The Jewish Healthcare Foundation of Pittsburgh

February 2003

BRANCHES

Leadership Mandates
Become a first-tier health department

Operational Requirements
Trump bureaucratic inertia

Program Imperatives
Be accountable for performance targets

A VISION FOR HEALTH REFORM

THE ROLE OF THE DEPARTMENT OF HEALTH

In 1994 the Jewish Healthcare Foundation prepared *Leadership in an Era of Change: Recommendations for the Governor*, a report for Pennsylvania's Governor-elect Tom Ridge. It offered a series of recommendations for retooling a health department perceived as weak and ineffectual for leadership during massive health system restructuring.

The conclusion in 1994: "political and structural barriers have for decades prevented the Department from effectively fulfilling its mission… [The Department's] traditional weakness compromises the Commonwealth's competency in health policy leadership, regulation and public health programming."

Unfortunately, a similar assessment could be made today, eight years later, as a result of interviews with over 40 leaders in health – both internal and external to the Department. The general consensus is that the Department lacks stature: its standing among other state departments falls short of its inherent importance.

In addition, the Pennsylvania Department of Health fails to rank among first-tier health departments, and has not received the attention and support required for excellence. Consequently, perhaps, in measure after measure, from diabetes to cardiovascular disease to cancer, health indicators in Pennsylvania are discouragingly poor, in spite of the wealth of respected medical centers and academic institutions in our state.

The picture is not all bleak. The Department has made progress in some areas, and it has much of what it takes to be a first-tier health department. And Governor Rendell's creation of the Office of Health Care Reform promises a new spirit of cooperation among other state departments and agencies.

The Department faces both a requirement and an unprecedented opportunity to lead, given the issues that are now foremost on the public agenda. They include the threat of war and domestic mass casualty, healthcare access and cost, medical errors, medical malpractice and tort reform, access to care, the care of chronic conditions, and the need for rapid translation of research discoveries into improved practice.

Is it possible that the glory days of public health lay ahead of us? Certainly, the new Administration gives every indication that health reform is at the top of its agenda.

"The Department of Health will be important if the governor challenges it to be; effective if the legislature supports its direction and critical functions; and successful if its leadership and staff are held accountable."

A "REPORT CARD" ON THE PENNSYLVANIA DEPARTMENT OF HEALTH

According to interviews with over 40 key stakeholders in Pennsylvania's health sector: selected items

+ MERITS PRAISE

- **+ tobacco settlement fund distribution (health-focused, inclusive of research, education and treatment)**
- **+ data capacity in epidemiology**
- **+ crisis response (West Nile Virus, emergency preparedness)**
- **+ working relationship between Physician General and Secretary**
- **+ long-term care demonstration project**

- NEEDS ATTENTION

- **- managed care oversight**
- **- sharing of data with other departments and at the local level**
- **- regulatory apparatus**
- **- federal funding**
- **- measurable health improvement in selected conditions**
- **- use of data to guide decision making**
- **- statewide unified emergency response system**
- **- inclusive network of physical and mental health, dental and drug and alcohol services for unserved populations**

LEADERSHIP MANDATES
TOWARD A FIRST-TIER HEALTH DEPARTMENT

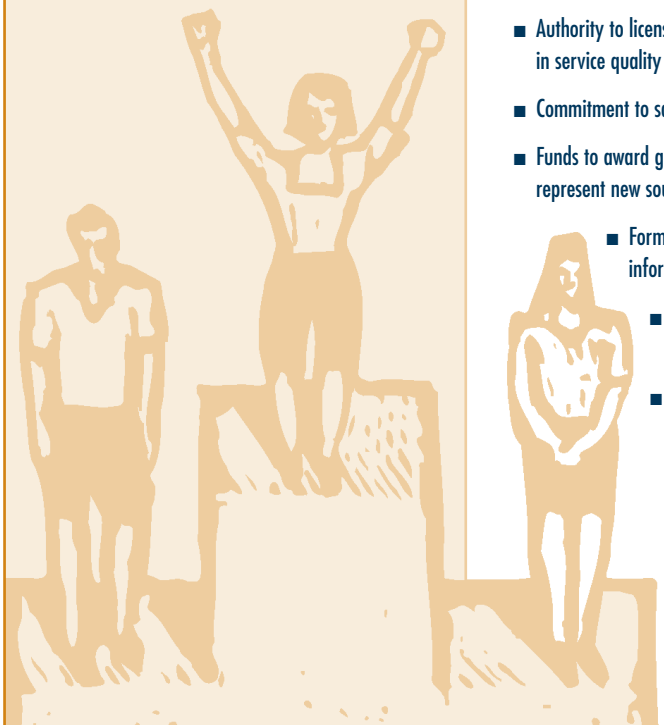
LEADERSHIP ROLES

1 **Manager.** Departmental leadership must demonstrate an ability to activate an organization, to assign resources for maximum impact, to inspire excellence from staff, and commit to attaining the highest quality and safety standards.

2 **Crisis Administrator.** Departmental leadership must have a steady hand in the event of a large-scale health crisis – whether terrorist, viral, or accidental.

3 **Advocate.** Departmental leadership must convince key audiences of the centrality of Health Department functions and aspirations. An uninspired public will not charge its legislators to approve the requisite policy and funding.

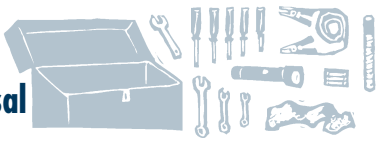
4 **Entrepreneur.** Pennsylvania has the lowest funding per capita of any state health department in the United States. Departmental leadership must be aggressive in assembling and sharing resources to strengthen local health functions and provider networks. The assurance of public health is essentially a local function, but the Department must attract federal funding and private dollars to support those efforts.



Not all state health departments enjoy the same reputation and stature. There are "first-tier" departments, and there are the rest. First-tier departments demonstrate their leadership and their ability to maximize resources – financial, human, and clinical – to produce outstanding health outcomes for their states. In nobody's estimation is the Pennsylvania Department of Health (DOH) in that first tier. But we can get there. Key factors that can propel the DOH to success include:

1. an Administration that respects and promotes the inherent value of public health;
2. an entrepreneurial Secretary who maximizes opportunities to generate support from the federal government, nonprofit and private sectors;
3. the right leadership team with national experience and reputation;
4. unwavering commitment to quality and safety and improvements in health outcomes;
5. productive relationships and stature with the legislature and other government departments;
6. working partnerships with the state's network of medical and academic resources;
7. widespread and real-time data and surveillance capabilities that trigger corrective action; and
8. adequate resources, effectively deployed.

Tools at the Department's Disposal



- Ability to coordinate, analyze and report from multiple data elements, collected by DOH itself or by the other Departments and agencies, including the Pennsylvania Health Care Cost Containment Council (PHC4), to direct action and policy
- Authority to license and regulate health facilities: apply licensure and regulation to measurable improvement in service quality and, therefore, health outcomes
- Commitment to safety supported by the creation of the Patient Safety Authority
- Funds to award grants and subsidies (the recent tobacco settlement and emergency preparedness funding represent new sources)
- Formal department linkages to administration and legislature that could serve to educate and inform key decision makers about the nature and dimension of health problems and solutions
- Gubernatorial commitment to reform demonstrated by creation of the Office of Health Care Reform
- Partnerships with some of the nation's leading health centers and academic institutions

OPERATIONAL REQUIREMENTS

Trump Bureaucratic Inertia with Urgency of Mission

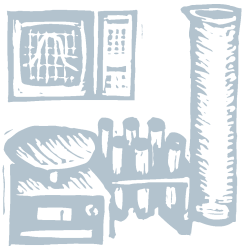
The Department should be encouraged by the Administration and the new Office of Health Care Reform to establish working partnerships with the other State departments with a role in health improvement, monitoring, education, licensure and funding. They should all be charged with similar performance goals. External partnerships should also be encouraged where the partners share similar goals or have expertise beyond the current capacity of DOH. Such partnerships have occurred recently: work on the tobacco settlement; establishment of the Patient Safety Authority; and overcoming of obstacles of decentralization and diffused departmental responsibility in responding to the West Nile Virus. Coordinated efforts are required among and between responsible agencies and departments; the Office of Health Care Reform can make them happen.

Use Data to Drive Decision Making

The Department has a wealth of data at its disposal. Obviously, data sources differ in timeliness, scope and quality, but together they represent a powerful tool for setting priorities, targeting interventions and determining accountability. There has been significant progress in data capacity at the Department of Health over the past decade. The Pennsylvania Health Care Cost Containment Council (PHC4), a separate entity, also has expanded its reach. The need remains to expand the breadth of data collected (to include chronic and emergency care), to improve timeliness and ease of use, and to apply this information rigorously to program, service, policy, licensure, technical assistance and funding decisions departmentally, locally, and regionally. Accountability for the application of data to decision making should trigger better consolidation and coordination of data sources.

Let Research on Best Practices Drive Process Improvement

Department-sponsored research on best practices should generate essential information to spur process improvement. The Department's relationship with the health organizations it regulates should grow to include identifying, supporting, sharing, and developing best practices in healthcare. Through this partnership, the Department's regulatory function will evolve into a supportive, process-improvement focus. The Department should therefore aggressively generate funds for research into clinical and operational best practices. Every program sponsored by the Department should be in a "research mode." Staff, including those of local health departments and providers, should be hired for their comfort with, or be trained in, data use. Ongoing programs should be regularly assessed for continual improvements in outcomes. Where necessary, the Department should supply technical assistance to local communities for data collection, analysis, and application.



Hold the Department of Health Accountable for Measurable Results

The Administration should set an annual agenda with priorities and performance goals for the Department. This new level of accountability should empower the Secretary to instill unity and direction among its many components. Among performance targets, one central measurement should be patient outcomes in certain conditions. Updated licensure regulations should tie to an outcomes focus, rather than process or structural measures of quality and safety. Compliance is a weak substitute for patient outcomes (i.e., continuous improvement in clinical care) as a consequence of regulation. The rapid translation of research discovery to clinical practice will advance health status.

PROGRAM IMPERATIVES

Support Community Health Providers in Achieving Health Improvement Targets

Pennsylvania currently ranks 26th among the 50 states on major health indicators, such as breast cancer, colon cancer, lung cancer, stroke, suicide, and motor vehicle accidents – a fall from its 1992 rank of 22. A first step toward improving this ranking and the health of Pennsylvanians is to enlist a network of providers at the community level, whether freestanding or affiliated, public or private, to achieve selected performance targets. The Department's role would shift to providing this network with data, process improvement technical assistance, and other resources. DOH will uncover where current policy and structure fail to support the best performance from community providers.

Take for example, diabetes. The community health provider network could be charged to achieve specific target improvements in diabetes treatment and to reduce poor care outcomes. With the Department's support, each member of the network would:

- revisit available data and identify gaps in service and health disparities among minority, rural, and low-income populations;
- collect, analyze and apply local data on quality and safety in the treatment of diabetes;
- share knowledge within the Department and across regions; and
- disseminate, teach and adopt local best practices as appropriate.

Essentially, each community health center would be a local health provider and a research facility, drawing strength and mutual accountability from the Department.

Achieve Quality and Safety Targets in Acute and Long-Term Care

Many of the licensing and regulatory measures available to the Department of Health no longer fully reflect the shifts that have occurred in the healthcare delivery system since the 1960s. Managed care growth, cost containment pressures, and technological advances have meant that lengths-of-stay in hospitals are much shorter than they were. The venues for treating patients discharged from acute care facilities have changed, and the medical condition of those discharged patients, especially older ones, is often more complex or frail than it used to be.

The Department faces the urgent challenge of reviewing the regulatory measures at its disposal for their impact on quality health services delivery, as evidenced by health improvement indicators.

With updated regulatory measures in hand, the Department can enlist providers of, for example, long term care, assisted living and personal care in efforts to achieve quality outcomes in targeted conditions by:

- working with the facilities to rigorously apply best practices to produce better health outcomes;
- establishing targeted conditions from which to measure progress; and
- providing training and technical assistance in process improvement techniques to achieve the highest standards of quality and safety.

CONTINUED ON REVERSE

MEASURE OUR SHORTCOMINGS BY THE NUMBERS:

9 to 57 percent: patients with diabetes who receive routine care – eye and foot exams, kidney monitoring, lipid screening and control

75 percent: the increase in hospitalizations due to preventable diabetic complications in the last five years in Southwestern Pennsylvania

$1.27 billion: additional charges due to an increase in preventable hospitalizations.

Source: PHC4 data, 2001

A FIRST-TIER HEALTH DEPARTMENT ASKS ITSELF:

- Do we use and share DOH and other data resources to inform local providers about their population's health status and outcomes?
- Do we regulate and license to drive health improvement?
- Have we best allocated DOH resources centrally and locally to advance healthcare delivery?
- Do we maximize federal revenue streams?
- Do we understand, catalyze, and advance best practices?
- Do the state's key decision makers understand the economic, social, and political consequences of our surveillance, management and education activities?

CONTINUED FROM REVERSE

PROGRAM IMPERATIVES

Strengthen Surveillance and Rapid Response Capacity

The Department has begun to participate in an integrative response to bioterrorism and preparedness for other large-scale public health emergencies. Armed with data and response plans, DOH must coordinate clinical, law enforcement, and local emergency medical services when catastrophes occur. The objective is to build the capacity of all regions to respond to adverse health events capable of injuring large numbers of people. This agenda would have several components.

- The DOH should assess the baseline capacity of every region to respond to health emergencies, epidemics, and unanticipated health events with widespread health risks. This should include an inventory of equipment, personnel, training facilities, and other resources of first-responder and provider organizations. The inventory should assist in quantifying, locating and assigning a value to resource gaps.
- The State should have a resource acquisition, allocation and funding strategy to achieve a universal baseline capacity (this can include a sub-region and interregional resource sharing strategy). The DOH could issue periodic, updated capacity assessment reports.
- The DOH should extend the surveillance capacity of systems like the Real-time Outbreak Data System (RODS) to cover both intentional and unintentional health risks.

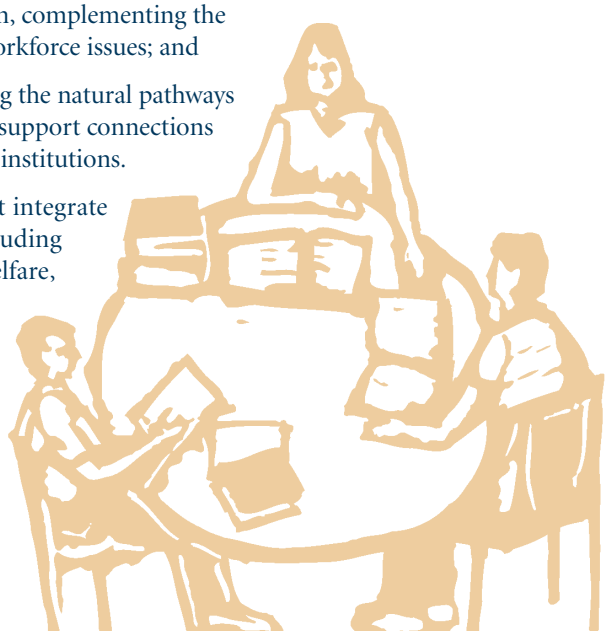
Close the Gap between Workforce Supply and Demand

A skilled, experienced and adequate health workforce is essential to the quality of health care, progress in community health, capacity to respond to large-scale health threats, and overall economic health. The DOH should:

- lead the Commonwealth in shaping its health workforce agenda;
- create a standard, ongoing, reliable and relevant data system in order to measure, anticipate, and respond to workforce inadequacies;
- consider the creation of a State Center for Health Careers;
- consider the creation of a Nurse General position, complementing the Physician General, to play a leadership role in workforce issues; and
- strengthen the most successful components along the natural pathways to health employment and career advancement; support connections between the Department of Health and training institutions.

To achieve these objectives, the Department must integrate the workforce activities among Departments including Aging, Education, Labor and Industry, Public Welfare, Community and Economic Development, State (professional licensure boards), the Pennsylvania Higher Education Assistance Agency, and the Pennsylvania Workforce Investment Board.

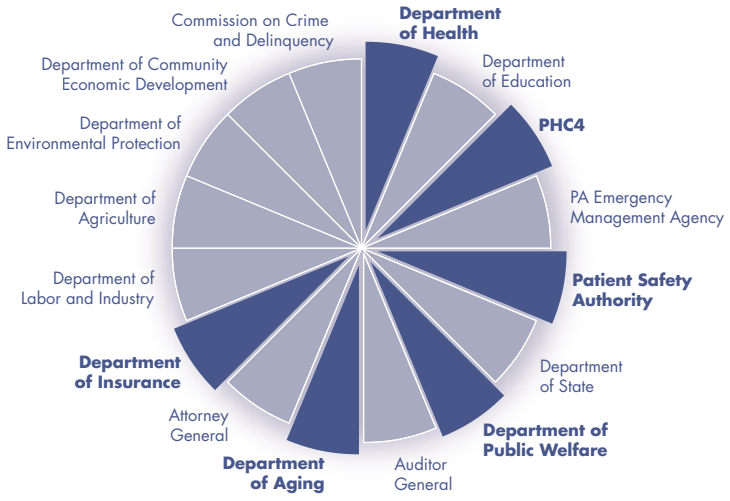
A SKILLED, EXPERIENCED AND ADEQUATE HEALTH WORKFORCE IS ESSENTIAL TO PENNSYLVANIA'S QUALITY OF HEALTH CARE.



A FOUNDATION FOR IMPROVEMENT

Who Controls Pennsylvania's Health Agenda?

Responsibility for the good health of Pennsylvanians is dispersed among DOH and other Executive Departments and agencies of Commonwealth Government. Gubernatorial administrations over the past several decades have not explicitly and operationally designated the DOH as the "lead agency" in meeting this important goal. In fact, other departments allocate more health funding or assume a greater leadership role in health. The recent creation of the Office of Health Care Reform (OHCR), under the leadership of Rosemarie Greco, ties together six of these key stakeholder units (shown in darker blue), and is a positive step toward improving the health of Pennsylvania.



A Respectful Proposal for the Office of Health Care Reform

We believe we are capable of having a healthcare delivery system that is as safe and reliable as aviation, widely accessible, and exemplary in population health. Based on the Foundation's past and current investments in the improvement of healthcare in the southwestern Pennsylvania region, we respectfully suggest that the OHCR undertake:

- recasting the medical malpractice debate around safety and best practices – prevention, not punitive damages, addresses the source of the dilemma;
- institutionalizing first-hand observations of consumer experiences with the healthcare system and diligent documentation of pathways of care;
- structuring state programs to respond to consumer needs with an emphasis on access, quality, safety;
- investigating the feasibility of a statewide demonstration of universal coverage;
- acting as the quality watchdog for public programs and community providers; monitoring enrollment, care delivery, and evaluation; and
- connecting departments to address health workforce issues comprehensively.

List of Interviewees' Organizations

Over 40 individuals from a range of private and public health organizations, and with a range of perspectives on health, were interviewed in the research for this issue. Many wished to participate, but only anonymously. Their organizations are listed alphabetically:

Allegheny East Community Mental Health Center
Bioterrorism Department, UPMC Health Systems
Center for Public Health Preparedness, University of Pittsburgh
City of Pittsburgh Emergency Services
Community Care Network
Community College of Allegheny County
Consumer Health Coalition
Emergency Medical Services, Allegheny County
Family Health Council, Inc.
Federal Bureau of Investigation, Pittsburgh Office
Government Relations, UPMC Health Systems
Hospital Association of Pennsylvania
Hospital Council of Western Pennsylvania
Institute for Research Education and Training in Addictions
Local and State health department representatives and leaders
Long Term Care and Hospital Providers
Pennsylvania Health Law Project
Pennsylvania Coalition of AIDS Services Organizations
Southwestern Pennsylvania Partnerships for Aging
Pennsylvania Coalition of AIDS Services Organizations
Pennsylvania Community Providers Association
Pennsylvania Department of Health
Pennsylvania Health Law Project
St. Margaret's Family Health Center
Three Rivers Workforce Investment Board
Turtle Creek Community Mental Health Center
University of Pittsburgh, Center for Minority Health
University of Pittsburgh Center for Rural Health Practice
UPMC – Braddock

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