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Conference of Boston Teaching Hospitals director gives perspective on health care evolution

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To say that John Erwin, executive director for the Conference of Boston Teaching Hospitals, is embedded in the health care debate would be an understatement.

Erwin serves as an advocate on both a state and federal level, supporting 14 Boston teaching hospitals from Cambridge Health Alliance to Massachusetts General Hospital. His teaching hospital perspective has been central to his role on the state's Health Policy Commission Advisory Committee, and he will soon join others to discuss rate variations on a second commission group.

It is a busy job as the health care market, Medicaid/Medicare funding, and hospital reimbursements are in the midst of change. Erwin discusses the transformation, and the perspective that has brought some of the largest Boston hospitals together.

What role do you see yourself playing in this provider price variation commission, which is a committee being established under the Health Policy Commission?

The role, for us, is explaining the differences between rates at community hospitals and rates at teaching hospitals - explain what goes into the cost of training medical residents and what goes into the costs of research. (We need to detail) the cost of specialized services, like burn centers, level one trauma units, transplant units - how those costs are different in a teaching hospital verses a community hospital, and how those services

make sense in the context of the entire healthcare system. Though those costs are born individually by a hospital, the benefit is to the entire healthcare system.

There are some at the federal level that would like to see readmissions analyzed as a quality measure to augment Medicaid and Medicare payments to hospitals. How do you feel about this "pay for quality" mentality?

Obviously there is an increased focus on paying for quality, which I don't think anyone could disagree with. There are areas where the devil is in the details. Readmissions for a simple procedure may be something that a hospital could have prevented, but readmissions for complex procedures - there are instances where you couldn't have foreseen that readmission.

And there are certain types and certain kinds of patients. A lot of people don't have the support in their home to prevent readmissions, or to follow through completely on a discharge plan. So obviously, we agree with paying for value, but the devil is in the details. We want to make sure there are accommodations for individual patients' needs…

There is legislation at the federal level that would carve out certain procedures from the readmission policy and take into account the socioeconomic status of the patient.

National Institutes of Health funding - all the teaching hospitals are clamoring about declining research grants. But the budget has increased since fiscal year 2013, and is planned to be higher in fiscal year 2015. Is it as dire as it seems?

If you presume, as I think you have to, that sequestration will occur again (it is dire). Sequestration for NIH would be about a five to eight percent cut in real dollars. When you combine that with level or slightly decreased funding over the last five to seven years, and account for inflation, it is a real concern for us.

I think the unpredictability of it is something that really concerns everybody. Previously, when there was bipartisan agreement to gradually increase NIH funding, you could expect some sort of predictable growth rate. Now with sequestration and other budget battles, there is no guarantee that you'll be able to keep pace with inflation.

The topic of conversation lately has been decreasing health care costs. What is the Conference of Boston Teaching Hospitals doing in order to deal with those rising costs?

I think a lot of that is happening at the individual hospital level. Hospitals are taking new initiatives to reduce costs. A couple (hospitals) have demonstration projects for Medicare, (such as) assigning nurse case managers to highly complex cases to reduce costs. At least four of our hospitals are part of the Medicare Accountable Care Organization pilot program, where we're starting to see costs reductions over there, so there's a lot of individual initiatives. Once you figure out if they work or not, you can replicate those, not just in our hospitals, but hospitals throughout the state and throughout the country.