to pay everybody a lot

more money; it's about redistributing what is available.

        LISA SUMMERS, CNM, DRPH: My name is Lisa Summers.

I'm with the American College of Nurse-Midwives. I actually

came to the microphone when the comment was made that CMS

doesn't directly reimburse nurses which, of course, generally

is true when you're talking about hospital-based nurses, but

I wanted to make the point that CMS does directly reimburse

advanced-practice nurses, nurse-midwives, nurse

practitioners, nurse anesthetists. Regina's comment about

the APNs in her institution to some degree answered my

question about how you see the role of APNs and their value

in the system. I really appreciate her comments. But I also

wanted to point out, with regard to CMS, that in the very

early days of discussions about pay-for-performance I know

many of the groups of APNs, the MPs, the CNMs, the CRNAs,

very much wanted to be a part of that discussion. I would

just encourage you as you continue to develop this to think

beyond the role that physicians play because that group of
providers is playing an increasingly important role in
healthcare and I think has proven to be a very cost-effective
group of providers.

   BARRY STRAUBE, M.D.:   I'll respond.   Again, I hope
I've made it clear that my own personal feeling is that I've
relied on nurses my whole entire career; I couldn't have
survived in my career without nurses, not only as assistants,
but as educators to me when I was a medical student and so
forth.   We do pay nurses.   I think we're struggling with
limited resources; we have to start in big dollar areas, but
can't forget the nursing piece.

   BOB GRIST [ph]:   Bob Grist with the Institute of
Social Medicine and Community Health.   We've been talking
about quality as if hospitals all have the same level of
resources, technical skills, uncompensated care and all the
things that we know vary tremendously within our healthcare
system.   How does the pay-for-performance methodology address
the inequalities that the hospitals bring to the table when
they're trying to improve quality?

   BARRY STRAUBE, M.D.:   I'm not sure I get the question
entirely?   Could you just talk about little bit more?

BOB GRIST: I was reacting to the fact that even in the IOM report on *To Err is Human*, it didn't focus on inequalities among hospitals that contribute to the variation in quality. By bringing the best examples of hospitals to our panel here and saying, "Look, we can even improve over what we did last year," I'm wondering if we are addressing the inherent inequalities in the healthcare delivery system, or whether we're just going to be furthering the gap in performance by rewarding the hospitals that are most effective.

JACK NEEDLEMAN, Ph.D.: Good point. I was trying to get at that a little bit in my comments in terms of whether we reward just the top performers, many of them who have benefits to begin with, which almost guarantees that they're going to do better than other people, as opposed to developing a system where even the people who are at the very, very bottom of performance, if they can demonstrate improvement, we would reward them also. My own personal bias is that we have to do a bit of both. We have to reward the top performers, but I'm leaning a little more myself towards rewarding anybody who has some improvement, as long as they initially are at least at a basic minimum standard. I don't think we should allow the persistence of people who are

giving inadequate care, which we can all agree that is just
not acceptable. It's interesting; the Premier Hospital
Demonstration is 260 hospitals including large hospitals,
small hospitals, rural hospitals, urban hospitals, academic
medical institutions, and community institutions. I think
the takeaway from that demonstration is that there was
improvement among all of those types, regardless of where
they started. We didn't talk about Premier Demo as a
negative takeaway after the second year to those hospitals
that don't meet some basic performance on that. If they
don't get that, they'll have negative payments taken away
from them under that demo. We're hopeful, as I think the
Premier groups are too, that they'll all get above that
baseline minimum. Be that as it may, there are still certain
hospitals, hospitals with large disproportionate hospital-
share payment systems, rural hospitals, hospitals in the
inner cities, all sorts of hospitals that start off at an
extreme disadvantage, and I think we have to keep trying to
address that disadvantage they have and bring them up.

     ED HOWARD: We have time for one more question I
believe, during which time I would ask you to pull out your
blue evaluation forms and fill them out. Yes, sir?

TODD KATCH: I'm Todd Katch; I'm with the American
Health Quality Association. I think tied into this question
is the idea that not all hospitals have the same sort of
resources available in them. I think the nurses in the room
would probably acknowledge this, especially in a smaller
facility you have a nurse who is responsible for admitting
patients, triaging, assisting the physicians, and at the end
of the day trying to do an extraction and then lead a quality
improvement effort? These people are overburdened as it is
and it's hard to find time, as I understand it, to go out and
look for the resources. "What are the best ways to improve
upon my aspirin rate for heart attack patients? I want to
improve it, but I don't know what some of the best practices
out there are for getting me to that next level of
performance." So how do we help those people? I will say
that I represent the Medicare Quality Improvement
Organizations and certainly that's something that they're
doing every day, but I would ask the panelists how important
is to have that opportunity to have sharing among your peers
to learn what the best ways are to do it? Dr. Straube, in
particular, whether it's through the Quality Improvement
Organizations or through other mechanisms that CMS is
thinking about, how do we further encourage that kind of
dissemination of best practices so that we lift all boats?

REGINA BERMAN, R.N.: Can I make a comment? I think there are a couple of points. One is that I know part of the commitment in this Demonstration Project was for the sharing and learning so that everyone benefitted. I think on of the reasons we saw the results of everyone benefitting was because that was built in. I think that's an important component. I can tell you, and I'm sure Rob will verify this, that as two of the hospitals that are called upon frequently, it does become a yeoman's task or quite a burden to continue to do that. We probably get 15 or 20 calls a day. We have had requests for site visits. Part of our commitment with Pursuing Perfection was transparency and was to help with constant sharing and learning. So we've done that, but it's at a tremendous expense from a resource standpoint. We keep doing it, but it gets harder and harder and harder because as this has grown, we have hundreds and hundreds of hospitals trying to do that every day. So that's one piece of it. I think the other component where you spoke about the nurse doing all of her direct patient-care tasks and then trying to do data extraction, I think that may be a workforce model that has to be looked at, because the commitment for the work with Transforming Care at the Bedside is to really keep that special skill set with the patient and to try to take away those other elements that distract or detract from that that. I know in our organization we have

built it into the information management infrastructure;

we've made a firm commitment not to make the nurses the data

folk. But we've also made the commitment to keep the data in

front of them constantly so they can use it, react to it, and

do what needs to be done to improve it. Thanks. [Laughter]

     BARRY STRAUBE, M.D.: First of all, Todd's comment,

and I've mentioned the QIOs a couple of times, the Quality

Improvement Organizations that we have, I think, are a very

key part from the federal standpoint of trying to give

technical assistance and helping all providers of healthcare

to do better. I've inherited a program that has been heavily

scrutinized in the last year or more, and indeed people are

questioning as to the amount of expenditures that go into

that program, what comes out of it? I would say in defense

of the program first that $1.2 billion every three years for

the QIO program, which amounts to about 0.1-percent of

Medicare expenditures. Most private companies or payers of

healthcare contribute 1 to 2-percent or more of the total

dollars that go into premiums et cetera for quality

improvement purposes. So in fact, again, for those of you on

the Hill, I would remember those figures. Federally we are

putting 0.1-percent as opposed to 1 to 2-percent into quality

improvement on the federal level. That works out to about

$10 per Medicare beneficiary per year for quality

improvement, which is arguably not a large amount. On the

other hand, $1.2 billion is a huge amount of money, whether

it's 0.1-percent or more, and I think we are challenged to

demonstrating that the efforts that our QIOs do put into

quality improvement do, in fact, lead to a significant

improvement. I can assure you that we're very much focused

currently and over the next several years on doing that. But

I do believe that QIOs are very important. There are other

players here though. I think that the health plans have a

responsibility to perform the same kinds of improvements and

they have been over the years, some more than others, and we

should recognize that and encourage it going forward in the

future. The employers are increasingly coming up with more

dollars to fund issues like this, and we should encourage

that and insist on it. In addition to formal technical

assistance, such as the QIOs and the other people I've

mentioned, I think the way is the formation of large

national, regional, and local collaboratives where people can

leverage their resources and determine the best and most

important tasks to focus on and the best way within that

local, regional, or national perspective to deal with it.

        The last thing I want to say is something we haven't

talked about this afternoon, this whole business of pay-for-

performance. We did talk about it a little bit in terms of

patients and how we can get them involved, but one of things

we haven't talked a lot about has to do with our choice of

metrics and reimbursement schemes and whatnot. The question

that arises is, is that what patients want? Do they care

about some of the quality measurements that we have that

we're paying these large dollars of money to improve upon?

Indirectly they do, but most patients want to feel better,

get better, and feel like they're being taken care of. I

think they have a somewhat different perspective than we have

as policy makers, payers, and healthcare workers. So I think

as we're devising these pay-for-performance methods, we have

to keep going back to patients, and we all are potentially

patients, and asking them what they want. There have been

some national studies and surveys looking at this. In fact

and not surprisingly, many patients will answer the question

of whether they think their hospital or doctor or whatever

should receive extra money for doing a good job, the majority

of those surveyed as patients will say, "No, we think they

should be doing a better job for the money they're already

getting." I think that then leads also to what the metrics

are that matter to patients and what do they want to know

about?

        ROB COLONES: There is a business case for quality,

even though a pay-for-performance system may or may not be

there. There are savings that are real from doing this work

that free up dollars to do other things, and you don't need

to always have a lot of extra resources. The ventilator-

acquired pneumonia initiatives are available on the internet

through the IHI web site with no cost to us other than

meeting time to implement those standards, and that was about

$640,000 in savings in two years by having no ventilator-

acquired pneumonia, so it doesn't always take extra computer

systems and people to do the work.

        JACK NEEDLEMAN, Ph.D.: I'd just like to share a

couple of insights from the Transforming Care at the Bedside

initiative that relate to the question that was asked. First

of all, one of the things that we heard Regina and Rob talk

about was the creation of systems that work. What we've seen

in many, many hospitals, particularly around the systems that

nurses work in are systems that regularly fail and then

nurses have to compensate for the system; they are basically

work-around cultures that the nurses are living in. One of

the big changes we're talking about here is moving from a

system of a work-around culture to a culture of improvement

where system failures are fixed rather than lived with day

after day. That's a real shift in front-line staff

perspective that can be hard to come by. One of the real

challenges in that is answering the question, "I haven't go

time to do my job today; where am I going to find the time to

do this extra work?" So part of it is thinking about how we

structure this work to build the system improvement into the

data-to-day work of the nurses that are there. The hospitals

that are here seem to have built some success there and the

Transforming Care at the Bedside hospitals are working on

that set of issues. Many of the hospitals have found

additional staff resources, whether it's in their performance

improvement process, buying some overtime, or buying some

additional shifts to give people some flexibility in the

short run to work on the issues of system improvement. In

the long run, those may well pay off in terms of not needing

the staff down the road because we're simply not doing as

much work around and as much fixing things, but in the short

run, those resources may be necessary. The second thing

we've seen in the Transforming Care initiative is the very

powerful role of learning from one another. One of the real

benefits that hospitals cite from the work that they've been

doing in that initiative is the ability not just of the

performance improvement people and the leaders to get

together with the same people at other hospitals, but also

the front-line unit managers and the front-line stuff. We

need to find ways to stop having our learning from

organization to organization go up the ladder to the top

level, across, and then back down. We need to find ways, and

I think Transforming Care and some of these other initiatives

provide some models of finding ways to build the lateral

connections between front-line staff and different

organizations, the unit managers and truly the front-line

staff to build the skills, build the commitment and learn

from one another what works.

    SUE HASSMILLER, Ph.D., R.N.: I just want to say once

again how much I appreciate everyone coming out. As with any

very good panel, this has given me a lot to think about as I

move forward with our agenda at the Robert Wood Johnson

Foundation. I would just say that you have given me many

more questions at this moment than I have answers, so thank

you for that.

    ED HOWARD: Let me add our thanks to the Foundation

staff and the Alliance staff who had the yeoman's duty of

putting this briefing together. Thank you for your

commitment and your attention during this, the Foundation for

the support of and sponsorship of this briefing, and thanks

also to our panelists. As Sue said, I think we've had a very

thoughtful, very useful discussion. I ask you to join me in

thanking them. [Applause] Thank you for filling out those

blue evaluation forms.

    [END RECORDING]