

# ROUNDTABLE

## BUILDING A BUSINESS CASE FOR QUALITY HEALTHCARE

*HEALTHLEADERS* CONVENED A PANEL OF EXPERTS TO DISCUSS THE BUSINESS CASE FOR AND AGAINST QUALITY INITIATIVES IN THE HOSPITAL. AN EDITED TRANSCRIPT OF THE DISCUSSION FOLLOWS.

The basic economics of healthcare don't necessarily jibe with the rules that are the nature of other industries. In manufacturing and any service industry, the quality of the product and the cost of creating that product are the X and the Y that equal success. In healthcare, there are certainly punitive business consequences for poor quality—liability and market share drain, among a few. And there are some demonstration projects from the Centers for Medicare & Medicaid Services to reward quality, along with some payor-based pay-for-performance programs. But do these add up to the seeds that will create a true business case for healthcare quality in the near future?

### Panelist Profiles



**JIM MOLPUS**, editor of *HealthLeaders Media*, served as moderator.



**MAUREEN SPIVACK**, managing director in the healthcare practice for UBS in New York, N.Y.



**THOMAS BARTRUM**, a partner in the healthcare law practice for Waller Lansden Dortch & Davis of Nashville.



**FRANÇOIS DE BRANTES**, national coordinator for Bridges to Excellence in Washington, D.C.



**DANIEL VARGA, M.D.**, chief medical officer for Norton Healthcare, Louisville, Ky., and president of the Kentucky Medical Association.

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# Roundtable Highlights

## State of Expectations

**JIM MOLPUS** (Editor, HealthLeaders Media): *Dr. Varga, could you tell us the extent to which your hospital's quality initiatives are inculcated into the operations of the hospital?*

**DANIEL VARGA, M.D.** (Norton Healthcare): In March of 2005 we launched the *Norton Health Care Quality Report*. Right now it displays just shy of 400 indicators that are on our Web site. You go to NortonHealthCare.com, and right in the middle of the home page is a big Q. Click on the "Quality Report" and find anything you want to find out about how we perform clinically.

**MOLPUS:** *Norton Healthcare is somewhat unique in the extent to which quality indicators are tracked and reported. Why?*

**VARGA:** People criticize hospitals and doctors for being late to the table on this. One of the reasons they are late to the table is because there has been a hyperfocus on outcome reporting instead of process indicators. The problem is that "outcome" is a multivariate scenario, even when you're talking about an episode of care in a hospital. What the consumer should expect from one of the hospitals in the Norton Healthcare System is that if you have a diagnosis, you should want to know how frequently we do all the right things for you. Outcome depends on your genetics, your socioeconomic level, your race and ethnicity, and a whole host of things. What you should absolutely require of a hospital is that we do all the right things for you with a very high level of reliability.

**MOLPUS:** *Every strategic decision made by the hospital is mapped out by the financial impact over a number of years. They're tracking ROI of a CT scan for the next five years and how that impacts market share. Do qual-*

*ity initiatives have the same place in a hospital's financial plan?*

**VARGA:** Right now, for most health systems and hospitals, quality is in the embryology world; it's a little vestigial flipper that sits on the side and nobody is really sure why it lives there. I would tell you very bluntly that Norton is doing this as a component of stewardship. Right now, I don't believe Norton Healthcare sees the quality initiative yet as something that is a business imperative.

**MOLPUS:** *How does performance on quality indicators wrap into the hospital's financial picture? Maureen, when you go into a hospital's books to assess a deal, does quality show up in the CFO's spreadsheets?*

**MAUREEN SPIVACK** (UBS): About 85 percent of the hospitals out there are not-for-profit hospitals. This is a highly capital-intensive business where they are very much tied to the tax-exempt

bond market for financing all of their capital expenditures. Quality is something that people want to know about.

"Most of the problems that hospitals have are self-inflicted and stem from the belief that revenue is more important than profit margin."

—François de Brantes

However, if I'm a tax-exempt hospital, I'm dependent on obtaining the best credit rating because that's going to influence the cost of my debt. It's very simple. I think that the credit agencies want to check off that "yes, you're a part of the quality system. You are participating in the pay for performance and the various other quality programs that



**JIM MOLPUS**  
Moderator  
HealthLeaders



**MAUREEN SPIVACK**  
*Managing Director*  
 UBS

are out there.” But the bottom line is that rating agencies want to understand what are your centers of excellence, utilization, profitability and anticipated market share over the competitor so that they can make judgments on your longer-term viability and give you a credit rating that reflects that.

**THOMAS BARTRUM** (Waller Lansden Dortch & Davis): Quality has a much more negative impact than positive impact. Low quality is going to affect your credit rating. But there’s sort of an assumption there that hospitals do not receive an increased rating for better quality.

**VARGA:** Somebody who is rating the financial health of a hospital would probably rather see that they have a disproportionate market share in cardiovascular or orthopedic surgery, independent of the quality that they produce in those service lines. Across the street there may be another hospital that treats a predominantly med-surg population that lives in the top quality performance decile. This hospital has a low-reimbursing case mix but is delivering incredible quality. But the first hospital has all the business that pays very well.

### Word from Washington

**MOLPUS:** *Are there any indications that changes from Washington could change the reimbursement equation to one that is more favorable to quality performers?*

**VARGA:** There’s been some Centers for Medicare & Medicaid Services stuff recently that may be telegraphing a punch that’s coming nationally, and that is the reweighting of DRGs that could redirect the way hospitals are structured in the value—or lack of value—of certain service lines. There is this AHRQ-funded study that came out of Dartmouth that looked at expenditures at the end of life measured against outcomes. The study shows that CMS has spent some 33 percent of its budget for treatment in the last two years of life for no improvement in outcome. (CMS Administrator) Mark McClellan is a really smart guy. The best way to spend 33 percent more of your budget is to kind of draw a line across here and say, “I’m going to reweight my DRGs so that we are not readmitting chronically ill patients over and over again in the last two years, but we will give providers an incentive to get into the disease-

management business and so forth.” So I think there’s going to be a business case for it in fairly short order.

**SPIVACK:** More than 20 years ago in my first master’s (Health Planning) program, I took a health planning course and the professor discussed the fact that 80 percent of the healthcare that is consumed is consumed in the last 20 percent of one’s life. Nothing’s changed. Consumption patterns for healthcare remain the same.

**MOLPUS:** *Thomas, are there any other indications that the government is starting to demand the bang for the buck in the way it spends its healthcare dollar?*

**BARTRUM:** There is on occasion. CMS has launched a couple of demonstration projects that have actually paid out. So you can look at the numbers last year and see that one particular hospital did rather well. But what they didn’t tell us is how much they had spent to get that level of quality. So you are seeing some CMS payments, but the

“If you have to be accountable for a body of work and your operations can’t efficiently deliver that work, then you’ll either get out of that work or you will figure out how to deliver the product.”  
 —Daniel Varga, M.D.

question becomes, are they really putting the money in that’s causing readjustment? And a problem with CMS’ paying and regulation policies is that they start at the least common denominator, based on the fear that something will go wrong or that fraud will be committed. These safeguards may really tie both hands of the provider when they look to get creative on quality.

**MOLPUS:** *But is CMS really going to get into the marketplace and pay top performers more?*

**FRANÇOIS DE BRANTES** (Bridges to Excellence): Go back to the Balanced Budget Act of 1997, which was really an attempt to create some market discipline and take some inefficient hospital providers out of the marketplace. Politically it's very unpopular, and Congress has gone back again and again and given money back to the hospitals. Well, if CMS got serious about quality, they could pay quality hospitals higher. They could cut and let the market take care of poor-performing hospitals, but politically that is very hard because it comes down to the individual case and its impact on local residents. If your community's hospital is failing, you call your congressman in that district and he responds.

## Perverse Incentives

**MOLPUS:** *Hospitals are paid for episodic care. For quality to ever make business sense, incentive realignment must happen. What are some of the first steps to realigning incentives?*

**DE BRANTES:** You really need a couple of ingredients. The first one is to understand that the cost of change is very significant and requires an incentive offset. The challenge on the private sector side is that there's still a belief on the part of health plans that one can design a program that's slightly different than the other and hope to have an impact. You end up with lots of fragmentation on where the incentives are focused. There's a little bit of change and hope in that area because of the work that plans have been doing around (consolidating) the quality measures. So at least for 35 or 40 measures, it's a beginning. But in the end, the lack of consensus from plans means providers just can't

get to enough incentives to be able to compensate for the cost of change. The second ingredient is that you need a mix of positive incentives and market share shift.

**MOLPUS:** *Why is that important?*

**DE BRANTES:** Without market share shift, you don't get to the crux of the financial analysis Maureen laid out, which is about the long-term viability of the facility. If we can demonstrate to credit underwriters that the lack of focus on certain quality measures or outcomes is going to cost the facility good market share in the profitable service lines like cardiac and orthopedics, credit scores will be impacted by poor quality, and therefore a facility's cost of and access to capital will be significantly impacted.

**MOLPUS:** *Aren't hospitals limited in their ability to influence payors on the measures they include?*

**DE BRANTES:** My counsel to providers is that you have got to stick to your own guns and force plans with whom

you contract to take nationally accepted outcome measures. We talked a little bit about hospital funding streams, and I guess they're like junkies on the funding stream they have now. Prying them out of that is just going to take something huge, some sort of fundamental shift in the way they're compensated. Quality is just going to be talk, and the incentives are never going to realign if hospitals have a business case for ignoring quality.

**VARGA:** François just kind of summed up the revenue side of the equation, but I think where hospitals really miss the point on quality is that they don't fundamentally think about the way they operate their enterprises as being directly tied to the product they produce. On an assembly line in a car factory, the way that the assembly line works is directly tied to the product that rolls off at the end. People look at that both from the standpoint of the quality product coming off and the efficiency with which they deliver that product. Hospitals are using 21st century technology, and we're all building



**FRANÇOIS DE BRANTES**  
National Coordinator  
Bridges to Excellence



new buildings, but all we're doing is plopping a 1960s operations model inside a new box with new toys and we wonder why everybody's margin is still the same. By focusing on how much more revenue we can get out of an insurer or the government, we keep missing the fact that our expense base keeps rising, in large part because of the fact that our operational model is old and inefficient.

**DE BRANTES:** Recently, I was with a group of physician leaders from different medical specialty societies. One of them was from Michigan and remarked that the healthcare industry is very similar to the big three automakers in the way they think. Healthcare has never adapted to a different environment. While the healthcare industry doesn't have the competitive pressures that the big three automakers have, most of the problems that hospitals have are self-inflicted and stem from the belief that revenue is more important than profit margin, because they don't necessarily think in terms of profit margin. They have a very poor understanding of true fixed costs versus variable cost. Most of them do not understand what a sunk cost is, and they're plodding along much like the big three autos—and driving to pretty

much the same probable outcome unless the industry finds a way to reshape itself. The fact that the hospitals are struggling to deal with two issues at the same time—people calling and asking for pricing, which they can't provide, and then figuring out how to consistently deliver good quality care—is indicative of an industry that's stuck in the past century as opposed to a vibrant, efficient, effective one producing 21st century care.

“In healthcare, I see organizations that are not necessarily creating value but are surviving by the sheer fact that we all age and come down with diseases.”

—Maureen Spivack

### Pressure Points

**MOLPUS:** *Where are the pressures to create a business case for quality going to come from?*

**BARTRUM:** I think really until you see CMS step up and do more of the

demonstration projects, or maybe the reweighing of DRGs, that we will not see a start to the process. Until you see that type of activity, I think you're just going to have piecemeal pay-for-performance programs from the payors. But if you really want national change, CMS is going to have to lead this.

**DE BRANTES:** I get nervous about CMS tinkering too much with the system because they haven't been very successful in the past, so there's no real reason for us to be optimistic that any widespread reform guided by CMS is going to be successful in the future. I'd rather have them do smaller things instead to inform all of us on what could work. On the other side, there ought to be more willingness on the part of the private sector payors to innovate.

**VARGA:** My argument—and it's a minority argument inside organized medicine—is that we have screwed up and continue to screw up by not being at the table, by not leading this. We clinicians have been obsessed with the perfection of the indicator and the perfection of the attribution methodology as opposed to saying there is a right way to do most of the stuff that we do day in and day out. Because we've left a void, a lot of other people have come into the void. Clinicians should be driving a lot of this.

### Consumer pressure

**MOLPUS:** *Consumer-driven healthcare has the potential to create pressures necessary for substantive change in quality if you believe that consumers are going to select, investigate and compare, make the right decisions, and thus enforce on the system a discipline that the system has not been able to generate. Are we really going to get to a critical mass where enough consumers are out there demanding quality?*

**SPIVACK:** The relationship between consumers demanding and receiving qual-



**DANIEL VARGA, M.D.**  
*Chief Medical Officer*  
 Norton Healthcare

ity is directly related to information. In certain disease categories—cancer, for example—where there is such a wide disparity of outcome, consumers seek more individual information to make informed decisions. In that disease area, consumers are driving delivery of care because they have, and they want to have, much more knowledge and information. However, the desire for information is not consistent across all of healthcare.

**VARGA:** It's one of the real questions there. And your example around cancer is a model for what can happen. If you look at the concept of breast-sparing surgery, you do lumpectomy with tamoxifen or lumpectomy with radiation and get the same result as a modified radical mastectomy. All of that was consumer-driven, and by that I mean that it was advocacy driven. Consumers said they would prefer to not have a mastectomy if they can get the same outcome. And now, in fact, one of the indicators for breast cancer is the percentage of surgery in your institution that is breast-conserving. So consumers can drive a big chunk of not just quality of care, but how you care for it.

**MOLPUS:** *When we talk about the cost of going for quality, it's not like this is a capital expense that will come in a definable line on the budget. How do hospitals look at this when assessing business priorities?*

**VARGA:** Hospitals take an approach to say, "you know, when our margins get better we'll add quality on. Or if somebody throws a pay-for-performance program out there, then we'll make a change." The real barrier to getting true high-reliability, high-quality healthcare delivery is the fact that there is such a gulf between what we should expect from hospital care and the way hospital care is operated. I think it's more of an operational issue than it is anything else.

**MOLPUS:** *To build a business case for anything depends on getting the price right. Are hospitals working pricing into their quality plans?*

**SPIVACK:** Hospitals have so many competing priorities. We have this "quality initiative." But at the same time, hospitals have to cope with the requirements of consumer-driven health plans, such as better information systems and staff training to support it. Employees need to be able to consis-

tently and correctly answer consumer questions about pricing. Access to and understanding of pricing for specific services is, at this time, a significant organizational challenge.

**BARTRUM:** But in the process of that transparency—in other words, to create that price—isn't it inherent in the hospital to go back and do the analysis? What does it cost to deliver that service? What is everything that happens in a total bill?

**DE BRANTES:** They have no idea.

**SPIVACK:** Agreed, they have no idea. That information is not uniformly and consistently available across all diagnoses. So it's not comparable to another hospital, so it could be meaningful to the consumer. I call your hospital and you tell me the cost of a service is \$22 and then I call Thomas' hospital and he says it's \$350? What did the consumer really ask for, and how do they compare the two choices?

## Future Business Case?

**MOLPUS:** *We have discussed why there is no consistent business case for quality today. Do you see that changing anytime soon?*

**BARTRUM:** I think there is reason to be optimistic. We've witnessed so much momentum in the past three to four years in how you measure quality, how you compare quality and how you deal with the fragmentation and delivery services in the healthcare system. One thing we haven't talked about much today is the fact that we're seeing pay for performance for physicians, and we are seeing pay for performance for hospitals, but we're not seeing a lot of integrated pay for performance. That's where we really have to go. Are you getting the most efficient, highest quality of care being given by the most appropriate provider of that care? And I think until we move there, we're going to con-

tinue to consume so much of our healthcare dollar in the last phase of life. We really have to figure out a way to integrate the providers of care so that

“I think until you see CMS step up and do more of the demonstration projects, or maybe the reweighting of DRGs, that we will not see a start to the process.”  
—Thomas Bartrum


everybody’s moving in the same direction for efficiency, quality and, ultimately, to provide a good service.

**VARGA:** I see more stick than carrot. I think that it strikes me that the revenue opportunity for quality is relatively small given the overall nut. Somebody can throw a few pennies into the pot for that, but I think the real business case for quality lies in transparency. If you have to be accountable for a body of work and your operations can’t efficiently deliver that work, then you’ll either get out of that work or you will figure out how to efficiently deliver the product. And I think that the business case for quality at a hospital level has usually been looked at in two questions: Will you give me more money if I do X? And can I avoid certain cost if I do Y? It’s never really gotten down to the point that you will go out of business if you can’t deliver a level of performance that is a direct by-product of the way you run the train. Hospitals that look at that business case proactively have an enormous economic opportunity, not only for the redirection of market share and everything else based on quality performance, but also looking inside and finding there’s 10 percent or 15 percent waste inside the system because of the way you work, and

there’s no value to the redundancy. If you’re a \$6 billion system and somebody says you’ve got 15 percent waste laying inside, your margin just went up.

**SPIVACK:** I am optimistic that we will create a business case for quality, but the one caveat that I would have is that healthcare is not like any other industry in the sense that if it doesn’t achieve quality it will go out of business. The thing that I know is that every one of us will be a day older tomorrow than we are today and that, unfortunately, given statistics, we are going to come down with diseases. In other businesses, we would be talking about creating stakeholder or shareholder value. But in healthcare, I see organizations that are not creating value but are surviving by the sheer fact that we all age and seek care from a convenient provider in that community. I think the business case for quality is one that ultimately creates value for hospital stakeholders.

**DE BRANTES:** During this entire conversation we have made the point that the healthcare industry continues to

survive despite its inability to deliver good quality and value to its customers. If the fight to consistently deliver greater value to customers exists in all other industries, why doesn’t it exist in healthcare? There are clearly a lot of institutional barriers around that. I think most of them are solvable by just focusing on the two changes that we know are coming. One is transparency and the other one is incentives. You really need both of them for markets to function effectively. On the transparency side, clearly there’s a lot of momentum that’s going to continue very strongly in the next few years. And on the incentive side, it will be a combination of things—the way Medicare pays for care and private sector programs like Leapfrog’s. And then there’s the growing impact of the consumer-directed health plan wild card. So I’m cautiously optimistic on all these fronts, and a lot of what happens next for hospitals will depend on how they want to react to these changes: whether they want to be in the driver’s seat or the co-pilot seat, or whether they want to wait it out and hope it all goes away. 



**THOMAS BARTRUM**  
*Partner*  
Waller Lansden  
Dortch & Davis