

Healthcare Quality

February 2007



The Call to Improve Healthcare

Over the last several years, policymakers and the medical community nationwide have focused heavily on monitoring healthcare quality. The Institute of Medicine issued groundbreaking reports in 1999 and 2001 which found that despite enormous advances in healthcare, the prevalence of medical errors routinely places patients at risk. Recently, policymakers have taken steps to increase transparency, assess healthcare quality, and compare hospitals. Additionally, health plans and the federal government have provided incentives for superior healthcare quality by linking patient performance in certain best practice measures to additional reimbursement (i.e., pay for performance).

Our Commitment

The University of California (UC) Health System – its physicians, nurses, staff, and administrators – commit to providing excellent quality healthcare to all patients. Our quest to improve healthcare quality influences how we care for patients, but also our work as educators and researchers. We recognize that “to err is human” and strive to continuously improve. Because we know that constant improvement is necessary, UC Medical Centers consistently reinforce that patient safety and quality healthcare are our highest priorities.

Every UC Medical Center patient will receive high quality, safe healthcare

As we provide clinical care, patient safety is our number one priority. Additionally, we seek to provide all patients “the right care, at the right time, in the right way.” We share the goals of the National Committee for Quality Assurance (NCQA) and the Joint Commission on Accreditation of Healthcare Organizations (JCAHO), aiming to provide healthcare that is safe, effective, patient centered, timely, efficient, and equitable.

The UC Health System will lead the way in quality advancements

The UC Health System pledges to push even harder to become a leading force in the drive for safe health care – we are well positioned to leverage our resources to do so. Each

day, UC Medical Centers train healthcare workers, working to instill techniques that improve patient health outcomes. Via clinical research, UC Medical Centers uncover effective treatment methods and influence evidenced-based practices. While all five UC Medical Centers have made great strides, we aspire to lead the field and commit to sharing best practices with our fellow healthcare providers. We also commit to learn from our peers, improving our own practices to better patient health.

Our Action

How do the UC Medical Centers ensure quality healthcare? It begins with hiring capable staff, often trained in the medical centers where they now practice. This staff, and the UC Medical Center leadership, is committed to the following actions in order to better patient care:

1. Utilizing evidenced-based practices

Patient care improves when healthcare providers follow proven clinical practices, such as providing antibiotics within one hour before certain surgeries. The UC Medical Centers follow evidence-based guidelines developed by our own researchers and documented by organizations such as the federal Agency for Health Research Quality (AHRQ).

2. Employing technology

Information technology has proven a useful tool in improving healthcare quality. All UC Medical Centers are working towards implementing an electronic medical record (EMR) to assist in quickly delivering vital patient information, especially in the emergency department when time is of the essence. For example, the UCSD Medical Center is implementing the IMPACT-ED program, which will make EMRs accessible to community clinics and emergency departments via an internet based system.

3. Embracing transparency

Providers, consumers, and regulatory agencies all agree that transparency is one key to improving quality. The UC Medical Centers collaborate with numerous organizations that strive to increase data transparency including the Leapfrog Group and the University Health

UNIVERSITY OF CALIFORNIA ACADEMIC MEDICAL CENTERS

Healing patients • Training healthcare professionals • Advancing medical care

Care Consortium. We also participate in, and support, government-led efforts to improve healthcare by reporting results for key measures posted on the U.S. Department of Health and Human Service's *Hospital Compare* web site.

4. Monitoring progress

The UC Medical Centers know that measuring progress yields results. We have already seen evidence of how such basic steps improve patient quality outcomes. For example, UC Medical Center tracking of the Health Quality Alliance Measures has improved the treatment of infectious disease in surgical patients and care for patients suffering from heart attacks.

Additionally, the UC Health System has initiated a process to analyze key quality data across its hospitals in order to facilitate benchmarking. The UC Health System regularly convenes the medical directors of each hospital, creating an opportunity to share best practices. The SAFER California program – Strategic Alliance for Error Reduction in California Healthcare – was born of this collaboration.

5. Holding ourselves accountable

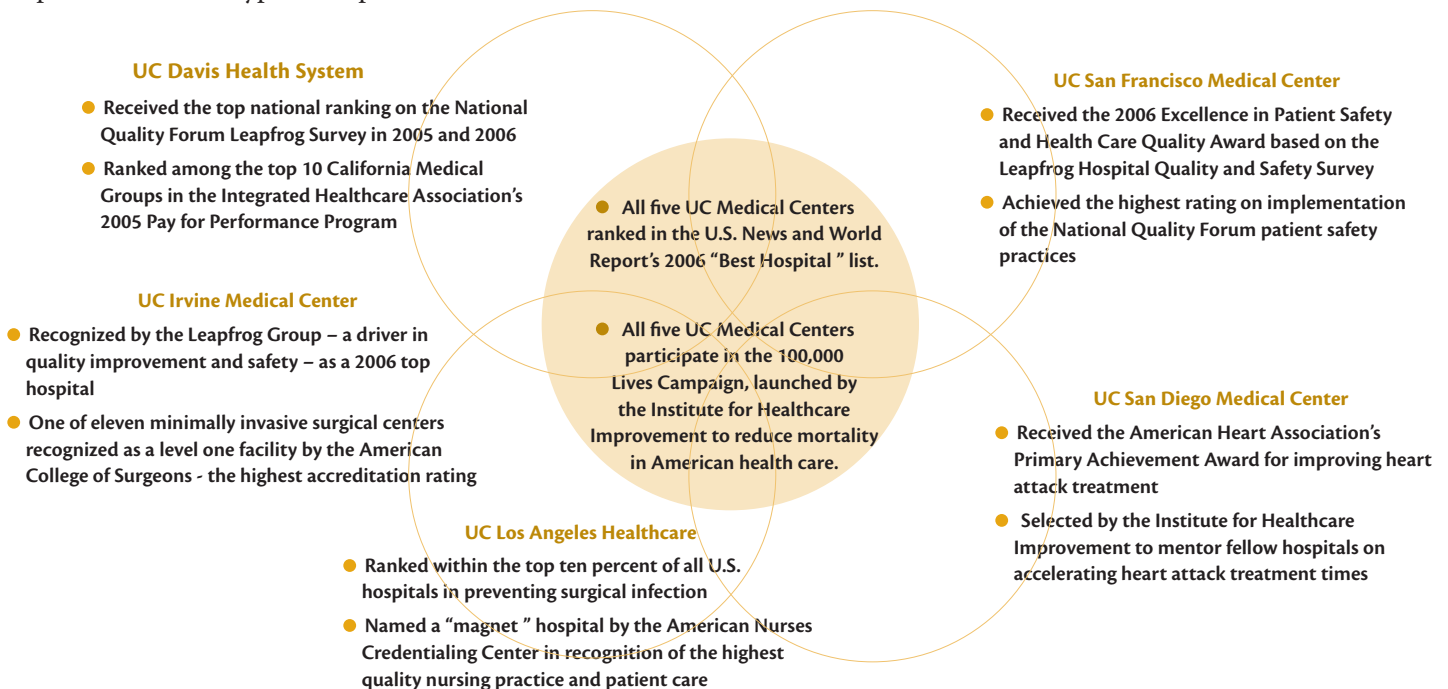
Every employee must work toward improving healthcare quality and stand accountable for results. Within the UC Health System, this includes senior leadership, clinical faculty, residents, pharmacists, nurses, research faculty, and laboratory assistants, just to name a few. As academic medical centers, UC has more individuals involved in patient care than typical hospitals because of our threefold

mission: patient care, education, and research. The UC Medical Centers are working diligently to ensure “a culture of safety,” encouraging employees to report medical errors and highlight concerns. As a first step, we are surveying hospital staff to determine if any reporting barriers exist.

6. Improving healthcare policy

We are committed to working with policymakers to improve healthcare quality. Toward that end, ensuring that healthcare providers have uniform, best practice quality measures is critical. Accepted quality measures capture whether healthcare providers follow specific processes (i.e., whether a caregiver takes a specific action at a specific time). However, there is relatively little attention placed on outcomes, or a patient's health or quality of life after treatment. In order to assess healthcare quality fully, both process and outcomes must be reported.

Effective quality measures that are soundly based on improving patient outcomes must become the norm. With these measures and pay for performance, healthcare providers have an opportunity to highlight excellent work and reap financial rewards. However, adequate transition time to vet best practices, research patient outcomes, and implement appropriate technology and billing system, is critical. Additionally, policymakers must consider how to avoid pay for performance's unintended consequences, such as providers avoiding difficult patient cases and the effect on the healthcare safety net.



The UC Health System is comprised of five academic medical centers, which include a medical school and one or more teaching hospitals. The academic medical centers – affiliated with the UC Davis, Irvine, Los Angeles, San Diego, and San Francisco campuses – together form one of the nation's largest academic health systems. At UC, patients access highly specialized, complex healthcare services. Approximately 4,100 physicians care for patients, while training healthcare workers and conducting cutting-edge medical research.

Medicare

February 2007



The Challenge

The cost of providing healthcare for Medicare beneficiaries is on the rise, increasing nine fold since 1980. In the near term, expenditures will climb even higher with the surge of baby boomer retirees and their expanding clinical and pharmaceutical needs. In California alone, population growth for individuals over 65 will rise 130 percent between 2000 and 2030. This reality, alongside projections that the hospital Medicare fund will run dry by 2018, has driven the federal government to contain Medicare costs via proposed budget cuts. Additionally, the federal government aims to increase efficiency as it promotes cost and quality transparency as well as pay-for-performance.

Appropriate cost containment is necessary, but unfortunately hospitals and physicians are often squeezed in the process. The American Hospital Association estimates that Medicare pays 92 cents for every dollar spent to treat patients. For academic medical centers like those run by the University of California (UC) Health System, the challenge is even greater because it treats complex patients that require highly specialized and costly care. In 2005 alone, the UC Health System absorbed \$35 million in uncompensated Medicare costs. Medicare's reimbursement structure sets a regional payment rate for specific medical conditions and adjusts for costly patient cases; however, only recently did the federal government suggest additional refinements for the severity of a patient's illnesses. Additionally, academic medical centers incur teaching and research costs that increase the overall cost of patient care. The federal government subsidizes these costs via graduate medical education (GME), indirect medical education (IME), and disproportionate share hospital (DSH) payments. However, the federal Medicare Payment Advisory Commission (MedPAC) is suggesting a scale-back of IME and DSH payments.

Physicians, too, find that securing adequate Medicare reimbursement rates is challenging. For the last several years, the sustainable growth rate (SGR) payment formula

has required annual cuts in Medicare physician payments. Under the SGR formula, Medicare rates decline if a patient's use of healthcare services expands beyond the growth in the gross domestic product (GDP). Most policymakers agree that linking patient care to the GDP is inappropriate; however, comprehensive rate redesign is costly and Congress has opted to annually address physician rate cuts rather than overhauling the SGR structure.

Our Response

The UC Health System meets the healthcare needs of a growing Medicare patient population – since 2003, the number of days Medicare patients spent in the UC Medical Centers increased by 16 percent. Medicare patients account for 27 percent of UC Health System patients and nearly a quarter of all clinical activity by UC physicians is dedicated to Medicare beneficiaries.

We are also prepared for the future. The UC Health System performs cutting-edge research to improve senior healthcare, driving advances in Alzheimer's disease and osteoporosis. Additionally, the UC Medical Centers prepare medical residents and other health professionals to specialize in geriatric medicine and other sub-specialties critical to elderly patient care.

Our View

1. Ensure adequate reimbursement for physicians and hospitals

An adequate number of Medicare providers is critical for patients and sound reimbursement rates help ensure a viable network. The UC Health System commits to work with federal policymakers to ensure that the inpatient prospective payment system (IPPS) and the outpatient prospective payment system (OPPS) adequately compensate academic medical centers for the highly advanced care provided to Medicare patients. Additionally, the UC Health System

UNIVERSITY OF CALIFORNIA ACADEMIC MEDICAL CENTERS

Healing patients • Training healthcare professionals • Advancing medical care

stands ready to collaborate toward a long-term solution that replaces the SGR physician payment formula with a system that fairly and adequately reimburses physicians.

2. Support physician training

Medicare's long-standing support of physician training allows teaching hospitals to remain viable in the market and maintain services for Medicare patients. By continuing IME and GME payments, policymakers create a solid foundation for tomorrow's healthcare system.

3. Publish data that assists patients and providers

It is worthwhile to increase hospital cost transparency; however, aligning the Medicare costs of an academic medical center and a community hospital compares apples to oranges. The added expenses associated with the specialized treatment academic medical centers provide must be captured. Additionally, the value associated with academic medical center teaching and research must also be considered. This information ensures that patients have accurate information and allows meaningful comparison across hospitals.

Similarly, it is beneficial to publish quality data. In that effort, reporting the appropriate quality measures is critical. Accepted quality measures now reveal whether healthcare providers follow specific processes (i.e., whether a caregiver takes a specific action at a specific time). There is relatively little attention paid to patient outcomes or quality of life post-treatment. In order to examine healthcare quality, both process and outcome measures must be reported.

4. Consider how Medicare rates affect state policy

Because the Medicare program is the largest single purchaser of healthcare services, the federal government sets the stage for market negotiations when determining Medicare rates. Additionally, state lawmakers often reference Medicare rates when setting policy for other healthcare consumers. Given declining Medicare reimbursements, it must be continually assessed whether Medicare is an appropriate reference point for state policy.

The UC Health System is comprised of five academic medical centers, which include a medical school and one or more teaching hospitals. The academic medical centers – affiliated with the UC Davis, Irvine, Los Angeles, San Diego, and San Francisco campuses – together form one of the nation's largest academic health systems. At UC, patients access highly specialized, complex healthcare services. Approximately 4,100 physicians care for patients, while training healthcare workers and conducting cutting-edge medical research.

Medicaid/Medi-Cal

February 2007



The Challenge

Safety net hospitals, like those run by the University of California (UC) Health System, ensure that Medicaid and uninsured patients can access critical healthcare services. Historically, the safety net has relied heavily on federal funding to care for Medicaid recipients. Now helping patients for over 40 years, Medicaid (known as Medi-Cal in California) is under increasing scrutiny, with policymakers seeking ways to control costs. At the state level, there have been various efforts to “redesign” Medi-Cal; at the federal level, Congress adopted a 2006-2007 budget that cuts Medicaid by \$10 billion over five years.

To stabilize Medicaid funding for safety net hospitals, California negotiated a hospital financing waiver in the Fall of 2005 with the U.S. Department of Health and Human Services. From 2005-2010, the waiver allows safety net hospitals to draw supplemental Medicaid funding for healthcare services provided to poor and uninsured patients. As it did with other states, the federal government fundamentally changed how it pays Medicaid funds to hospitals. The federal government dramatically reduced the use of intergovernmental transfers (IGTs) and shifted to a system where public hospital costs – or certified public expenditures (CPEs) – are the basis for drawing federal funds. Essentially, this policy shift has required the creation of a new Medicaid payment system. The UC Health System, together with the coalition of California’s safety net hospitals, has worked closely with state and federal policymakers to create that system and ensure a seamless transition.

While the hospital financing waiver works to stabilize Medicaid cost reimbursement through 2010, the UC Health System is concerned that it may not do so. The Centers for Medicaid and Medicare Services (CMS) has proposed regulations that restrict Medicaid payments under the waiver, placing the stability of the safety net in jeopardy.

The UC Health System’s 4,100 physicians are equally concerned about adequate Medicaid rates, given their dedication to treating the poor and uninsured. In 2006, California reversed a state-mandated five percent cut in physician Medi-Cal rates. While this policy decision was critical, reimbursement for physician services is still not sufficient to cover costs.

Our Response

The UC Health System meets the healthcare needs of Medicaid patients – they make up 23 percent of all patients. Three UC Medical Centers operate in regions without county hospitals and, therefore, treat an even greater number of Medicaid patients (26 - 36 percent of total patients).

The UC Health System treats five percent of Medicaid patients statewide. However, a much larger share of these patients trust UC to provide highly specialized care, including 44 percent of those Medicaid patients receiving organ transplants. Overall, UC Medicaid patients have illnesses 50 percent more severe than Medicaid patients at other statewide hospitals. Many Medicaid patients travel quite a distance to receive UC treatment. For example, most growth in the UC San Francisco Medical Center’s Medicaid patient load stems from referrals outside of San Francisco.

Our View

A strong Medicaid program allows the UC Health System to ensure that poor and uninsured patients can access the same highly specialized healthcare services as the privately insured. As federal and state policymakers work to improve the Medicaid program, it is important to consider the following:

- 1. Ensure adequate reimbursement for healthcare services**
To maintain healthcare access for Medicaid and uninsured

UNIVERSITY OF CALIFORNIA ACADEMIC MEDICAL CENTERS

Healing patients • Training healthcare professionals • Advancing medical care

patients, the Medicaid program must support hospitals and physicians. The UC Health System supports innovative uses of Medicaid funding such as coverage initiatives for the uninsured. However, innovative policies should build on a solid safety net that is equipped with a strong network of physicians and hospitals.

2. **Avoid cost shifts**

In addition to sound provider payments, it is important to consider how Medicaid benefit cuts affect healthcare providers. Implementing co-payment, deductible, and premium increases may result in federal cost savings, but in reality these costs often shift to the healthcare safety net. If Medicaid patients are unable to pay co-payments and deductibles, safety net hospitals and physicians do not turn them away and, thereby, bear the cost of uncompensated care.

3. **Promote coordinated care, address complex healthcare needs**

Coordination of Medicaid patient care is necessary to increase efficiency and drive down costs. However, many senior and disabled patients – especially those receiving highly specialized care at the UC Health System – require costly medical procedures. Managed care health plans must adequately reimburse hospitals for such procedures. Without this protection, managed care savings will not be cost savings at all – instead they will be borne by healthcare providers.

The UC Health System is comprised of five academic medical centers, which include a medical school and one or more teaching hospitals. The academic medical centers – affiliated with the UC Davis, Irvine, Los Angeles, San Diego, and San Francisco campuses – together form one of the nation's largest academic health systems. At UC, patients access highly specialized, complex healthcare services. Approximately 4,100 physicians care for patients, while training healthcare workers and conducting cutting-edge medical research.

Access to Healthcare

February 2007



The Challenge

Nearly seven million Californians are uninsured – the highest number of any state in the nation. This figure is on the rise given declining employer based healthcare coverage and, everyday, the University of California (UC) Health System sees evidence of this in its emergency departments. The uninsured account for eight percent of patients admitted to the UC Health System, and in certain facilities, this number climbs to 14 percent. The UC Health System's total cost for uninsured patient services has increased by 44 percent since 2001.

The number of on-call specialists treating uninsured and Medicaid patients is limited – for this reason, patients routinely transfer to UC emergency departments from community hospitals. As a result, the UC Health System cares for a significant share of California's uninsured, incurring 13 percent of the state's uninsured hospital inpatient costs. Certain UC Medical Centers provide even more care for the uninsured in their regions. For example, the UC San Diego Medical Center treats 38 percent of San Diego County's uninsured.

Under-insured patients are also on the rise. As high deductible coverage plans become increasingly popular, more and more UC Health System patients must pay significant out-of-pocket healthcare costs. When patients cannot afford to pay these costs, they are absorbed by healthcare providers.

Our Response

Ensuring healthcare access is a top priority of the UC Health System – that's why we are working on immediate "on-the-ground" solutions. First, the UC Health System is improving communications with patients who need care in our hospitals,

but cannot afford to pay for it. This includes ensuring that patients understand hospital financial assistance policies. We believe all hospitals should do their fair share to care for the uninsured and have supported legislation enacting mandatory financial assistance policies.

The UC Health System also promotes health access by reaching out to the under served in our communities. We prioritize outreach to vulnerable populations – whether it's through the student run healthcare clinics at the UC Davis Medical Center, the Federally Qualified Healthcare Center run by the UC Irvine Medical Center, or UC Los Angeles Healthcare's numerous health education programs.

Additionally, the UC Health System works to allocate healthcare resources efficiently by streamlining clinical care. Our clinical researchers uncover techniques to manage chronic diseases such as diabetes, hypertension, and asthma. We find one example of this work at the UC San Francisco Medical Center, where researchers developed a tool to assess when asthma patients need hospital treatment. Use of the tool saves time, lowers costs, and frees up limited hospital resources.

Our View

The UC Health System supports universal access to affordable healthcare. We believe that policy solutions should allow flexibility and capture regional innovation, rather than prescribing a one-size-fits-all approach.

1. **Share uninsured cost burden among all stakeholders**

All stakeholders must share the cost of caring for, or covering, the uninsured – the local, state, and federal

UNIVERSITY OF CALIFORNIA ACADEMIC MEDICAL CENTERS

Healing patients • Training healthcare professionals • Advancing medical care

government; healthcare providers; insurers; employers; and consumers. As healthcare providers, we have an obligation to care for the uninsured – all hospitals and physicians must do their fair share.

2. Ensure primary and specialty care access

Access to primary care improves healthcare and drives down overall healthcare costs. However, providing primary care in a hospital setting pulls resources away from acute care services and, in the case of the UC Health System, its ability to maintain specialty care access. Community clinics, hospitals, physicians, and academic medical centers each play a unique role in preserving healthcare access within their communities; each must concentrate on their area of expertise.

3. Expand coverage and support the safety net

Public policies that expand healthcare coverage should not do so at the expense of supporting hospital and physician services. Healthcare coverage and a strong safety net, must go hand-in-hand – healthcare access requires strong provider networks.

4. Use innovative pilots to improve access

The UC Health System commits to sharing its own best practices to streamline healthcare delivery and expand access. We are encouraged by the innovative work of our physicians, researchers, and hospitals. Additionally, the UC Health System is willing to test-pilot innovative ideas raised in policy discussions.

The UC Health System is comprised of five academic medical centers, which include both a medical school and one or more teaching hospitals. The academic medical centers – affiliated with the UC Davis, Irvine, Los Angeles, San Diego, and San Francisco campuses – together form one of the nation’s largest academic health systems. At UC, patients access highly specialized, complex healthcare services. Approximately 4,100 physicians care for patients, while training healthcare workers and conducting cutting-edge medical research.

Healthcare Information Technology

February 2007



The Challenge

Information technology is an important tool to track healthcare data and improve healthcare productivity. While healthcare information technology (HIT) requires significant capital investment, if used appropriately, HIT can reduce clinical errors and lower costs for healthcare providers and consumers. Policymakers recognize this and spur innovation via demonstration projects such as those sponsored by the Agency for Healthcare Research and Quality and the Federal Communications Commission. The creation of electronic health records (EHR) is a core element of these strategic investments. State and federal policymakers suggest different timetables for making EHRs widely available, but the goal is simple – EHRs should be readily accessible by hospitals and physicians and allow patients to receive better healthcare.

It is a challenge to create interoperable health information systems. Hospitals and physician groups are proactive in solving their unique needs, thereby investing at different times and choosing different HIT platforms. As a result, compatibility and data transmittal standards vary. The University of California (UC) Health System finds this challenge among its own five academic medical centers. UC's 4,100 physicians, eight acute care facilities, and two psychiatric hospitals today have various HIT systems, each with unique strengths.

The UC Health System uses HIT not only to improve patient care, but also support its research and education missions. Researchers require a solid technology infrastructure to access clinical data and ensure its security. Clinical faculty require a solid technology infrastructure to use data for clinical education and provide students virtual training.

Our Response

Each UC Medical Center is implementing an EHR system in order to: 1) provide clinicians timely and secure access to vital patient information; 2) improve healthcare delivery; and 3) broadly collect and share information for research purposes. For example, the UC San Diego Medical Center – voted one of the nation's "most-wired hospitals" – records prescriptions, lab results, and patient conditions on a network of 4,800 computers. The UC Irvine Medical Center shares EHR data to improve public health, participating in a Centers for Disease Control and Prevention program where symptoms are monitored on a real-time basis to detect biohazard events. At the UC Davis Health System, outpatient clinical information management systems have been implemented to speed and improve the delivery of care.

Additionally, the UC Medical Centers collaborate with regional partners and industry to improve patient safety. The UC Health System joins forces with regional health information organizations (RHIOs) to create electronic connections among emergency departments. Additionally, the UC Medical Centers work with local clinics to streamline patient care by sharing electronic appointment and referral systems. Collectively, the UC Medical Centers partner with vendors to improve prescription drug bar-coding and enhance the system of checks and balances in medication delivery.

Telemedicine – or the exchange of medical information electronically from site to site – is another way the UC Health System improves healthcare via technology. At the UC Davis Health System, the Center for Health and Technology connects specialty physicians with rural healthcare providers.

UNIVERSITY OF CALIFORNIA ACADEMIC MEDICAL CENTERS

Healing patients • Training healthcare professionals • Advancing medical care

Additionally, the UC San Diego Medical Center's Stroke Center guides emergency physicians in remote sites to provide acute stroke diagnosis and treatment.

Our View

1. Encourage HIT adoption and innovation

We encourage policymakers to consider seed money and tax credits to support HIT investments by public hospitals and further develop regional health information networks. Pilot projects should influence policy and public-private partnerships should be explored as a way to maximize investments. By supporting the evolution of HIT standards, policymakers promote a robust and competitive healthcare marketplace.

2. Recognize the added value, and expense, of HIT

In order to comply with the growing number of state and federal reporting requirements, hospitals must have sound HIT systems. These systems are becoming even more important as policymakers work to improve healthcare

quality and shift to pay-for-performance. As public policies that require advanced HIT systems multiply, the imbedded expense of HIT implementation for healthcare providers must be recognized – particularly for public hospitals.

3. Continue state and federal leadership on HIT issues

The UC Health System supports the relatively new role of the National Coordinator for Health Information Technology. As California evaluates how best to encourage HIT investments and further HIT policy, the UC Health System looks forward to assisting key state policymakers.

4. Break down collaborative barriers

Collaboration between physicians and hospitals is essential for seamless communication to become a reality. Policymakers should consider appropriate exceptions to Stark and anti-kickback laws and regulations, allowing the sharing of technology equipment and services among providers. Additionally, appropriate data sharing should be encouraged in order to promote system interoperability.

The UC Health System is comprised of five academic medical centers, which include both a medical school and one or more teaching hospitals. The academic medical centers – affiliated with the UC Davis, Irvine, Los Angeles, San Diego, and San Francisco campuses – are the nation's largest academic health system. Patients access highly specialized, complex healthcare services via the UC Health System. Approximately 4,100 physicians care for patients, while also training healthcare workers and conducting cutting-edge medical research.