



October 4, 2007

Contacts:

**Harold Miller, Strategic Initiatives Consultant
Pittsburgh Regional Health Initiative (412) 803-3650**

**Karen Wolk Feinstein, PhD
President and Chief Executive Officer
Jewish Healthcare Foundation and the Pittsburgh Regional Health Initiative (412) 594-2556**

**Maulik Joshi, DrPH
President and Chief Executive Officer
Network for Regional Healthcare Improvement (410) 829-6252**

National experts and regional coalitions call for healthcare payment reforms

Although healthcare reform is at the top of the national agenda, most of the current debate focuses on coverage for the uninsured when an equally serious problem is the high cost and unreliable quality of health care. A group of 100 healthcare leaders from across the nation convened by the Network for Regional Healthcare Improvement (NRHI) agreed that one major cause of cost and quality problems is that current healthcare payment methods penalize hospitals, physicians, and other healthcare providers who deliver the highest quality, most efficient care. They called for changes in the payment system.

NRHI convened experts at an invitation-only *Summit on Creating Payment Systems to Accelerate Value-Driven Health Care* to propose options for restructuring payment practices. The conferees proposed new payment methods and recommended that they be tested through regional demonstrations. They rejected marginal pay-for-performance bonuses that many insurers use to encourage practice improvements as insufficient to incentivize major care improvements in an inherently flawed payment system.

A summary of their conclusions and the new payment models they proposed have just been published in *Roots*, a special publication of the Jewish Healthcare Foundation (JHF) and the Pittsburgh Regional Health Initiative (PRHI), a founding member of NRHI. JHF, the Commonwealth Fund, and the California HealthCare Foundation funded the Summit. The full report on the Summit findings is available on NRHI's web site, <http://www.nrhi.org>.

“Our current payment system is one of the chief culprits behind the high cost of health care and it’s also responsible for many of the quality problems,” said NRHI President and Chief Executive Officer Maulik Joshi, DrPH. “As we move toward the presidential primaries, these findings should weigh heavily in any discussion of healthcare reform.”

Under the current reimbursement system, physicians are paid fees for each service they provide and hospitals typically receive lump sums for every patient admitted or readmitted. As a result, the incentives of health care are weighted toward the number of services delivered, not the quality. Mishaps that result in additional need for treatment, such as infections contracted because of hospital stays, can even mean additional payments. Because of that, improvements in the quality of care often financially penalize doctors and hospitals by diminishing the number of services patients need or reducing the need for hospital care. Similarly, physicians often are not compensated adequately for the time-intensive care and counseling involved in preventive medicine or optimum treatment of patients with chronic illnesses, such as diabetes and high blood pressure.

“We need to improve the quality of care to control costs,” said Karen Wolk Feinstein, PhD., who serves as Chairman of NRHI and is President and Chief Executive Officer of JHF and

PRHI. “Without payment reform, quality improvements are doomed to be anecdotal in nature and glacial in pace.”

Summit conferees proposed payment reforms for several broad categories of health care, including preventive care; care for patients with chronic illnesses such as diabetes, asthma, and high blood pressure; major, acute conditions such as heart attacks and strokes that come on suddenly and require hospitalization; and end-of-life care. The proposed payment methods were designed to shift the incentives of care toward the best, evidence-based practices of medicine and improved outcomes for patients. For example, instead of paying physicians for each office visit from a diabetic patient, reimbursements might be restructured to provide periodic (e.g. monthly) Comprehensive Care Payments to cover all of the care management, preventive care and minor, acute services associated with the patient’s chronic illness. The payments would be based on specific diseases and on patient-specific factors, such as age, that are likely to affect the level of services required.

In addition to the conferees’ conclusions and recommendations, the edition of *Roots* in which they are published provides firsthand accounts from physicians about ways the current system of incentives frustrates their efforts to provide the best care or prevents them from improving substandard care. For example, a Pittsburgh physician who implemented a new model for treating diabetic patients, which has both improved outcomes and efficiency at a government-funded VA Hospital clinic, lamented he would be unable to use the same model in his university hospital-based practice because of private payment restrictions.

Roots also describes some innovative payment approaches, including a warranty on open-heart surgery at Pennsylvania’s Geisinger Health System and a change in reimbursement that helped Seattle-based Virginia Mason Health System implement a new, cost-saving protocol for treating patients with back pain.

The Geisinger and Virginia Mason experiments are examples of creative reform initiatives percolating around the country, including some under Medicare and Medicaid. Building on those, PRHI and other NRHI members plan regional demonstrations of payment reforms.

"Summit participants agreed that reforming payment systems will be challenging, but changes are essential in order to achieve efficient, effective, and sustainable improvements in the quality and costs of health care," said Harold Miller, the Summit Coordinator, who also authored the paper that framed the discussions at the Summit.

"Parties agreed that the next step should be a variety of regional demonstration projects to test the real consequences of innovations," Miller added.

The Network for Regional Healthcare Improvement (<http://www.nrhi.org>) is a nonprofit organization of regional, multi-stakeholder coalitions formed to accelerate improvement in the quality and value of healthcare delivery in the United States through reforms at the community level. Its members include: Institute for Clinical Systems Improvement; Massachusetts Health Quality Partners; Minnesota Community Measurement; Pacific Business Group on Health; Pittsburgh Regional Health Initiative and Wisconsin Collaborative for Healthcare Quality. It is supported in its agenda by the California HealthCare Foundation, the Jewish Healthcare Foundation and the Robert Wood Johnson Foundation. For more information about NRHI, contact Maulik Joshi, DrPH, President and Chief Executive Officer, at (410) 829-6252.