Kathleen Sebelius, one of America’s leading voices on health policy and healthcare reform, was the Keynote speaker at the 2016 PIAA Medical Liability Conference. From April 2009 through June 2014, she served in President Barack Obama’s Cabinet as Secretary of the U.S. Department of Health and Human Services. From 2003 to 2009, Sebelius was Governor of Kansas. From 1995 to 2003 she was the elected Insurance Commissioner of Kansas. Before assuming statewide office, Sebelius served four terms in the Kansas legislature.

In an exclusive interview with Inside Medical Liability, here’s what she had to say about a number of critical issues for healthcare today and, in particular, her perspectives on patient safety and medical professional liability, as the current healthcare climate continues to evolve.

**Interview with... Kathleen Sebelius**

You’ve said that the passage of the Affordable Care Act has given significant impetus to improvements in patient safety. How did that come about? Do you see sustained improvements in the future?

Sebelius: First of all, I do think patient safety will continue to improve. Part of the Affordable Care Act was a framework to improve the delivery system of healthcare. One of the primary goals was to have better patient care, better outcomes—and, in part, it came about when the Centers for Medicare & Medicaid Services, the administrative authority, aligned, for the first time, financial payments with outcomes. We began to measure what was going on.

One of the very first target areas was hospital-based conditions that were causing roughly 50,000 deaths a year, and lots of hospital stays and higher costs. But they hadn’t really been a focus area. CMS declared this to be one of the target areas, and drew a data baseline for both infection rates and mistakes occurring in hospitals and then set up a protocol that after some training and collaboration, which went on for the first 18 months, hospitals began to be penalized, financially, for rates of hospital-based harms.

There has been a fairly dramatic response to that—a decrease of about 17%, across the country, in the first two years. People estimate that this equals some 87,000 deaths that have been averted. So this initiative has worked by aligning the financial incentives with outcomes. I don’t think that people were intentionally causing harm, but it probably was not one of the principal focus areas. And it has become one of the principal focus areas.

And, for the first time—although this seems like an obvious thing, for the first time the federal government is actually setting up a system to reward providers for keeping their patients healthy in the first place.
And yes, again, improvements in patient safety will continue.

**IML:** The ACO concept has really taken off in the last few years. Does this model for care decrease risk and, on balance, promote patient safety?

**Sebelius:** I think it can. Certainly, that is one of the overall outcomes that will be evaluated. And, as you know, among the ACOs, some are hospital-led organizations, some are provider-led organizations. But I think it is a concept that is centered on coordinating patient care, and again, around some shared financial risk. And, for the first time—although this seems like an obvious thing, for the first time the federal government is actually setting up a system to reward providers for keeping their patients healthy in the first place.

You used to be able to make money primarily by doing things—more tests, more diagnostics, more days in the hospital. The ACO is conceptually a different model, where you actually can be financially successful by intervening at an earlier stage—avoiding hospital days, managing chronic disease in a different way. Both patient safety and overall health are likely to improve. And costs are likely to decrease. At least in the best models, they have determined that costs are beginning to go down.

**IML:** Are there ramifications of the proliferation of ACOs for medical and healthcare professional liability insurers?

**Sebelius:** I think the whole new system of care delivery has some potentially significant implications. Because for the very first time, it's set on a platform of data and measurements. It's digital medical information. The HITECH Act that passed in 2009 has really flipped hospital and doctor records to digital rather than paper.

So you can finally measure things—look at cost outliers, drive practice protocols, figure out quality measures that will go down to the level of the individual provider and to the individual hospital. That will have, I think, a significant impact, then, on liability. Because you will have transparency—people will be able to track and see what's happening—and that may cause some angst and potential litigation. But I think you will also see, if somebody becomes an outlier, whether it's in terms of infection rates, for example, or botched surgery, that this trend is going to live in a much more transparent space than has ever happened before.

So I think that the expansion of ACOs does have a significant implication for MPL.

**IML:** What new applications do you foresee for EHRs, and will these serve to increase quality, and diminish risk?

**Sebelius:** The first step, as I said, was the creation of a national protocol around EHRs, and putting in place a platform—and putting in place a financial incentive, so that both hospital groups and doctor groups were motivated to adopt electronic records. In 2009, when this started, only about 10% of hospitals and about 20% of doctors had any kind of comprehensive electronic record.

That has changed dramatically, so that the vast majority of both of those groups are on a digital platform, and collecting information in a very similar fashion. The next big step in the new framework, which recently has been announced by the government for Medicare payments, will be using this system to pay doctors in a very different way. So, rather than fee for service, it will really drive value-based propositions, along with measurements of what the outcomes are. And Medicare payments will be directly based on that. The rule was just put out for comment about a month ago.

This is kind of “phase 2” of EHRs. First you had to get the records in place, and we had that. There may be some back and forth, and the final rule may look a little bit different. But that's really the big new chapter. And there is now a real push for interoperability, so that the data systems will be able to talk to each other, across a state, across the country.

Providers and vendors will essentially be penalized for any kind of data blocking. I think that does a couple of things—transparency in measurements, in a way that never happened before—and it really enables consumers, health consumers, to own their own data and to follow, in a very transparent way, what's been going on. This has never happened before.

So it really opens up a whole new world. The government's interests are to improve individual patient care, and to improve overall population health, by driving adoption of the best standards, the best protocols, driving down infection rates, and measuring what's happening.

And eventually the outliers will be—for the first time—clearly identified. Then, they can either be financially penalized, and/or go out of business. Because I think that the system that is in place now does not allow that to happen very easily. It's anecdotal.
I think that from the consumer side, people will, and I think they actually will do this, get to the point where they will be looking at quality measures, looking at outcomes, looking at costs, to make healthcare decisions in a very different way. And that's a good thing.

**IML:** Telehealth and telemedicine, transition of care, physician burnout, and the growing role of advanced practice specialists are just some of the key trends in healthcare being watched by medical and healthcare professional liability insurers. What other areas should they be monitoring?

**Sebelius:** Again, I think this whole electronic digital platform opens a lot of horizons, around care protocols, in a way that is likely to improve care, but it also could have some pitfalls. Another area to watch is what happens with diversification of the work force inside a hospital setting, and inside a practice setting. This raises issues around standards of care and training.

If a doctor sends a community health worker out to follow up on something, and they screw up, who's got that liability—who is at the end of the day responsible? So there will certainly be issues around that.

I think that the new rule for Medicare shows the federal government is at least encouraging the expansion of telemedicine. That can help solve access issues, and it also is often enormously productive in getting timely visits. But again, how that is handled, in terms of the whole umbrella of responsibility and liability, will need some updating and some scrutiny.

I think there is a lot of change underway in terms of various kinds of protocols concerning second opinions, and getting people to the right specialist quickly. If you want to lower costs, and if you start with the notion that the most expensive patients are the ones who drive costs, you find that in the Medicare system, the top 10% of spenders consume 60% of the resources. Some of that is end of life care, or very expensive care for chronic diseases, or multiple hospitalizations. How do you deal with that?

There are a whole variety of issues, as you try and minimize costs. You don't restrict care at the same time. There will be questions around liability in regard to the process of decision-making in this area, since financial incentives are more aligned with doing less, as opposed to doing more. Is that going to create potential harm?

**IML:** What innovations can medical professional liability insures adopt now, to position themselves best for the healthcare market of the future?

**Sebelius:** Well, I think everybody now is in a process of gathering data and analytics. That will be a major factor in driving healthcare in the future. And a lot of systems, whether hospital or office-based, will be trying to work with data input, and put in place continuous systems of improvement, and ways to really drive and measure what actually is happening.

But I think the more that medical liability, first, understands those trends, but also uses those same analytic tools I've mentioned to properly insure this new world of risk, it will be beneficial.

Because things are really shifting, if you shift from just a straight fee for service system to value based care, if outcomes are really transparent to the public at large, to the patient, then individual hospitals, individual patients are going to be measured in a different way, and will potentially incur liability in different ways.

Insurers should be building their own data systems, so they can stay a step ahead, tracking the trends, aware of the outliers. Some carriers put docs in categories according to specialty areas and they have different kinds of insurance, by type of provider or specialty. I think carriers should consider similar categories, not necessarily based on practice area, but instead based on individual risk profiles. It may be appropriate, going forward, to begin to categorize insureds differently, to sell differently based on the kind of information that patients may be using and the kinds of information that providers will be measured on and paid on, on an individual level. These factors could well be driving liability costs, on an individual level.

So there needs to be some kind of connection between what the insurance umbrella looks like and the actual risk that a given provider represents.

**IML:** Are you optimistic that the healthcare system will be in a better place in 2020?

**Sebelius:** I am. There is a huge change underway—probably long overdue—and it's actually happening, in real time. People tell me that it's the biggest practice change they've seen in their lifetime.

Just the electronic records themselves are the best investment that any system can make—not just in hard cash out the door, but also in teaching and effort—it is the single best investment in better care.