

Appendix 1

TOTAL VALUE OPPORTUNITY PROPOSAL – SENATE FINANCE COMMITTEE

CORE IDEA OF THE PROJECT:

The Institute of Medicine reports and a wide range of other studies and reports have highlighted things gone wrong in the U.S. health and medical care sector. The evidence consistently suggests that major improvements in patient outcomes and the health care status of Americans could be achieved while reducing costs by 30-50%. However, while there is a great deal of activity in response to these findings there is not much evidence of a significant improvement in patient outcomes, and cost increases continue unabated. Why?

Policy makers react to the aggregate evidence by seeking one or two major “levers” to radically improve the quality, safety and efficiency of care. But the problems of complex systems such as American health care delivery can not be solved by edict. At the local level, practitioners believe their error rates are small, regrettable but largely inevitable, within the national norms, and that they are under compensated and underappreciated for what they do. They are opposed to transparent identification and sharing of things gone wrong because of perceived legal risk. Many see waste and aggravation in things they are required to do – filling out insurance forms, for example -- but not many see opportunities for quality improvements and cost saving in things they believe they can control.

Both groups – policymakers and practitioners – would be guided toward more constructive action by the creation of a compelling “business case” for the application of

quality ideas and principles in the health and medical care sector by specifying and quantifying the financial value associated with:

- ❖ Errors (e.g., extended stays associated with wrong medications or wrong procedures. Cost of injuries to staff; lost work days and restricted work)
- ❖ All repair activity (e.g., time spent clarifying illegible or incomplete medication and other doctors' orders)
- ❖ All non-value added activity (e.g., time spent searching for needed materials - - medications, equipment, supplies)

RELEVANCE OF THE PROBLEM AND PROPOSED INNOVATIONS:

The current problems of safety, quality and waste in the American health care system directly harm tens of millions of Americans each year and indirectly harm the interests of every American. The failure of policymakers and executives to understand how to address safety, quality and cost problems should now be the central focus in this arena. Practical, powerful diagnostic techniques proven to speed radical improvements in other large, complex, high risk industries could be used to address this gap.

APPROACH AND METHODOLOGY:

Select and work with five high reputation hospitals to document the difference between current patient outcomes and cost performance and the potential results if the care process eliminated errors and the waste associated with system design inefficiencies.

Assemble a team of analysts with successful experience in using and deploying the ideas of systems analysis, six sigma, lean manufacturing, the Toyota Production System and activity-based costing. Over a period of twelve months, analyze all major pathways in the patient care process to produce the project objective.

INTENDED CHANGES IN HEALTH CARE:

To provide the operational facts that are needed to press for accelerated improvement in American health and medical care, by:

- Creating a greater public sense of urgency to change health care by showing specifically where value is being lost and providing a better set of tools to help the public understand how it might be accomplished.
- Providing health care executives a map of their core processes that highlights the problems that embed error and waste in the system, and provides targeted tools to help the executives eliminate those causes.
- Strengthening the will and fact base of policy makers and corporate purchasers to:
 - Overhaul reimbursement systems to successfully reward value creating care.
 - Recognize the areas in which well-intended rules and regulations are impeding progress toward safe and perfect care, and remove those impediments.

Healthcare Issue Brief: Transforming Medical Malpractice

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If the purpose of the medical malpractice system is to provide a powerful incentive for health institutions and providers to eliminate error, the system has failed. Based on Lucien Leape's scholarly work, over 300 million medication errors occur each year. The Institute of Medicine estimates that between 50,000 to 98,000 deaths per year are attributable to medical errors. There are countless other measures of total system failure including never-ending streams of falls, empty oxygen tanks, and unmet patient needs. These errors also have a steep economic cost, building rework and instability into the system and driving a substantial portion of the growth in health care spending.

When people who are injured are asked what they want of the system, the most common responses are:

1. To receive an apology for the harm that occurred.
2. To be told exactly what happened, immediately and with complete honesty.
3. To be assured that everything has been done to guarantee that the same problem won't victimize anyone else, and;
4. To receive full compensation for lost wages and medical costs.

Apart from failing to prevent harm, the current medical malpractice system fails to deliver any of these outcomes desired by victims of error. A simple analysis reveals why.

The malpractice system functions on the assumption that, if the punitive damages for harm are great enough, doctors, nurses, and hospitals will make every effort to avoid error. There are two fundamental problems with this logic. First, people working in health care are already doing everything they know to avoid errors, but the way the system is designed makes errors inevitable. Secondly, the people who are running health care organizations are functioning without the commodity they most need to solve these problems, information about the real root causes of these system errors.

The current medical malpractice system actually impairs the ability of health care leaders to offer patients the thing they most want, error-free care.

There is a rough parallel to this problem in the evolution of the worker's compensation system. By the early 1900's, thousands of workers were killed or maimed each year by industrial systems that were not designed for safety. As a direct result, businesses were bearing enormous legal costs defending themselves against numerous lawsuits. It led to a crushing insurance burden. Between 1911 and 1940, as the problem became a crisis for both workers and businesses, they agreed to legislative compromises in every state that addressed many of the system problems from a safety and a cost perspective. Government required employers to buy insurance to offset the economic burden of medical costs for people who were hurt and could not work through the workers compensation system. In exchange for this reduction in legal exposure, companies were required to share information about every incident so that all employers could avoid similar events.

We propose a similar system for medical malpractice, upgraded based on current learning and technology. The federal government (or state governments as an at-scale laboratory) would set up a fund to pay the economic damages for patients harmed by the health care system in exchange for mandatory reporting of everything gone wrong and systemic actions to remedy problems that could cause harm. In return for this protection from liability, anyone failing to report an incident would be liable in the regular court system for treble or quadruple damages. Reporting could take place in a national, real-time database designed to make it easy for anyone to share problems in the system with the potential to cause harm. Additionally, anyone could look to this database to learn from root cause solutions shared there.

This system would allow people to reduce the medical malpractice problem by preventing recurring errors at their root rather than focusing on the financing. Most importantly, this proposal would remove blame from the culture and free health care systems to expose and learn from their mistakes in the pursuit of perfect patient care.

The Value Capture Policy Institute is a non-profit organization dedicated to advancing state and federal policies that create the conditions for every human need to be met without waste or error. For more details on this proposal or to schedule time to learn more about how to eliminate medical malpractice, please call Geoff Webster at (412) 553-1197.

Appendix 3

washingtonpost.com

Truth in Medicine

By Paul H. O'Neill

Friday, December 24, 2004; Page A17

If the president and Congress want to accomplish something truly important over the next four years, how about this: a fundamental change in the playing field for health care.

I have a few suggestions. They are based on 40 years of work on health care policy and operations, including my current role as leader of a community effort in Pittsburgh to set the world benchmark for safety, quality and efficiency in health care delivery. My thoughts are also based on leading a major company, Alcoa, to become the world's safest place to work.

First, the government should create powerful incentives for medical care providers to immediately tell the truth about errors and poor outcomes -- tell it to patients, families and colleagues around the country. The purpose is not to punish but to learn rapidly from mistakes, something that is required in any high-risk, high-performing industry. The benefit won't just be safer, clinically superior health care but less expensive health care. Why? Because safety is realized only when organizations focus on their customers and constantly improve the quality and efficiency of the processes that serve them.

Today we don't report and disclose even the tip of the iceberg of things gone wrong in health care, dooming ourselves to repeat the mistakes, without ever rooting out the broken processes that are producing them in the first place. For example, the nation's leading researchers estimate that less than 1 percent of medication errors are identified.

To address the issue, we ought to have society assume the cost of things gone wrong, in the interest of creating a genuine learning system. Victims of errors would be paid fair compensation, and doctors would not have to pay for malpractice insurance. But if doctors didn't openly and immediately detail errors or poor outcomes to patients and to a national learning system, they would be subject to large, personal financial penalties or loss of license.

At Alcoa, the first principle I had to ingrain throughout the company was this: Every person was responsible for sharing details of things that went wrong, immediately, so that we didn't have to learn the same lesson over and over again. We are far from that standard in health care, but if we stop fighting the wrong battle over medical malpractice, we can get there. Our objective should be to get lawyers out of the medical system, not to cap the money they are taking.

Second, the president should appoint a commission with a tight deadline to redesign the health care reimbursement system with the goal of making it pro-patient. Today, in many

corners of even our most significant federal payment systems, we still pay clinicians and facilities for activity, not for the quality of the job they did for the patient. The way to use payment to drive improvement is beginning to emerge in a few experiments around the country, but the status quo will prevail unless the president puts his weight behind rapid change.

We also need a better map of how to achieve dramatic improvements in cost and quality. The federal government should start the mapmaking by commissioning a detailed, three-month analysis of the nation's leading hospitals to fully document not only the cost of errors but also the wasted time, effort and resources embedded in much of health care delivery. Such a study could be accomplished for \$10 million and would make the case for change in a management framework that couldn't be ignored. The team of experienced industrial engineers and health care leaders I work with in Pittsburgh has yet to encounter a health care process that could not provide higher quality at half the current cost.

That map can be brought to life if the government then joins with a single major medical complex that declares its intention to be the best in the world -- measured by objective data -- at every single thing it does. Across the American health care landscape, improved performance has occurred only in parts of organizations. When we have a place that's "done it," we'll have a model that others can see and learn from. We'll also have taken away the age-old excuse that "nobody's done it, so how can we?"

Apart from these federal priorities, the industry itself has its own set of solemn obligations to act on. The 30 to 50 percent of national medical care spending that is currently paying for waste and errors can be captured only through deliberate action at the local level. With the health care industry and the government playing their parts, hundreds of billions of dollars can be freed up. This would make it easy to solve the so-called "access" problem of uninsured Americans and still leave large amounts for other important needs.

The writer was secretary of the Treasury in 2001-2002.

COMMENTARY

Paul H. O'Neill

what health care can be an expanded role for financial leaders

Glimmers of changes to healthcare governance, policy, and financing are on the horizon. How can you be a driver of change?

AT A GLANCE

- > Patients should receive safe, high-quality health care.
- > Healthcare financial executives need to participate in problem solving, and one problem they need to take on is the structure of finance and payment.
- > There are no magic bullets. Healthcare financial executives should be champions of change.

In Pittsburgh and in other places around the country, we have helped hospital leaders perform thousands of hours of observations of nurses, unit clerks, custodians, physicians, supply clerks, and other front-line staff working. The story is always the same: Roughly 40 percent to 50 percent of the staff's time is spent on truly value-added work. About 50 percent to 60 percent is spent working around problems that occur and recur, day after day. In other words, 50 percent of the time and cost is wasted.

In a recent one-hour observation of four staff members at a fine health system, 81 problems occurred in meeting a patient's needs. For only one problem was a solution attempted that might have prevented it from happening the next day to the same patient and staff member, let alone others across the organization and the country. Only one problem was reported in the institution's formal incident reporting system, where it will end up as a data point on a monthly risk management report full of information that is not useful for understanding what happened or how to prevent a recurrence.

This is how we have designed the system. We have conditioned front-line staff to work around

problems rather than participate in solving them, and we have assigned quality and risk management functions to small teams of people who can't possibly support effective problem solving across the organization. We sit around in endless meetings with the wrong people trying to create and impose the wrong solutions. Does it surprise us that 50 percent to 60 percent of the potential value of your institutions' resources is being wasted every day?

How can you begin to capture that value? By restructuring approaches to problem solving and process improvement to involve everyone in the organization in three areas of activity geared toward solution:

- > Identifying everything that goes wrong
- > Rapidly investigating causes and implementing experiments as close to the front line as possible to prevent recurrence
- > Openly sharing learning

There are no magic bullets or secret solutions here, just models that have been proven to work in organizations that handle complexity and risk very well. As a point of comparison, Alcoa's 131,000 employees across 43 countries arguably work with much more risk in their industrial production environment than American healthcare workers. Yet today, their lost workday rate of 0.07 per 200,000 work hours is 27 times safer than the rate for the average American hospital.



Paul H. O'Neill serves as nonexecutive chairman of Value Capture LLC, Pittsburgh, which provides support for leaders of healthcare institutions who are determined to radically improve the safety, quality, and efficiency of their

care. He was a founding co-chair of The Pittsburgh Regional Healthcare Initiative. He serves as a director at the National Quality Forum, RAND, Eastman Kodak, and Celanese, among others. He is a senior adviser to The Blackstone Group, New York.

O'Neill served as the 72nd Secretary of the U.S. Treasury from 2001 to 2002.

O'Neill was chairman and CEO of Alcoa from 1987 to 1999, and retired as chairman at the end of 2000.

During that time, Alcoa became the safest corporation to work for in the world and increased its market capitalization by 800 percent. Before joining Alcoa, O'Neill was vice president from 1977 to 1985 and then president from 1985 to 1987 of the International Paper Company.

He worked as a computer systems analyst with the U.S. Veterans Administration from 1961 to 1966 and served on the staff of the U.S. Office of Management and Budget from 1967 to 1977. He was deputy director of OMB from 1974 to 1977.

Questions or comments about this article may be sent to him at poneillpa@aol.com.

What Can Healthcare Financial Executives Do?

What does any of this have to do with financial staff in hospitals? In most places, regrettably, not much. In my experience, people trained in finance and accounting are inclined to think in systems terms if they are permitted to do so.

Yet I know of no place in the nationwide health-care system where there is a full-fledged activity-based costing system that links costs to outcomes—work that can

and should be done by the financial staff.

When was the last time someone from the financial staff in your institution visited a medical floor for several hours to understand the near chaos of the work process and the things gone wrong, and developed

the authority of knowledge required to participate with the staff in designing a system for continuous improvement?

How many of your hospitals have a system that identifies every medication problem in real time and takes action to find the root cause? And does something about the root cause, in real time?

How many financial staffs have calculated the wasted money spent in dealing with illegible prescriptions and physicians' orders to target that waste for elimination? Some financial staff may need additional training to do this work, but others are already well equipped.

At one hospital, we helped the staff do an activity-based costing analysis of the inputs and revenues derived from patients who developed

Does it surprise us that 50 percent to 60 percent of the potential value of your institutions' resources is being wasted every day?

central-line associated bloodstream infections (CLABs) in their medical intensive-care units. Management had assumed that since these patients generated large outlier payments, the institution was at least breaking even on these train wrecks. The facts were that on a fully loaded basis, the institution had lost \$10 million per year on just three classes of infections, because the

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costs of providing the care far outstripped the outlier payments. They'd also killed 40 percent of those CLAB patients (that is, 17 people). Happily, we also helped them drop the rate of CLABs in their medical ICUs by more than 90 percent in 90 days, so these savings—human and financial—were not theoretical.

To emulate those results, healthcare leaders must begin to ask themselves these kinds of questions every day, and relentlessly act on them:

- > How do we know if we are getting each patient exactly what she or he needs?
- > How do we know if something we expect to happen doesn't (or something we don't want to happen does)?
- > How do we know if our people are able to solve that problem to its root?
- > How do we know if our people have made an improvement?
- > How do we know if they are able to learn from others—across the building and community and nation—instantaneously?

At a broader level, financial staff and their bosses need to take on the structure of hospital finance and payment. There is no other industry that keeps two sets of books as a matter of convention. Last year, Pennsylvania hospitals were paid 30 cents for every dollar billed—the exact level they expected. In my experience, asking a large segment of your employees to

Hospital CFOs should be the internal champions of moving toward well-designed pay-for-performance payment systems.

carry out a function every day that is a cynical fiction has a corrosive effect on an organization. If this is false, employees wonder, what else is? It also further obscures the ability of managers to effectively link inputs with outputs in their decision making.

Hospital CFOs should also be the internal champions of moving toward well-designed pay-for-performance payment systems. At too many hospitals and health systems, I hear rhetoric supporting a link between payment and quality of service, but then learn that the same leadership has negotiated fiercely with payers to take pay-for-performance off the table and arrive at a global annual expected budget based on increased case rates.

And I do not understand how healthcare financial officers can tolerate formal processes for mitigating the risk of lawsuits that are profoundly counterproductive. The current system of secretive peer review inhibits rapid learning from mistakes and symbolizes the dysfunctional structures and approaches to things gone wrong in health care.

We are seeing the glimmers of changes to healthcare governance, policy, and financing that will make it easier for financial officers to use their extraordinary training to drive the provision of safe, high-quality medical care.

It's helpful to me to think of problems like this in terms of first principles. The first principle of health care for me is that patients should get the best possible quality of care, and it should be absolutely safe. That means that when things go wrong, the "things" need to be exposed and learned from, immediately, so that they won't be repeated.

It turns out that despite physicians' and hospitals' fears of lawsuits, openness about errors is what patients want most. A growing body of research and experience at places such as the U.S. Naval Medical Center and Kaiser Permanente show that when something goes wrong, patients and their families want to feel like they've been leveled with, receive a full apology, and be assured that actions have been taken to prevent the same problem from happening to someone else. They are less likely to sue if they get those things than if they don't.

Financial Leaders as Champions of Change

The financial community might champion two policy changes to advance these concepts. First is the implementation of a "blame-free" error learning system that can help healthcare workers learn from errors almost instantly across the country (enabling legislation is stalled in Congress). Second is the creation of a genuine economic incentive under medical liability laws for caregivers to use the system. If mistakes are reported to the learning system and the patient within 24 hours of discovery, and prevention measures are installed within a week, payments to the patient could be limited to their economic damages with some basic adjustments for fairness.

Those payments should be paid by society, not healthcare providers. In other words, no malpractice insurance. (The workers' compensation system is somewhat of a prototype.) However, if an error isn't reported promptly to the patient and the national learning system, the provider should be subject to treble or quadruple damages. This suggestion is something of an inconvenience in the current political battle over medical malpractice, but I suggest it will lead to profoundly more benefit for your institution than any of the "solutions" currently on the table.

At the end of the day, the first examples of true excellence in American health care will be those institutions whose leaders make it crystal clear through their daily actions that they are determined to realize their values by ensuring that every staff person, regardless of rank or station, can successfully contribute to getting each patient exactly what he or she needs. Excellence is possible where leaders act on the faith that the organizational benefits of being driven by clearly established values will outweigh any loss sustained from telling "big admitters" to take their business elsewhere if they refuse to comply with safety precautions or the short-term cost of a necessary safety fix.

We are seeing the glimmers of changes to healthcare governance, policy, and financing that will make it easier for financial officers to use their extraordinary training to drive the provision of safe, high-quality medical care. Realizing what is possible requires you to be leaders, not accepters of the status quo. ●

COMMENTARY

A New Idea for Social Security

By Paul H. O'Neill

Paul H. O'Neill was Treasury secretary in the Bush administration from January 2001 to December 2002.

February 15, 2005

The debate over what we should do, if anything, with the Social Security system is heating up. A political campaign-style assault has already begun; in the weeks and months ahead, prepare to be buried in markedly different versions of the truth.

If you are like me, you hunger for something better from the political class. How about a new idea to offer financial security for each American when he or she reaches retirement age? Here's one way.

If we decided as a society that we were going to put \$2,000 a year into a savings account from the day each child was born until he or she reaches age 18 — and if we assume a 6% annual interest rate — each child would have \$65,520 at age 18. (The worst return for a 25-year investor in the stock market from 1929 before the crash to 2004 was an average of 6% a year.) With no further contributions, again with a 6% interest rate, those savings would grow to \$1,013,326 at age 65.

If we began to do this now, the first-year cost would be \$8 billion; that is \$2,000 times the roughly 4 million children born each year. The second year would cost \$16 billion and so on until we were contributing \$2,000 per year to a savings account for every child from birth until age 18. When fully implemented, the cost would be \$144 billion per year. To put this \$144 billion per year into context, this year's combined spending for Social Security and Medicare will exceed \$750 billion.

What this plan would do is "pre-fund" for the needs of old age. It solves the long-term financing problem for both Social Security and Medicare, allowing for the gradual replacement of programs like Supplemental Security Income and Medicaid and food stamps and housing aid for those over age 65. To make this work, the savings account money would need to be invested — my suggestion would be through so-called index funds. The administrative costs would be practically nothing because there's no need for a huge separate tax collection bureaucracy; the money would come from the general revenues of the U.S. government.

To be clear, this is a decision for our society to make. The U.S. government is just the instrument to bring it into effect. There are two crucial facts that distinguish this idea from traditional Social Security. The savings would be owned by the individual, and every person would have an account. (Everyone born before the plan went into effect would remain under the current Social Security system.)

Equal coverage for every American is an important part of this concept. Traditional Social Security does not provide equal coverage. For example, stay-at-home spouses get a smaller "dependent's" benefit, and some Americans are not covered at all. In effect, this would be a new birthright for those fortunate enough to be born here.

You might ask, "Can we afford it?" My answer is, in a federal budget of more than \$2 trillion, we can certainly afford it. In an economy that will be upward of \$12 trillion this year, we can afford it. By the time this plan was fully implemented, we would be living in an economy of \$20 trillion. We can afford it.

Some may say, "This is a terrible idea because more illegal immigrants will come here to get this benefit for their children." I say hogwash. The question suggests we should make our country a less desirable place in order to reduce illegal immigration. The proposition is absurd.

Some will argue that this prospective gift from society will reduce the incentive to save. There are two answers to this concern. First, as this idea is implemented, we will be saving because the money to pay for this will be coming from our taxes. Let me say this directly: This is savings. Second, maybe you know some 20-, 30- or 40-year-olds who would scale back their quest for current income because of some prospective annuity at age 65. I don't know any of those people.

This is a clear and straightforward concept. Why haven't we done something like this?

Over the last 30 years, both political parties seem to have stopped generating truly new ideas. And political mechanics have taken over in place of the visionaries who thought up Social Security in the first place.

If we could put this idea in place to begin ensuring old age financial security for future generations, it would reshape the action we need to take now to meet our obligations under the current Social Security system. Are there any politicians listening out there?

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