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Health Care Reform - DPC Process

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February 14, 1990

**HEALTH CARE REVIEW: PROCESS AND PROSPECTS**

In his State of the Union Address on January 31, the President said that we must give careful consideration to the recommendations of the health care studies now underway. He directed Dr. Louis Sullivan, the Secretary of Health and Human Services, to lead a Domestic Policy Council review of recommendations on the quality, accessibility and cost of our nation's health care system. The President said he is committed to bringing the staggering costs of health care under control.

The President's call for this review has already produced a variety of activities within the Administration on this issue. Before anything progresses further, it is important for the principals to meet to ensure common expectations about the scope, pace and timetable for the review.

The Domestic Policy Council, through its Working Group on Health Policy, now chaired by HHS Undersecretary Constance Horner, will be the formal process for coordinating this review. It will also be worthwhile to have a more informal process in addition, to make certain that the Administration is of one mind on these important issues.

An ad hoc group, consisting of Governor Sununu, Secretary Sullivan, Director Darman, Chairman Boskin, and Roger Porter, should meet at least every two months over the coming year, to discuss the progress of the review and its prospects for conclusions.

Several key questions should be focused upon by this steering group, including the following:

1. What is the scope of the health care review; for example, does it include only acute care or does it also include long term care?
2. Will the review focus first on cost containment, on access enhancement, or on both together?
3. What will be the relationship of this review to the FY92 Budget process?
4. What will be the level of consultation with persons and groups outside of the government, and to what extent will ideas be shared as draft results of the review?

# HIMD FAX

**TO:** Hans Kuttner

**FROM:** Steve Bauder

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## Quality of Care Proposal

- After a five-year transition period, hospitals would be required to have a comprehensive system for monitoring patient outcomes. Outcome statistics would be risk-adjusted (using detailed clinical data) to assure valid comparisons.
- The system would permit statistically valid comparisons of patient outcomes which, in turn, would enable hospitals to better identify possible quality of care problems for corrective action.
- Data collection and analysis would be standardized to facilitate comparison of outcomes between hospitals. All hospital admissions would be included in the outcomes monitoring system. (100 percent sampling is needed to identify low-frequency adverse occurrences for corrective action.)
- HHS would fund development of computer-based data acquisition systems to facilitate coding and data entry.

This reflects a recent recommendation of the Institute of Medicine and is fully consistent with ongoing plans within the Health Care Financing Administration to improve the Peer Review Organization (PRO) program.

Inclusion of non-Medicare patients is important because the proposed malpractice reforms extend to all patients, not just those covered by Medicare. Moreover, Federal quality standards for hospitals are uniform with respect to Medicare and non-Medicare patients. Medicare helps to fund state licensure of hospitals and other health care facilities through Federal funding of joint federal-state survey and certification activities.

There would be broad public support, because a specific proposal of this type would really help improve quality of care. In addition, employers would strongly support inclusion of non-Medicare patients because they are currently trying to get quality data to assist in purchasing decisions. Such a system would also permit gathering of the clinical data needed to support "effectiveness" research, sponsored by AHCPR, to better define which medical procedures work and which don't.

The technology needed is easily achievable within 5 years. Costs to hospitals would be minimal since many hospitals already have or are about to acquire sophisticated hospital information systems.