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Applying Evidence to Health-Care Policy, Business and Law

By Douglas A. Hastings

Having served on the advisory board of Bloomberg BNA's *Health Law Reporter* since its inception almost 25 years ago—yes, before the congressional and public debate over the Clinton health plan—I was asked by BBNA to offer a parting commentary as I step down from the board.

First, I would like to thank BBNA for allowing me to serve and for its important and substantial contributions, through knowledgeable and focused reporting, to our common understanding of the issues in health law as they have evolved over that time. Health law draws in lawyers over 12,000 members in the American Health Lawyers Association today for many reasons: it is complex, interesting, and ever-changing; the U.S. health care system is a huge economy unto itself, larger than the entire economies of all but a few other nations; it involves a large number of diverse and important potential clients; and it impacts the lives of all Americans.

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As for my comments, it was suggested that I attempt to capture my ''thoughts and hopes for a health care system that will ultimately attain the triple aim goals that you have long embraced.'' Actually, I would like to re-focus attention on six aims.

During these important 25 years in health care, out of thousands of reports and studies, there have been a critical few that have greatly influenced the direction of health policy, business, and law—and contributed the intellectual capital for significant changes in the law and the way health care is practiced. Among those few is the Institute of Medicine's *Crossing the Quality Chasm*, published in 2001. In particular, in setting forth the six aims of quality health care, the IOM introduced to a much broader audience of professionals, public officials, and the general public the concepts and vocabulary of evidence-based medicine.

While the 1980s and 1990s saw early developments in managed care and integrated delivery systems, the *Chasm* report helped launch an entirely new era of clinical integration, contributed much of the underlying rationale for the payment and delivery reform sections of the Affordable Care Act, and still drives much of the positive momentum of the health care delivery system today. It lays the groundwork for the current focus on accountable care, population health, social determinants of health, and many of the payment and delivery innovations under way. Its themes have largely been embraced by both political parties, the health care industry, providers of care, and increasingly the consumers of care.

Six Aims of Quality Health Care

Here are the six aims as set forth by the IOM. Health care should be:

- ***Safe***—avoiding injuries to patients from the care that is intended to help them.
- ***Effective***—providing services based on scientific knowledge to all who could benefit and refraining from providing services to those not likely to benefit (avoiding underuse and overuse, respectively).
- ***Patient-centered***—providing care that is respectful of and responsive to individual patient prefer-

 ISSN 1064-2137

ences, needs, and values and ensuring that patient values guide all clinical decisions.

- ***Timely***—reducing waits and sometimes harmful delays for both those who receive and those who give care.
- ***Efficient***—avoiding waste, including waste of equipment, supplies, ideas, and energy.
- ***Equitable***—providing care that does not vary in quality because of personal characteristics such as gender, ethnicity, geographic location, and socio-economic status.

Chapter 6 of the *Chasm* report is entitled ''Applying Evidence to Health Care Delivery'' and, among other areas, focuses on the importance of further developing and refining quality measures. Through the efforts of CMS, the National Quality Forum, the Institute for Health Care Improvement, the Leapfrog Group, and others, quality measures and metrics have come a long way since 2001. There are still debates and controversies as to their application, but these metrics provide a critical tool in achieving the six aims.

From a policy standpoint, quality measures can demarcate the pathway to value-based payment, informing decisions as to which measures and what benchmarks are driving health care delivery organizations to better and better performance and, ideally, fair payment for that performance. From a business standpoint, quality measures can serve as the constructive pathway to better cooperation and fewer unhelpful disputes between payers and providers as well as to guide payer and provider board members on their oversight of their organizations' missions. From a legal and regulatory standpoint, quality measures can help separate ''good'' collaboration from ''bad'' in antitrust, fraud and abuse, and other enforcement protocols in need of updating—as well as provide some rational basis for fair allocation of resources in connection with medical errors while also reducing the number of such errors.

Quality Measures

All of the above should proceed with the understanding that measures need to be applied in all six of the domains of quality—safety, effectiveness, patient centeredness, timeliness, efficiency, and equity. So, for example, a health system board could build a dashboard specifically containing measures in each category, such as, among others, a low rate of hospital acquired infections for safety; a low readmissions rate for effectiveness; a high HCAPS score for patient-centeredness; a positive score for timely transfers from the ER to the inpatient floor for timeliness; an appropriate average length of stay by condition for efficiency; and an appropriate and consistent mortality rate across race, gender, socio-economic status for equity.

We have developed enough evidence in this evolving area of science to double-down on our application of it. High performing health care organizations should be rewarded and encouraged through payment policy and regulatory oversight protocols. Fairer rewards by CMS for risk-takers that hit quality measures, expanded waivers from CMS and other regulatory agencies, and a greater willingness at both the state and federal levels to consider conduct remedies applying evidence-based measures of quality across the six aims should be the direction government takes.

CMS, through the Medicare program, should continue to take a leading role in payment innovation, given its role as the largest single payer. CMS's recent proposed rule on mandatory bundled payments for major joint replacements is a step in the right direction. There are policy debates over the effectiveness of bundled payments versus ACOs, as well as other approaches, but the whole point is to test different models of payment reform, with the expectation that our health care system needs to be a continuously learning environment, and one that recognizes the need for greater standardization while also recognizing regional and local differences.

Coordinated Reform

Private sector payment reform and innovation of course must keep pace with public sector reform. Each sector will lead in different ways and different times, but reasonably coordinated reform in both sectors is necessary. Consistently applying evidence, shared among payers and providers in both sectors, will help bring that result about.

Payers and providers, collaborating with employers, should be aggressively adopting voluntary protocols implementing quality measures across the six aims, including specific contract provisions addressing the rewards for achievement of benchmarks and the penalties for failure to achieve. Such efforts would help bring to an end what I saw referred to recently as the ''Thirty Years War Between Payers and Providers,'' an unhelpful conflagration. Competition can successfully coexist with cooperation through the application of evidence.

With *King v. Burwell* behind us, the task ahead is to consolidate and increase the gains made in coverage, quality, and cost efficiency since 2010. The percentage of uninsured Americans has come down, but not nearly enough. Outcomes and patient satisfaction are improving in certain exemplary locations, but there is a long way to go to reach consistently high quality elsewhere. Health care expenditure trends have moderated in recent years, a welcome trend, but there is still way too much fragmentation, inefficiency, overuse, and waste.

Social and Medical Determinants Interrelated

We are just beginning to see a broader acceptance of the importance of social determinants of health as interrelated with medical determinants. Responding to the health care needs and costs of the overlapping populations of those who are clinically at-risk or socially disadvantaged remains a fundamental moral and financial challenge. Among others, these populations include the frail elderly; the homeless; dual eligibles; low income individuals, especially within racial and ethnic minorities and rural Americans; at-risk young children; the mentally ill or cognitively impaired; and those with multiple or complex chronic conditions. It is with this highly vulnerable group that payment reform and coordinated care efforts have the biggest opportunity to improve quality of lives, lower costs, and reduce disparities.

So, my thoughts and hopes are that we will continue to vigorously pursue the six aims, that science and evidence will continue to advance and prevail in health

   ISSN 1064-2137

care policy, business, and law, that we will begin to see measurable improvements in population health across the U.S., and that BBNA will keep reporting effectively on our progress.