



An Opportunity for Leadership in Changing the Shape of Healthcare

James E. Ludlam, J.D. discusses the uniquely California response to previous health care crises and outlines an action plan to address current issues of access availability, quality of care and cost.

on the occasion of his receipt of The Mathies Award

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A CHALLENGE BETTER HEALTH CARE FOR CALIFORNIA

This is the edited response of James E. Ludlam, J.D. on receipt of the Mathies Award presented at Partners in Care Foundation's 2002 Vision and Excellence in Health care Leadership Tribute Dinner on April 19, 2002 at the California Club in Los Angeles, California.

Thank you. Thank you for giving me this captive audience, with the fellowship that's in this room. What a wonderful group of people we are participating in the health care field. What a distinct privilege it is for us to all be in the field together and to know each other and enjoy the companionship like this under the sponsorship of Partners in Care Foundation.

I can only say thank you to each and everyone of you and to the organization that made this possible. I also want to use this opportunity to issue a challenge to you and the other leaders in the health care field in how to respond to the rapidly developing crisis in health care relating to access, availability, cost and quality of health care in the present economic and social environment.

As I look back over my more than 60 years of active participation in health care policy issues I firmly believe we have much to learn from our past California experience in dealing with the periodic health care crises that we have faced just as we are facing one now. As in the past it is generally a part of a national crisis where everyone anxiously awaits a federal solution that rarely ever comes, with the possible exceptions of Medicare and Medicaid. Again, I would predict that the present partisan conflict in Congress would preclude any current action except some political temporizing.

As I will briefly recount, California has an historical experience of attacking these problems in a California way of bringing together the disparate elements to work together to develop a California solution. The approach is based on the assumption that there are potential solutions and knowledge available if the best leaders are brought together in the right setting with a commitment to develop a consensus for an action plan. This must combine the best expertise from both the public and private sectors and be multidisciplinary and individuals will rise above partisan bias to define the best solutions for statewide health care problems. Of equal importance must be the commitment to implement these solutions. For health care the continuing challenges relate to the big four interrelated problem areas of availability of care, access to care, quality of care and cost of care. Because of the rapid changes in health care, none of these are ever fully resolved.

Although prior to my time many primary steps had been taken, such as the development of licensure for the professions and institutions, the concept of peer review on the quality side, and the Hill-Burton financing on the availability side. By 1960 the problems were particularly acute and Governor Pat Brown, with full support from the medical profession and hospitals, created what was entitled "The Governor's Committee on Medical Aid and Health," with Roger O. Egeberg, M.D. as chair. The 19 member multidisciplinary group was broad based and broke up into task forces, who added additional participants, dedicated to particular problem areas with the objective of defining the problem areas and solutions, however controversial, for the following fifteen years. The Egeberg commission as it became known performed its role well and with the prestige of its membership set the pattern of action for the next 15 years. It was particularly strong in the areas of hospital planning and access to care.

However by 1965 the tremendous progress in the advent of new complex surgical procedures and the developments in anesthesia led to a major increase in quality of care issues as exemplified by the avalanche of medical malpractice cases. For example, the critical issue of whether a doctor should perform an emergency open-heart cardiac resuscitation became an extremely costly subject of jury verdicts, along with many others.

This led to joint action by the California Medical Association and the California Hospital Association to initiate in 1969 what was known as the “California Invitational.” This was a convening of a multidisciplinary package of workshops in both Northern and Southern California, to cover eight specific high risk areas of quality of care, including 1) patient elopement and suicide, 2) anesthesia, 3) surgical cardiac arrest, 4) emergency and floor cardiac arrest, 5) requirements for qualification of assistants in surgery and surgical privileges, 6) infection controls, 7) maternal and neonatal injuries, and 8) infection injuries. Seventeen prevention workshops were held throughout California, each reviewing each of the eight topics culminating in a unified three-day session that prepared the action report. To a substantial extent the recommendations were in the form of what we now call “protocol” or “best practice guidelines”. What is important to understand is that the very process itself initiated the many reforms that the report made. Effective implementation programs supported by the Liability Insurance carriers followed.

However, by the 1980’s the advances in the field of obstetrics again outpaced the ability of the hospitals and the medical profession to keep up with or fully cope with the major potentials in the delivery and care of infants. The situation became so critical that there was a serious question as to whether or not obstetrical practitioners were insurable. As a result, the California Medical Association and the California Hospital Association initiated California Invitational II- Neonatal Brain Injury Prevention. This followed the same pattern as Invitational I and led to the final three day session of the multidisciplinary group in 1985 to prepare the final report. Tens of thousands of copies of the report were printed and circulated to every hospital in the state, their Chiefs of Staff, affected department heads and all obstetrical personnel. The results were dramatic and as the 1990 National Study by ACOG reported that the medical malpractice premiums for Region IX which is limited to California, were the lowest of any of the regions in the country.

Of greater importance is that favorable impact on the quality of obstetrical care in California has continued. As a result of these activities, as well as the passage of the Medical Injury Compensation Reform Act of 1975, the presently rapidly developing national medical malpractice insurance crisis will not be nearly as serious in California as in other parts of the country, doctors going out on strikes over insurance costs in Texas and major carriers withdrawing from the markets in many states.

My purpose in briefly covering this historical history of what are only some of the most dramatic examples of the California approach to major health care problems through multidisciplinary action led by the best experts in the field dedicated primarily to voluntary action based on the best knowledge and experience available.

My challenge is that it is now time to follow the California pattern of coordinated multidisciplinary action by the leadership of all of the players in the health care field by the creation of a new Egeberg style commission with a title such as “Better Health care For California” which will first identify the critical issues of health care that can be impacted by system improvements. I will suggest how it is to be formed and financed at the conclusion of these remarks.

The commission will prepare its agendas of issues to be tackled and then will organize specifically identified task forces on the related issues with a group committed to not only producing an action plan but also dedicated to implementation. Too many good reports gather dust on a shelf for failure to have an implementation component - one of the major virtues of the two California Invitationals. Incidentally, California Invitational II recommended the potential calling together of California Invitational III.

As with the Egeberg Commission, the topics should be broad-based to reflect the increased complexity of the so-called Health care System. For example, one area that should have high priority is the critical friction that exists within the ladder of health care, from the patient to the practitioner, to the medical group, the managed care plan or insurance entity, ultimately to the individual, corporate and government purchasers and the safety net. There need to be standards of performance, definition of roles, and mutually acceptable

grievance procedures, all as identified by a committee task force, to not only reduce the existing antagonisms, but to improve the efficiency and quality of care.

Another problem area that could be effectively covered by the commission would be the matter of report cards now being required by not only business purchasers of health care coverage but also by third party payors. Here the basic problem is the accountability of providers for quality and cost control. The recent program of the Pacific Business Group on Health called the Leapfrog Project is a basic approach defining a package of benchmark procedures whose use or failure to use would test the quality performance of providers. This approach is designed to establish incentives for the providers to adopt and follow best practice protocols. The problem for the providers who may have a variety of contractual relationships with providers is that as this practice expands there will be an added burden of responding to a multiplicity of demands that are both costly and confusing. What is needed is an industry wide consensus on a pattern of reports on performance data on clinic practice that can be evaluated by the purchasers of health care. Similarly, there should be established criteria for evaluating the Managed Care Plans and other third party payors for their performance in receiving, processing and paying claims, and for establishing appropriate benefit structures.

The matter of public accountability and performance disclosure is not a new issue for the health field. Going back to the late 1960s and early 1970s, there was broad dissatisfaction by the purchasers of health care at all levels as to financial performance of hospitals, particularly as it was reflected in the charges and fees made for health services. In other words, was the public being ripped off and were the plans of hospitals for increases in charges justified? Very few hospitals published their financial statements so there was a real credibility issue. To respond to this concern, the California Hospital Association, on behalf of its membership, designed legislation to be known as the Hospital Disclosure Act, which established a seven member commission appointed by the Governor. The commission was given broad authority to establish a mandatory uniform hospital accounting system and other statistical performance reports with required annual reports from each hospital as a condition of licensure, with the reports to be subject to full public disclosure. This function is now vested in the California Health Policy and Data advisory committee.

As a part of the report on "Better Health for California" the commission could recommend appropriate reports to establish the credibility of all of the players in the health care system, either as a voluntary or mandated requirement, thus eliminating the duplication of effort and assuring public accountability as well as the information necessary for health care purchasers to make informed choices.

On the issue of quality of care we have to deal with bringing the medical malpractice issues up to date. Fortunately there exists in the office of Dr. Daniel Lang, Medical Policy Director for the National Health Foundation, a complete plan for a California Invitational III that already has the blessings of the California Medical Association, the California Hospital Association, and the leading medical malpractice insurance carriers. All it needs is a review by the new commission and the necessary funding to be put into action. With the benefit of access to the internet base of information and the improved communication available by the new technology the action to implement the process should both be simplified and expedited, including the implementation of the recommendations that will come out of the process. We are fortunate in California to have the benefit of the Medical Injury Compensation Reform Act of 1975, which acts to partially limit the cost of liability insurance. However, we must accept the fact that litigation is only symptom of the problem and the underlying problem is quality of care.

The Washington Based Medicare Payment advisory commission has just released its January 2002 Report to the U. S. Congress entitled, "Applying Improvement Standards in Medicare". Any action by a California commission will find this an excellent analysis of the current status of the various entities created to evaluate quality of care. The report also indicates sources of support for such activities as well as an evaluation of their current success. Two members of the commission are from California, Janet G. Newport from Pacific Care Health Systems and Alan D. Feezor from California Public Employee's Retirement System. This report

as well as these individuals will provide excellent resources in any design for action relating to quality improvement. Also, the commission is a potential resource for research or evaluation of proposals for action.

On the issue of cost of care, I would suggest that consideration be given the statewide unified attack on the problems of diagnosis and treatment of chronic care. This is a problem of both case management and disease management, which is supposed to be a major justification of the application of the system of managed care. The cost of chronic disease is generally accepted to represent 70% of the total cost of health care and is a problem for all of our citizens, but particularly burdensome for our underserved. At the present time great publicity is given the problems of diabetes and asthma as being the most widespread of the chronic diseases. With diabetes the major attack must be on the rapidly increasing problem of obesity. Obesity manifests itself as a cause of the whole spectrum of chronic diseases, including cardiac diseases, asthma, stroke and many others.

There are California models in place for cost effective attacks on the chronic disease problem. For example, the Huntington Memorial Hospital in Pasadena has recently received the AHA Nova award for a treatment and prevention program that has worked with the Pasadena School System in early diagnosis and treatment of asthma. The program has been expanded to treat all ages. Also, through a collaboration with three other hospitals, including Children's Hospital of Los Angeles, The California Hospital Medical Center, and the Hospital of the Good Samaritan, to expand the techniques to their patient population. The same four hospitals are also working on a collaborative endeavor to attack the obesity problem.

The advantage of the new commission would be to renew the work with these and other successful ventures to spread the experience of what works throughout the California setting. Certainly the involvement of the school system is to tap a critical asset to the mutual benefit of all by not only improving school attendance but also all student performance.

Now how may the health care field respond to this challenge? It would be my suggestion that a copy of this paper be circulated to all the California based health care foundations with the request that they, as a group, accept this challenge and as a group organize the commission to be known as "Better Health care for California" or other appropriate name. They would establish an organizing committee from their constituency and make a commitment to funding the process. The organizing committee would recruit the necessary initial staff, suggest a preliminary agenda and pick the members of the commission on a broad based multidisciplinary base by choosing individuals with both leadership and expertise. With that base the project would proceed. It would probably take a period of three years, which would include the first year of organization and staffing, with the selection of topics and goals and the creation of appropriate task forces, to be organized and to commence the work process based upon prior experience. The second year would be intensive work with involvement of all elements of the health care system, to publish its report, and the third year would be devoted primarily to implementation and evaluation of the recommendations.

For myself, all I can say is that at 87, my own participation will be severely limited – but to paraphrase Oliver Wendell Holmes' famous quote – "Oh to be 70 again." and to have the privilege of participating in this venture.