PERSPECTIVE

We Can't Reward What We Can't Perform: The Primacy Of Learning How To Change Systems

Patient need, not medical supply, must dictate care.

by Karen Wolk Feinstein

THE PIONEERING WORK of John Wennberg and his Dartmouth colleagues has served as a model for the Pittsburgh Regional Healthcare Initiative (PRHI). This coalition of hospitals, clinicians, health plans, and major corporate and small-business association purchasers uses risk-adjusted outcomes databases and constructs clinical data registries to improve outcomes in five areas of clinical practice. The coalition also seeks to eliminate medication errors and nosocomial infections and has put in place common patient safety reporting and shared learning platforms to reach its goal of zero. Finally, to apply its learnings with precision at the point of patient care, the coalition has launched experiments with scientific method-based, problem-solving approaches (the Toyota Production System, or TPS) in hospital units.

The paper by Wennberg and colleagues invokes evidence of unexplained variation in the processes of care across the country; reimbursement levels from Medicare that do not correlate with patient outcomes; and utilization patterns that correlate with the amount of delivery system infrastructure, rather than morbidity, to constitute a rationale for both the evidence-based medicine movement and constructive rethinking of national health care policy. Wennberg and colleagues suggest that Medicare could do more to support providers, institutions, and regions that are committed to providing just what each patient needs, when they need it, without error or waste.

For obvious reasons, we at the PRHI strongly support federal investment in community demonstrations to systematically apply and measure the tools of informed, shared decision making; evidence-based medicine; patient safety; and system improvement in patient care. Federal agencies should organize to participate as active learning partners in these demonstrations, jointly and systematically investigating the policy implications of experiments to deliver best-practice care to every patient. To date, there has been virtually no federal investment in such demonstrations and no organized, coherent approach linking policy development to "on-the-ground" experiments.

However, here is a caveat. Wennberg, a pioneer in evidence-based medicine, indicates through his paper that our health care providers lack a framework to systematically apply error-free best practices with anything like the precision we demand in aviation or nuclear power or even the production of automobiles. Removing financial disincentives and adding new rewards might provide momentum over time to improve providers' performance. Alone, however, they will fail if our health systems do not know how to fundamentally restructure their process of delivering care—a process that must be painstaking, deliberate, and circumspect.

Karen Feinstein is chair of the Pittsburgh Regional Healthcare Initiative and president of the Jewish Healthcare Foundation.

Enacted too hastily and prematurely without support and direction for time-consuming process improvement, payment directives could actually impede real improvement in performance. In the meantime, health care providers must acquire the capacity for sustained improvement of care, and Medicare must develop a capacity to measure actual performance. This requires introducing reimbursement incentives in the right context and sequence. Ultimately, if the needs of informed patients—including their values and preferences as well as medical contingencies—become the organizing principle for health care, patient- and not payer-derived directives will remove overuse, underuse, and misuse of medical services on their own. Let me explain.

In the Pittsburgh region we have evidence that providers are prepared to undertake the demanding process of care improvement. They are engaged right now in installing the databases, training care teams, and experimenting with new process improvement strategies in which patients' needs dictate every intervention. This infrastructure is essential if we are to capture and understand real performance improvement and build on it continuously.

Locally, we rely on principles derived from the TPS model to demonstrate how health care teams at the point of care reduce cost, error, and overcapacity. When teams deliver only the care the patient needs and approves, supply no longer dictates care. When reimbursements are "pulled" by best practices and only to support the needs of an individual patient, institutions will lose money trying to sustain unneeded capacity. Wennberg's solutions respond to a current condition in which patient need is not the organizing principle of providers and insurers. The key is to engage all stakeholders in the elimination of waste from error and poor quality through clinical excellence. Therefore, we propose that the Centers for Medicare and Medicaid Service (CMS) embed the Wennberg demonstration in the following context.

■ **Encourage flexibility of regional models.** Allow each region to customize its own approach to perfect, efficient care delivery based on patient need. While the categories outlined by Wennberg and colleagues are fundamental, the demonstration would benefit from encouraging and measuring the relative efficiency of different strategies based on common goals and outcomes.

■ **Invest in and support infrastructure to improve the system.** The 30–50 percent potential gains in the efficiency of health care that have been documented in the PRHI's early stages are not possible without support for institutions that install and aggressively apply critical platforms and tools for informed, shared decision making; patient safety; and evidence-based medicine. These demonstrations will require the CMS to (1) provide financial incentives for infrastructure investments, possibly tied to the coming Medicare payment adjustments; (2) test new Medicare standards for patient-centered platforms including those necessary for an electronic medical record; and (3) measure carefully the costs, savings, and outcomes of units restructured for clinical excellence.

■ **Relax counterproductive policy directives.** A primary example of these are the proposed Health Insurance Portability and Accountability Act (HIPAA) regulations, which frustrate health services research and evaluation.

■ **Continue federal experimentation.** Disclosures of patient outcomes by institution, modeled on Medicare's dialysis center outcomes data project, should be launched only in areas where data can be clearly interpreted and protected from gaming and where the painstaking, multiyear "buy-in" from clinicians and institutions regarding the legitimacy of the data has been achieved.

■ **Introduce appropriate sequencing.** After all of the above steps have been taken, federal experiments tying "bonus payments" to prescribed levels of performance should be implemented. However, the CMS must stringently prevent the gaming of the system. This will probably require reliable Medicare and state data tracking systems and the full cooperation of all participating providers.