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Innovations in Patient Care: Lessons from the Field

Alliance for Health Reform
July 11, 2008

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ED HOWARD: Good day to you. My name is Ed Howard with the Alliance for Health Reform and I want to welcome, on behalf of our congressional leadership, Senator Collins and Senator Rockefeller, and our board of directors to this briefing to explore the relationship among nurses, nursing, health care quality, better health care value, and all the related topics. We have an hour and 45 minutes, we can do it all, I am sure.

I work crossword puzzles when I am not doing health policy and the one frequently finds a clue in those puzzles that says something like what we get from nurses and the answer is always TLC, tender loving care. True enough, but not nearly complete enough.

I think there is a growing realization that if we are going to really reform, as in reform, the U.S. health care system to get a handle on costs, to improve the quality, which the experts tell us is at best mediocre; we have got to harness more fully, the skills and the dedication of America's nurses. Those nurses are working in, sometimes, leading interdisciplinary teams of health care professionals and we want to explore that phenomenon as well today.

I want to thank the United Health Foundation for its support of today's briefing. And in the interest of full disclosure, I want to point out that the Senior Vice President

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of the Foundation is none other than Dr. Reed Tuckson, whom you will hear from momentarily. He also happens to be a founding board member of the Alliance for Health Reform and we are very appreciative of that support in many ways.

I also want to acknowledge the huge contribution to the program today by the American Academy of Nursing. Pat Ford-Roegner and her colleagues have helped identify and recruited for today's program what the Academy designates as edge runners that is nurses who exemplify and carry out the best in innovative care that nurses are involved in today.

Let me just mention a couple of logistical items for those of you not familiar with them, by Tuesday morning, you will be able to view of a web cast of this briefing on Kaisernetwork.org. You will also be able to look at the materials electronically that are in your kits, both on Kaisernetwork.org and the Alliance website, which is Allhealth.org and then a few days later, there will be a transcript posted in both places and you can view that.

At the appropriate time, I want to invite you to fill out one of the green question cards. There are also a couple of microphones that you can use to ask your question directly and we would encourage that along with, at the end of the program, filling out the blue evaluation form to help us improve these briefings.

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Now, I want to dip right into the program. By the way, I really, really mean this, would you please turn off your cell phones or put them on buzzers or whatever it is you have to do so that you will not disturb other people who are trying to listen to the program. Thank you.

You are going to want to listen to this program. We have an excellent line-up of speakers today. We are going to start with the aforementioned Reed Tuckson, who is not a nurse. He is a physician. He is also the Executive Vice President and Chief of Medical Services for the United Health Group as well as vice President of the United Health Foundation.

Reed has been a senior official at the AMA. He has handled public policy for the March of Dimes. He has headed one of the best medical schools in the country at Drew Medical University in Los Angeles, even ran the D.C. Health Department for a while in an earlier life.

And I am pleased to say, again that he has served for as long as there has been an Alliance Board, on the Alliance Board. He is now a member of the Executive Committee as well. Reed, thank you for helping to arrange this briefing and for being a part of it.

REED TUCKSON: Well thank you very much and it is a great pleasure to be here. The best claim to fame that I have is that I was raised by a visiting nurse and so I have learned

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my lessons well from the actions of my mother. There are four, I think, contextual forces that are very relevant to the discussion today and that define why this panel is so important to not only our country but to each of you.

Number one, of course as Ed Howard said, is the determinant dyad of quality and cost concerns. As a result, we simply, as a nation, must do better at maximizing all of our available health care assets. We have got to make sure that every one of our assets are used appropriately, that they are used safely, and that they add to efficiency and health care delivery.

As you will see, the role of nursing is not only important but as of today, underexpressed in that equation. Number two, the context is that there is the obvious need to expand access to comprehensive care services not only for the uninsured but also for the underinsured particularly those who are living in rural America and in inner-city and those folks currently are not seeing their health care needs being met by the current organization and array of health care resources.

Number three, and very relevantly, the aging of the American population with the concomitant increase in chronic disease, this inevitably means that we will have millions and millions more Americans who will be living with at least one and quite often, more than one chronic disease requiring a

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comprehensive array of medical and medically necessary social support services.

These services will increasingly be community-based and will require skilled individuals to be able to organize them and make them available in a coordinated and effective way. This will require a new definition of the health care team, new leadership for the health care team, and ultimately consolidated work to figure out how we will overcome what is today a dysfunctional fragmented and disconnected delivery system.

Finally, number four in terms of context, is the drive to a patient-centered and increasingly consumer-oriented health care delivery system. We know that inevitably because of the problems of cost and quality that people will be given significantly more financial risk for making even more important and complex personally appropriate health care choices.

People will be on the line to take complex information, translate it into personally appropriate and meaningful action, and there will be significant economic consequences associated with either failure to choose or incorrect choices.

This will inevitably mean that there will be a need to support people in making better choices and navigating a wider array of complex information and applying it to their

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individual circumstances. The genetic revolution is but one of this dynamic. Think about this for a moment. As you look at the escalation in our sophistication of the results of the genetic revolution.

There are, in America today, 2,437 certified genetic counselors. That is one per 123,600 people. Obviously we have a real problem with how we are going to confront those issues and relatedly, how we will be able to help individuals navigate through managing their own diseases in context with the overall health care delivery team.

Well within this context, what lessons have we learned from the field? Four quick observations. Number one, obvious and simple, we need more nurses and those nurses need to be trained to do an increasing variety of important and variable tasks. These tasks include from population-based public health nursing for prevention .It includes the provision of primary care as we will hear from one of our panelists in a moment. Those provisions of primary care will inevitably bump up against concerns around scope of practice.

Let me just tell you now that the concerns around scope of practice are going to be important and I will come back to them but ultimately, we need to maximize the opportunity for people to contribute as we go forward.

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Third will be related to this is the counseling and decision support tasks that we must help nurses to be well trained for, and then given just those kinds of new jobs, what happens to the traditional bedside nursing, which is such the bedrock of what the health system needs and what nurses have done. There are obviously, as we have more and more tasks for nurses to do, fewer and fewer to be at the bedside. This is reaching a crisis situation.

Number two challenge, what we have learned. Nurses need to be central to the policy debates in health care. I am lucky enough to participate in a large number of the health policy forums around the country. It is always interesting to me how underrepresented nurses are in that discourse. We seem to devalue this expertise.

It is also interesting to me when we read news articles as to who is quoted for their learned opinion about a topic here or there. Very rarely is it a nurse who is quoted despite the special observations, insights, and expertise.

So for those of you who are Congressional staff, we do hope that you will continue to add nurses not as an afterthought to your panels but as a fundamental prerequisite for your learned discourse.

What we have learned, number three, nurses can and do provide innovative care that results in better quality and

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lower costs for both private sector and public sector purchasers. In our company, United Health Group, we have a division of business called Evercare. It is a multi, multi, multi-million dollar enterprise that is designed and run by nurses providing community and in-home support and nursing home support. It has three fundamental principles.

Number one, that it works on a collaborative model with physicians; number two that they provide a coordinated care experience integrating the work of multiple health care disciplines and third that it requires special training and expertise by those nurses to be able to meet new emerging tasks.

The result of their work has been that for our nursing home-related work, a 70-percent decrease in the consequent visits in emergency rooms and in-patient hospitalizations preventing extraordinary amounts of poor outcomes and wasted resources. For our community-based in-home work, a 70-percent decrease, over the last four years, in the number of people who have been going to nursing homes for nursing home placement, so keeping people in the least restrictive, most appropriate environment.

Well the fourth and concluding observation from the field that I would leave you with is that this scope of

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practice and I just want to spend just 10 seconds on it and close.

I am concerned about this debate because any time you have conversations within the house of medicine about scope of practice; inevitably, it is intense, complex, and acrimonious. It is often based, at its best, on real concerns about quality. However, it is often based also on issues that have to do with personal credibility, ego, and ultimately it has to do with money.

So we need to be very careful and cautious about this conversation as it goes forward and try to have a conversation that recognizes unmet needs, new health care system challenges, and new opportunities for everyone to get involved in an era of increasing demand and great scarcity for important roles.

We look forward to the rest of the panel and the conversation but these are important issues not only for the field of nursing, but more importantly, these are important issues for the entire nation and its healthcare infrastructure.

ED HOWARD: Great. Thank you very much Reed. Excellent, excellent context setting and let me just pick up now on the third one of your observations in the latter set that with respect to innovations in nursing. You are about to hear a couple of excellent examples of innovations and innovators.

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The first we will hear from is Mary Naylor who heads the Center for Transitions and Health at the University of Pennsylvania. She is also a Professor of Gerontology there. She is one of the leading health researchers in the country. She runs the Robert Wood Johnson Foundation Interdisciplinary Quality Research Initiative.

She is, I am pleased to say, a veteran of several Alliance programs over the years. She is one of the edge runners of the American Academy of Nursing that is for her work in making the transition from hospital to home care safer and less expensive for older patients. Mary, thank you very much for being with us. We look forward to hearing from you.

MARY NAYLOR: Thank you Ed. I want to thank the Alliance for Health Reform and the American Academy of Nursing for presenting me with this opportunity to showcase for you a model of care that I think is illustrative of the capacity of nurses when put with the right evidence to make a major contribution to all of the priority health issues that we face in this country, issues related to access to care, patient safety, quality, and cost.

I would like to mention that the work that I lead has its roots here in Capitol Hill. A number of decades ago, I was on the staff of the Senate Committee on Aging when we were, at that time, looking at the impact of the perspective payment

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system on the financing of health care in this country and I began to look at its impact on the quality of care for older adults.

Well in those past two decades, a great deal has changed primarily on the face of the population that we are now serving in hospitals is older adults, thanks to medical technology and advances in medicine and science, are living much longer and consequently we are confronting, in hospitals, individuals who are very complex, living and coping with multiple chronic conditions, and often the reason they are hospitalized is because of an acute episode of that chronic condition.

I have the great fortune to lead a team of clinical scholars from nursing, medicine, and health services researchers in the Wharton School in the design and testing of the model of care designed to be aligned with the changing needs of this population to honor their preferences and their choices and, at the same time, to improve quality and cost.

The work is called Transitional Care and Transitional Care Services has been defined by the American Geriatric Society as a set of services or environments that are specifically designed to enable at-risk populations, move with much greater ease from one level of care to another across settings and across multiple providers.

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I want to share with you that the context of care for many elders today is not just the hospital admission to hospital discharge an acute episode for older adults extends from Friday evening when they confront a big health problem and are brought into the emergency room through a post-acute set of services and back into primary care.

So while we call things discharge, they do not feel discharged from the medical experience. They are still continued in experiencing all of the troubles and issues associated with an acute event.

There are different trajectories of people walking through this. Sometimes, it is individuals who had their first hospitalization for a chronic event but more often, it is individuals with multiple complex chronic conditions, other health risks, and many times, it is individuals who are at end of life.

The consequences and the case for transitional care is really quite a compelling one. We have very high rates of medical errors. We recently did a study using data from our latest clinical trial that showed that 70-percent of patients were discharged with the wrong information related to their medications and about three quarters of those were medications that had a very high risk threat. Many of them were blood thinners, anticoagulants, et cetera.

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Study after study report patients have serious, and family caregivers, have serious unmet needs that contribute to poor outcomes; high rates of dissatisfaction, in fact, dissatisfaction with the hospital experience and discharge to home is among the greatest dissatisfiers of all; very high rates of preventable admissions, readmissions. It is estimated across numbers of studies that about a quarter to a third of all hospital admissions of Medicare beneficiaries could be prevented.

In 2005, Medicare had 600,000 index hospitalizations for heart failure, DRG127 alone. Within 30 days, 27-percent of the Medicare beneficiaries had been re-hospitalized, within 90 days, 50-percent. If we were to prevent one quarter to one-third of those hospitalizations just for that one DRG alone, we would be saving this system between 400 and $600 million, that could be better spent in prevention of chronic illness and dealing with risk than we are currently doing.

So we have been tackling this issue now and testing and refining a model of care for over the last 20 years that is a collaborative care model but it is nurse-led. It starts with identifying and we have now a very well-honed risk profile who, coming into the emergency room or hospitals are at high risk for poor outcomes and need something much more than we are currently providing to them.

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It enables us to engage patients and family caregivers. We are placing little attention on the needs of family caregivers in this country and honestly, they could be a major and in our work, have been consistently demonstrated, to be a major partner in assuring positive outcomes for patients.

A lot of these patients are not being managed well. They have six and seven physicians who do not talk to each other. They are engaged in context with multiple nurses and therapists who do not talk to each other and there is poor management. We place a premium on streamlining their medication and other therapies and getting them in good shape.

Then we are positioning them to be able to better managed themselves but believe me, self-care is not an option for many of these people. Our notion of self-management is knowing what to do when you run into trouble.

It is a collaborative model. The nurses, in this case, interact with all of the physicians in the hospital to home, et cetera and it places a premium on things that we know that are important for good outcomes, trust, care coordination, and collaboration.

Care is delivered, in this case, by advanced practice nurses. These are masters-prepared nurses with advanced knowledge and skills of the unique needs of this population.

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These advanced practice nurses pick patients up at hospital admission.

They work with the staff there to make sure not just to do good discharge planning but to make sure that that patient is well cared for while hospitalized. Those same nurses follow the patients into the home for an average of two months post-discharge, available seven days a week for questions and concerns of patients and families.

We use evidence-based protocols. We know exactly what to do. The nurses know exactly what to do when they visit within 24 hours of hospital discharge. They know that people are at their lowest ebb seven to 10 weeks post-discharge and they know that they need a call at that point in time.

So this is a real strong evidence-based unlike though, other transitional care models. This is not just about improving handoffs. This is about positioning patients and their family caregivers with the knowledge, skills, and resources that they need to do much better.

We have had consistently positive findings from clinical trials published in Annals, JAMA, JAGS. Our latest clinical trial demonstrated 52 weeks reductions in re-hospitalizations all cause for these patients at a mean savings per patient of $5,000 after taking into account all that we know with the cost of the intervention.

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Twenty years later, we still have not had this model of care adopted by and employed by our health systems. There are numbers of barriers to that, the organization of care, the fact that we place a premium on what happens inside a box, hospital admission to hospital discharge, not on what happens to the care of these people over an acute episode of illness.

So all of our incentives are in those boxes, hospital care, home care, et cetera, and the culture of care. We do not commit ourselves to chronic illness in this country. We are really still focused on acute care. We do not focus on longitudinal care, collaborative care, the things that people need.

So we embark to, over the last couple of years, on engaging partners, Kaiser, and Aetna, and supported by a number of foundations to test our model of care, to translate it, and integrate it into those organizations and as a result of that, the transitional care model, because it has been defined by Aetna as a high-value proposition, is proposed for expansion in Aetna; Kaiser, the data is ongoing; the University of Pennsylvania, believe it or not, you can be a profit in your own land if you live long enough, has adopted the model and Blue Cross and Blue Shield in Philadelphia will be reimbursing it starting in September.

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Our next steps are to continue to promote evidence-based models of care such as this led by nurses but really relying on the participation of all to make things happen. We would love to be able to continue to promote our findings and promote the policy changes necessary to make sure that every older adult who comes in to a hospital today, who needs this kind of service, receives it. We are continuing to build the science through our trials.

Let me just spend one minute on a program that I hope you will become very familiar with and this is the effort of Robert Wood Johnson to continue to advance the science linking nursing to quality. Right now, there is a $10 million investment over five years to build interdisciplinary programs of research that help you in your work understand through rigorous evidence how nurses are contributing to preventing medical errors, to improving the care coordination, pain management, and all of the things that are important to people in this country and ultimately, to define the contribution of nursing to health systems performance.

This is information on our program and feel free to contact me at any point if you have any information but at the website, you will learn more about all the studies under way and the findings this year from our first teams. Thank you so much [applause].

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ED HOWARD: Thank you very much Mary [applause]. Next up we are going to hear from another American Academy of Nursing edge runner, Audrey Nelson, who directs the Patient Safety Center of Inquiry for the Veterans Health Administration, the VA. That center works to prevent falls and make wheelchair use safer for frail, older people. Dr. Nelson also holds academic positions in several different departments of University of Florida. We are very pleased to have you with us here.

AUDREY NELSON: Thank you very much. I am delighted to be here. Looking at the nursing practice quality of care issue. One way is to assume that if we just had more nurses, we would improve patient safety and quality of care but an often overlooked approach is to take a look at bolstering our existing workforce and one of the ways we lose 12-percent of our nursing staff a year is because of the physical demands of the job, which do have technology solutions. So I am going to present a new way of looking at bolstering that workforce.

While every work environment has its own special challenges, I think people often do not realize the hazards that nurses face each day in their job.

The United States is having an obesity problem that is affecting not only workers but the patients that we are caring for. A typical patient in the 70s might have weighed 120 pounds. The average patient now is about 250 pounds. When that

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patient is physically dependent and you are trying to move them across sites, it really, the physical demands of the job exceed what a human is capable of doing today, tomorrow, and especially over a long career.

Specifically, nursing is the only profession in the United States that has remained in the top 10 high-risk occupations since the Bureau of Labor Statistics has collected this data in the 80s and this is despite the fact that it is very well known that nursing is notorious for underreporting injuries and about 50-percent never get reported.

So despite this underreporting, we continue to have one of the highest risk occupational injury rates and this, we have surpassed garbage collection, construction work, coalmining, and other high-risk occupations. I do not think people realize the physical demands of this job.

The highest risk task contributing to these injuries is manual patient handling, moving patients from a wheelchair to a bed, repositioning them in bed, and performing tasks. Specifically in an eight-hour shift, it has been estimated that the cumulative weight a nurse lifts is equal to 1.8 tons per day. There are very few humans capable of an entire career of that level of physical activity.

The estimated costs in the VA alone are estimated annually at $222 million associated with the treatment of these

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injuries not associated with the recruitment and retention problems that this brings on.

The reason that this is such an issue is that the human adult form is an awkward burden. It does not have handles. It can weigh over 200 pounds. It is not rigid. The weight is not evenly distributed, and it is susceptible to severe damage if it is mishandled or dropped. The risk is very high unlike manufacturing where you have got boxes. All of the original research was on ergonomics, was done on men lifting boxes from a floor. It does not generalize to nursing at all.

There are strong links between keeping nurses safe and keeping patients safe in health care facilities. While severe injuries in lost work days, absenteeism, staff turnover, decreased retention, and problems with recruitment, nurses who work injured have to actually end up cutting corners with getting patients out of bed less frequently with cutting back on the number of times they are able to do certain high-risk tasks in order to make it through a day. That definitely impacts on quality of care.

There are safety impacts as well. Nurses who are either injured or who are tired may have a more increased chance of actually dropping a patient during one of these transfers or dragging them across surfaces, which can cause skin tears and other problems.

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We developed a program I have been working on for 10 years, which is address this issue and, in fact, we have been able to reduce almost 90-percent, most of the high-risk tasks that nurses perform using technology solutions, purchasing this equipment, identifying the risks, having facility champions and peer leaders, and mandating a minimum patient lift policy.

The United States is not the leader in this area. There are many countries that have national policies protecting nurses from these types of injuries including Europe, Canada, and Australia.

The outcomes of the program that we developed in the VA have been rather significant and they have been replicated outside the VA as well but it is about a third reduction in injuries immediately and sustained over a long period of time, an 18-percent reduction in lost workdays and then 88 reduction in modified work days, which means injured workers can return to work much more quickly when they are using equipment. This is keeping our most experienced, knowledgeable nurses at the bedside instead of having them go out with permanent disabling injuries over time.

Based on this, it was adopted by OSHA in their ergonomic guidelines and also adopted by ANA in their National Handle with Care Program. I am really proud to say, as a VA nurse, that the VA has adopted this and has funded a $210

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million initiative to implement this program across every VA hospital in this country.

Other solutions for capturing this workforce issue are to expand this to other areas outside the VA, to begin to change our curriculum in schools of nursing, which still strongly advocate manual patient handling, which is obsolete, to look at state legislation options.

There are now six states, which have passed minimal lift or no lift patient lift policies including Texas, Washington, Maryland, New Jersey, Minnesota, and three states that have supportive legislation passed but we need a lot more. It has been a long time coming and we are losing 12-percent of our nurses a year to this problem.

So I would say making this change is hard. The biggest obstacle is considered cost. We have developed a business case in the VA, which indicates that the return on investment is four years and given the quality and patient safety implications is a well worth it endeavor.

In addition to our nurses, the patients also deserve this. If you are in a facility that you cannot be moved out of bed as frequently as you like because the staff are unable to physically accommodate that, it does have implications for adverse events, mobility-related adverse events. So thank you

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all very much for your attention. I would be glad to answer questions later. Thank you [applause].

ED HOWARD: That is terrific. Thank you [applause]. Thank you Audrey. We have got sort of a bookend panel. We start with a physician. We have two Ph.D. doctors of nursing and we end with another physician to give you a well-rounded look at some of these issues.

We get that last of those well-rounded looks from Dr. Rick Kellerman who is a family physician from Wichita, Kansas. He is Chairman of the Board of the American Academy of Family Physicians, which as I might note, the Chairman of the Alliance Board, Bob Graham is the former Executive Vice President of, so we are very pleased to have you Rick.

He is in private practice in Wichita. He chairs the Department of Family and Community Medicine at the University of Kansas School of Medicine, Wichita and thank you for persevering with some transportation problems and making it here in time for the panel.

RICK KELLERMAN, MD: Well thank you for inviting me. I should start by saying that my wife is a nurse. She is immensely proud of her profession. She identifies herself as a nurse. We met when I was doing my newborn ICU rotation and she is the only good thing I got out of that particular rotation [laughter].

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Now I think we have already talked a little bit about problems the health care system is having with access, problems with quality, problems with patient satisfaction, health care disparities, and the cost. Several years ago, the American Academy of Family Physicians began an analysis of all of this and we started with pointing our fingers this way.

We said well you know, it is a problem with Congress and it is a problem with insurance companies and it is a problem with CMS and it is a problem with Medicare payment system. Then we turned it around and we pointed the finger to ourselves. We said well what is our responsibility for this mess and furthermore, what is our responsibility to get ourselves out of this mess.

Now there is a tremendous amount of health services research that shows that health care systems that are based in primary care have better access, better quality, less cost, better patient satisfaction.

The Commonwealth Fund, just a year or so ago, put out a huge analysis on health care disparities, whether they are socioeconomic, rural, urban, ethnic, racial. The only two things in the health care system that minimized disparities are whether you have health insurance and whether you have a medical home, whether you have a usual source of care.

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Now there is a lot of things outside the health care system that deal with disparities like do you have a job, what is your income, what is your educational level but the only two things that we do in the medical system are if you can answer this question, do you have, yes, answer it with yes, do you have health insurance and do you have a usual source of care?

Well out of that research and some brainstorming, the American Academy of Family Physicians along with the American College of Physicians, the internists, the American Academy of Pediatrics, the American Osteopathic Association, and IBM put together what is called the Patient-Centered Primary Care Collaborative and if you want to look this up, go to pcc.net and there is a whole range of information, some of which, I am going to talk about.

One of the things that came out of this is that we need to change that we practice in our offices and in our hospitals. Now I went into family medicine because I wanted to provide comprehensive care, coordination of care, continuity of care, first contact access. I see patients in the emergency room.

I hospitalized patients and that is what I want to do but in the last several years, primarily through the development of health information technology, the use of e-prescribing, the electronic health record, we have new tools,

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as a family physician that I can use to improve quality of care.

The second thing, we have new methods of health care delivery like group visits and e-mailing with patients and then number three, we have new thoughts about the team concept of care.

What I want to do is talk a little bit about the principles that these groups have put together in terms of the patient-centered medical home, and then I am going to focus on the team concept and kind of bring this along a parallel but a little bit different pathway and I think we end up at much the same place.

The principles that this group has put together are the following, seven principles of the patient-centered primary care, patient-centered medical home. Number one, every person needs a personal physician. It is that relationship between the patient and their nurse, the patient and their physician that is really the hallmark of care in this country. Despite all of the technology, it still comes down to relationships. It still comes down to care.

Number two, a medical practice that functions as a team. Number three, that the responsibility of the team is to look after the welfare of the entire patient, not just the heart, not just the lungs, not just the kidneys, but look at

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the entire patient and I think patients that are sick and we heard this, I am going to phrase it a little bit differently but patients do not experience illness in a vacuum.

They experience it with their own emotions. They experience it in the context of their family and the problems it causes in a family. They experience it within the context of their community. So look at the whole person and be patient-centered.

Number three, care must be coordinated and it must be integrated and I look at these as two different things. I think coordination is an organizational function that people get the right tests at the right time and that we do not duplicate tests but I look at integration a little bit differently because that is a different type of thinking process where, as a physician, I sit down.

I look at the history of the patient. I look at their physical examination, their lab work, their x-rays, the consultations that I get from sub-specialists. I look at my health care team, what they are telling me about the patient. I integrate all of that and then of course, we discuss with the patient what their preference is. Probably one of the things that we most commonly overlook is what does the patient think about this? What is their preference?

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Next, care must ensure quality and safety and health information technology, and we can get into this a little bit more, gives me a new tool to measure that quality. There must be enhanced access through e-mail communication, through open access scheduling, a new type of scheduling.

Finally and this may be the one that is overlooked the most, there must be some type of payment reform because paying me and paying my team through a fee-for-service, which is only face-to-face when I actually see that patient does not work in primary care. So those are the seven principles.

Well let me focus on this team concept. If you think about a team, a team is not a group of co-workers who happen to be in geographic proximity is not necessarily a team. So as I was flying here this morning, I put together some characteristics of a team. Think of a basketball team but this applies to the team in my office or in the hospital.

A team is where every individual knows their role. Each team member functions at an optimal level of their skill set. The team members must complement each other. The team must communicate and finally, the team has a goal and the goal for teams in health care should be making sure that patients receive the preventive health care services, the acute care services, the chronic care needs that they have, and also I put

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in there the end of life needs they have. Again, those are the sorts of things that I went into family medicine for.

Now, if the team is functioning well, if each of the team members in my office or in the hospital are functioning well, that frees me up to do the things that I am best qualified to do and I think it is that integration of care, taking all of this information, factoring it all in, and presenting that to the patient and allowing them to make their final decisions.

Let me give you some examples of how this might work in an office. Let us say that I diagnose a patient with diabetes. Well in the acute care model that we function under now, it is very easy for me because I see that the patient has diabetes, I prescribe them a medication. I give it to the patient. They leave, just like pneumonia.

Well that dose not work very well with diabetes because this patient needs a number of skills. They need to know something about the biology of their problem. They need to know more about their diet. They need to know about physical activity. They may need social support.

I do not have the time frankly to do all of that. I need a team to help me do that. That may be through nurses. That may be through a nutritionist. That may be through a

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change expert, someone that is helping the patient change their lifestyle but I need the team to do that.

Well let us say that the blood sugar of the patient is out of control. They are not very well controlled. I can sit down with them. I can increase their dosage of medicine but a couple of days later, I might need a team worker to call that patient and find out are you taking your medication? If not, why not? Are you having some side effects? Can you afford the medication?

Again, I do not have the time to do that and the payment system frankly does not pay me to do that under the current system but I think that we can deliver better care if we work as a team. Perhaps that patient needs Meals on Wheels. Perhaps that patient needs a visiting nurse.

Another way that the team members can help me and this is where it gets to health information technology, and we think of the electronic health record as the paperless office. I think it is much more than that. The advantage of electronic health records is going to be that, at some point, I can push the F7 button; it will give me a printout of all of my patients that have diabetes. We can sit down.

We can look at those individuals with diabetes. Those patients that have a hemoglobin A1C of less than seven and they got their influenza vaccine and they had their eyes checked for

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retinal problems, I do not have to worry about them as much. I will need to check up on them. I am not worried as much. What about those patients that have a hemoglobin A1C above 8.5?

I need to identify those people. We need to work as a team to treat those people because those are the folks that are going to have heart disease, they are going to have gangrene, they are going to have kidney failure, we need to focus on those. I cannot do that with a paper chart. I need an electronic medical record. I need a team that is going to help me deliver that and I need a payment system that pays me to do that.

So to sum this all up, the acute care model, as you have heard, just does not work for primary care services. It does not work for an aging population. It does not work for people who have chronic disease and most of these folks do not have one chronic disease. They have got multiple chronic diseases. They have got multiple comorbidities. They have emotional; anybody who has depression and high blood pressure and arthritis may have depression. This impacts their families. It impacts their communities.

So I think we have a lot to gain in terms of these type of discussions, in terms of the role of the physician, the role of the nurse, the role of health care professionals because the

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bottom line is how we provide care and patient-centered care to everybody in this country.

ED HOWARD: Great. Thank you very much Rick. We now get to the part where you guys get to participate and I would remind you there are green cards in your packets. There are microphones that you can repair to. If you have a card, if you have a question, put it on a card. Do what this gentleman is doing by raising his hand with the card in it and someone will bring it forward.

I want to let folks know that since you came into the room, we have acquired copies of an opinion piece by Reed Tuckson talking about the role of nurses in shaping health policy and you want to take an opportunity to grab a copy on the way out.

While we are waiting for that, let me just follow up on one of the points that Mary Naylor made. When you were talking about the experience with Aetna and how they are satisfied that this is a good enough model that they want to try to adopt it, at least, in part of their operation, I wonder if there is a movement in Aetna toward changing the payments to encourage the kind of model that you described, if as Dr. Kellerman pointed out, you have got a payment system that does not exactly move in the direction of encouraging the kinds of changes we have talked about.

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MARY NAYLOR: I absolutely think that there is. I think that the Medicare managed care programs are really obviously recognizing that their population, their members are these same members that are experiencing the fee-for-service sets of issues, that they are experiencing tremendous breakdowns in care because of the absence of attention to care needs over episodes, et cetera.

And they recognize that the value of having services that both deliver on quality, deliver on member satisfaction, deliver on physician and nurse satisfaction because all of those were measured, and achieve cost savings.

So obviously, the way that we were able to demonstrate that to that organization and make the case now to the Blues in Philadelphia to support this was to really work through not just a rigorously tested evidence-based model of care in the randomized clinical trial world but now it is integration and translation and I am measuring it is working in their organizations.

So I think that they see that this is our future. We need to be very much concerned about innovations that achieve all of these goals related to value.

ED HOWARD: So is it fair to say that that is, pardon the choice of the verb because I cannot find the right one, slapped onto the fee-for-service system?

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MARY NAYLOR: Oh, oh I am sorry. I did not answer that part of the question. In the way that this is, at least in two organizations that we are working with now, is that they are, I should clarify that Aetna has proposed expansion of this in 2009. Blue Cross will be starting to pay for only the University of Pennsylvania Health System members staring in September. They will be paying a case rate specifically for this service.

Our current fee-for-service system does not reimburse the delivery of care in the model that I described. It does not reimburse masters-prepared nurses to deliver services that extend across settings. So these insurers are in a position to be able to do that through a case rate specifically for this service and they are expecting, by the way, a return on that.

ED HOWARD: Very good. We have folks at the microphones. Let us start at the front. If you would identify yourself and—

KATHY HERWAY: I am Kathy Herway [misspelled?] with Congresswoman Jan Schakowsky. First of all, I want to thank the Alliance and Ed for putting this together. I think this is really exciting what is going on and I want to get back to something that Dr. Tuckson said and that is listening to nurses and have them be part of the discussion and part of the solutions at all levels of health care, which I think is really, really critical.

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My boss has a bill on nurse staffing issues. I know that Lois Capps has a bill on that. One of the things that has given me is the opportunity to travel around the country and talk to direct care nurses about what they see as some of the biggest quality problems that they face in providing care to their patients and staffing, understaffing is clearly one of them as is mandatory overtime, in addition to lifting, which create problems and exhaustion and physical problems.

But the second problem that they raise is in many hospitals, I think there is a level of nurses feeling that they are disrespected. It is very different from the types of collaborations that you all are talking about here.

So my question is how do we address some of these staffing issues, the issues that direct care nurses, in survey after survey, say their major problems both in terms of staying in the profession and being able to provide quality care to their patients and how do we address some of the culture of disrespect to nurses, which we have actually seen in the Chicago area where just to give you one example, nurses trying to deliver a petition on safe staffing ratios were literally locked out of their own hospital.

ED HOWARD: Reed?

REED TUCKSON: Well first of all, Kathy, thanks for not only the comment but also your leadership on trying to get

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those bills through. I think it is important. There are obviously no easy answers here. So let us just take a couple of quick cracks at it.

First and foremost is that we have got to do a much better job of keeping people out of the hospital that should not be there and when they are there, getting them out of the hospital as quickly as possible. You have described an almost impossible dilemma because what is happening is that the hospital-related cost to the health care system particularly the fixed costs of running hospitals, is continuing to drive so much of the escalation in health care costs that are going forward.

And so if the model becomes one where we then jump quickly to say okay, well let us just make sure that we increase and continually increase the number of fixed costs in American hospitals and drive up higher costs there. We are going to have some real, real problems, worst problems with the already significant problems with affordability.

So I am not giving you the answer that you want because I want to be cautious that we really got to be extremely careful about not continuing to have to over utilize hospital care when we really should not. We have got to turn the spigot off.

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Number two, though really also gets at it that within the culture of hospital operations, how do we organize health care services to be more cost effective within the life of a hospital and this really begs your point around how does the nursing expertise, the nursing understanding of efficiency in care delivery and so forth have a much more impactful voice within the leadership of the hospital as they define how do you operate hospitals more effectively, more ergonomically, whatever it is.

So I think the only answer there is that we are going to have to applaud the aggressiveness of the American Academy of Nursing and other nursing leaders. They are, in many ways, intimidating to people right now and I think that we are going to have to, as a health system, stop being intimidated by aggressive women and start to [laughter] listen to aggressive women. So it is a long culture shift.

The last thing I would say is, and again just trying to look at pieces of the dilemma you pose, is it is going to happen in education and training that the training programs in academic medical centers are thankfully at long last, increasingly interdisciplinary so that at least the next leaders of medicine are going to be people who will grow up with a different vision of this but in the short run, we have got some hard knuckle fights to have.

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ED HOWARD: Yes, go ahead Mary.

MARY NAYLOR: Just kind of let me briefly, first of all, I also applaud your efforts to try to address the nursing shortage. I think this is a great example of where evidence really helps point in the right direction.

First of all, we have compelling evidence about having not just the right numbers of nurses but the investment in those nurses in terms of making sure that they are delivering the highest quality care, evidence-based care and also in the right work environments in assuring that those nurses are positioned to be able to deliver the services that they have that they are not running around filling supplies, et cetera.

So there is really compelling evidence to support the impact of the right staffing in the right environment with the right level of education on very important quality issues including mortality, in-patient mortality. The work of Linda Akins has been associated with this, et cetera.

On the issue of culture, I was intrigued yesterday by a newspaper article that says that starting next year, JCAHO is going to be assessing the extent to which hospital environments have in place processes that deal with inappropriate behavior in terms of nurses, physicians interacting with each other.

I think that that is one tact but once again, the evidence that shows in those environments where there is

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colleagueiality, where there is shared governance, where nurses are at the table making the decisions about what people need, they have those patients have much better outcomes.

So I think we can approach it both ways but I would like to go with where the evidence takes us.

ED HOWARD: Yes, please.

VALERIE TATE: Thank you. Valerie Tate, I am a registered nurse. I am the Quality Care Program coordinator for the Nurse Alliance of SCIU Health Care. The service employs international union and this kind of actually goes right to the feedback into what Mary Naylor was just saying.

We represent 85,000 registered nurses for collective bargaining and we connect with another 200,000 non-union nurses through our value care, value nurses campaign and we are finding what we already knew is that nurses are the most engaged around issues of quality. That is where we connect with them on the deepest level. Also it is where we sustain that relationship over time.

My question goes to what you think would be the one innovative evidence-based project that could be implemented in acute care hospitals at the unit level, nurses sitting at decision making tables with their employers, with the interdisciplinary teams that would improve patient outcomes,

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that would increase nurse satisfaction, and that would build the science.

If we were to launch a project across the country in hundreds of hospitals with thousands of nurses and many thousands of patients, what would that project be?

MARY NAYLOR: Wow. This is like nirvana for me. I would say to you go to the evidence. I mean go to the science. CMS October first, implements the Never Events and hospitals are really looking at how is it that they are positioning themselves to prevent hospital acquired infections, bloodstream infections in this country; we have about 80,000 a year costing $2 billion annually, et cetera.

So let hospitals take a look at the available evidence. We have a team at Hopkins right now that has demonstrated that positioning nurses with best practices around prevention of blood stream infections in ICUs is having a major impact on quality and on cost but it is not just those areas, in falls, in all of the areas that are a great importance to us as a society. We have a growing body of evidence.

So I would say let the hospitals and their own environment determine what are the issues most pressing to them. Go to the evidence and make that a major quality improvement initiative and look at your return on investment.

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Of course I think you should look at transitional care too [laughter].

ED HOWARD: Audrey?

AUDREY NELSON: I served on the IOM panel that looked at work environments for nurses and quality and safety of patient care and there were several recommendations that came out of there and they thought infection control, bar code medication, and some other strategies would have the largest impact. So that would be a really good reference to have some of those science-based ideas available.

ED HOWARD: Okay. Yes?

BEVERLY KOMEN-MILLER, MD: Hi. I am Dr. Beverly Komen-Miller and I have spent 20 years as a nurse and now 20 years as a physician and during that time, I have noted that when I was in nursing school, I learned all about doctors and how to handle doctors.

When I went to medical school, I did not learn anything about nurses or their role or their academic excellence and I am wondering whether anyone is here from AAA and see who could, or AA and see who could begin the conversation about how this has to be taught in an attitude as opposed to just a simple lesson.

ED HOWARD: Rick, you have an academic medical hat. How is the atmosphere at the University of Kansas Medical School?

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RICK KELLERMAN, MD: Not very good actually. There is a medical school, an allied health school, and a nursing school, and the interaction is relatively sparse there but I do think this whole idea is starting in that there are other schools that are doing a better job than we are.

I wanted to say something about respect of nurses too. I tell you, you really respect them when you cannot find them on the floor and I absolutely mean that. I am really concerned about the staffing levels particularly in our hospitals and when I go and see a patient and there is a problem or something and I am looking around traipsing up and down the halls to find a nurse that is not a good situation.

I wanted to say something else about, we had a physician in one of our hospitals, it was particularly, I would just say abusive to nurses, and so they started a protocol that was called a code pink and I do not like code pink because it implies that all nurses are women but nevertheless, any nurse at any time could call a code pink and other nurses from, if the nurse was being verbally abused, could come from all over the hospital and confront the physician and [laughter] the number of episodes decreased dramatically [laughter].

ED HOWARD: If there is somebody from AAMC who wants to address this, they should repair themselves to a microphone and feel free to do it.

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MARY LUDELEON: I am not from AAMC. I am Dr. Mary Ludeleon [misspelled?]. I am from the University of Pennsylvania School of Nursing where I am an Assistant Dean but oddly enough, we were at the AAMC yesterday and at Penn, we take very seriously all of what you are talking about and I have here a team of fourth year medical students, Ph.D. biomedical scientists in the making at Penn and the senior Ph.D. pre- and post-doctoral nurses that are budding nursing scientists at the University of Pennsylvania.

And we have spent a week here working together to develop collaborative relationships from a leadership perspective as well as learning how to shape in health policy together as a coalition to promote the exact kinds of things that you are talking about and we are doing it early in time as opposed to later in the career so we can start to create the catalyst for change that you are talking about here [applause].

ED HOWARD: There we go. Yes?

FELISHA ASHRA: Hi. My name is Felicia Ashra [misspelled?] and I am with Ascension Health and my question is directed primarily toward Dr. Kellerman but everyone on the panel, again thank you for coming. This has been wonderful and I want to change a little bit with the number we have all heard over and over again of 47 million uninsured.

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How do the models that were spoken about here, medical home and the team environment break down change or even highlighted and shine when it comes to care of the uninsured who do not necessarily always go to the preventative and primary care models that we have been looking towards to cut costs and do go directly to the emergency room where there is no team that we can speak of right now.

RICK KELLERMAN, MD: Yes. Well that is a whole other topic if you ask me. First of all, Dr. Tuckson said that we need a primary care basis. There is absolutely no doubt of that.

I noticed on one of the policy papers, there are some triangles on an exhibit in one of the things that said that at the very bottom, we have preventive care services and then acute care services and intensive care services in our current system and what we need to get to is a broad-based primary care base and then secondary services, and then tertiary services. That was the model that the information pointed to. I thought that was brilliant. In fact, I am going to take it and use it.

So we need to change the underlying focus of our system and base it in primary care not that we do not need intensive care services, not that we do not need tertiary care hospitals. Their model is upside down and our payment system is upside down and where the Academy has come, by the way, there is a lot

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of talk, do we have a single payer system, public or private partnership.

We have come to the conclusion that it does not matter. If you do not have a primary care based health care system, if you do not have patient-centered medical homes, it does not matter what the rest of the system is based on. It is not going to work.

There is a whole stack of documents that show the value, international, national, state-by-state, even county-by-county documentation that if you have a primary care based system, quality is better, access is better, costs are controlled. Patients like it better.

REED TUCKSON: Let me reinforce that and just say that we have got a lot of experience eat our company in supporting the medical home model. I think we were the first ones to put money on the table to reimburse for the medical home model and so we are really committed to this idea.

The key to your question though and that is even why we sing Kumbayah about the important statement that was made and as I say we put our money in it, so we believe in it, is accountability. We cannot fool around on this thing, that we have got to be able to make sure that nurses are participating maximally and as they do so, a willingness to be accountable for the quality and cost effectiveness of the choices and

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decisions they make within the context of that team to the full extent by which they are willing to practice.

I think they are and that is the good news but there is no way we are going to get at this 47 million or implement the medical home model unless the medical home model proves that better quality of care is delivered appropriately and more cost effectively and so I would urge all the D.C. political offices here even as you drink the Kool-Aid, do not get loose on the standards that we expect around quality.

Similarly, if we are going to get at the 47 million problem, one important area is going to be the community-based health centers. So I would urge you as you influence the resource base for community health centers and thank God for you all for putting some money into community health centers, we have got to put in a couple of bucks that incentivizes the local academic health science center, the nursing school to have their students training at some part of their clinical rotation in the community health center.

If you visit community health centers, which I do on a regular basis all across the country, and you ask the people who work there how come you are here? How did you decide to choose this? Inevitably in every case it was because I was exposed to it when I was in training.

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So put some money as a condition of the community health center and/or nursing support money, what you sort of say is a requirement is that you spend some time in a community health center so that those places get the benefit of the things we are talking about and we get some people providing coordinated comprehensive services in these environments.

ED HOWARD: Before we follow up with that, let me just pluck one of these cards out because it builds on the question that has just been addressed. It is nominally aimed at Rick Kellerman but Reed, you might want to weigh in on it as well. You mentioned, Rick, the need for payment reform and the questioner would like you to lay out the best payment program you think there is for primary care centered practices.

RICK KELLERMAN, MD: Yes. Okay. There is probably not one best method. If you think of the current fee-for-service model, it is great. If you want to incentivize me for volume, pay me fee-for-service because I can chunk out patients and I will get paid.

So the good side of fee-for-service, it encourages me to promote volume. The downside is it encourages me to promote volume, okay. If you pay me by salary, you are paying me to do as little, as few hours as I can get by with. If you pay me through pay-for-performance, I may focus on the things that I

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am being paid what I am accountable for and perhaps, disregard everything else.

What the Academy has talked about is a blended system where there is a basic care management fee for every patient that I see to provide me support and my office support for all of these various things that I provide now for which I am not paid, things as basic as phone calls.

I am not paid for phone calls; after hours care, I am not paid for after hours care. In the future, it is going to be e-mail. When I sit down with a family because they have put grandma in the hospital and they feel guilty about it, I am not paid for that unless grandma happens to be in the room.

There are all of these services right now that we provide in primary care for which we are not compensated for and a great deal of those are provided by the nurses in our offices. So some basic care management fee, go ahead and pay me fee-for-service for those patients that I see face-to-face and then put on that some type of accountability, some type of pay-for-performance to make me accountable.

So there is probably some blended system out there and I think we are going to see a lot of experiments in how best to pay primary care but I can tell you that just pay me fee-for-service does not work. It may work for a procedure but the

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procedure starts at 10:04 and it ends at 10:14; pay that fee-for-service.

It does not work for everything that I provide in primary care. I think we have seen that in medical student choice and in a whole lot of other arenas in terms of the downstream effects of not valuing the provision of primary care.

ED HOWARD: Reed, not only what I would I like you to build on that question but I handed you a card that expands it to ask about payment in a hospital setting and whether or not you think as a principle payer in this country, we ought to be bundling payments to different providers in some sort of episode-based method to encourage the kind of coordination that we have been hearing about.

REED TUCKSON: The second half is complex. Let me take the easy part first and real quickly with Rick's point. The key thing from Dr. Kellerman is that as the leader of the AAFP, he has used the word willingness to be accountable and that is a paradigm shift. So the leadership of the AAFP is saying that they are stepping up to the plate to be accountable.

The cost savings, let us be honest. I mean let us not fool ourselves here folks. There is not new money. There is no new money. So all of the things he is asking for and wants to do, there is no magical person writing, you all know it better

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than I know from yesterday up here in terms of the stuff you all just went through on Medicare. So you all know there is nobody writing checks and printing money.

So at the end of the day, it is got to come from savings. So people are making a gamble. We are making a gamble. We are saying to the primary care docs and we are trying to say to the private sector people that are paying for health care, the medical home model will save money and out of the savings, you ought to get it because you not only did the right thing but this is the challenge as well, you invested in the infrastructure that allows you to implement the medical home model.

Now this is the real problem, because if you are Marcus Welby, just nice guy, nice gal doc who does not have a computer, just kindly and wonderful, you are not going to make it worth diddly squat in the medical home model. You cannot do it. So you are going to have to put some resources on the table. So therefore, you should have the savings.

How does the primary care doctor behave? Do they refer to a crappy doctor downstream, a doctor that is going to have complications and longer hospital admissions because their surgery went straight to heck? Do they actually say to themselves, I am only going to refer to the right person who is good at managing this particularly condition?

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They got to say to themselves am I really going to coordinate care so that Mrs. Jones does not have to go to the hospital and when she is there, we are going to get Mrs. Jones out of the hospital in a hurry and be able to document those savings that result?

So my point only is, is that the delivery model here that makes sense is a delivery model that actually produces savings, at the end of the day, which then the doc ought to enjoy the benefit of those.

Where you are going to get caught up as the policy leaders is going to be how do you sort of get some of these small onesies and twosies doctor offices sort of geared up to be able to have a computer system that United Health, we can dump all of our patient-specific information about Mrs. Jones into the office of the doctor and allow them to have the data they need to be able to coordinate the care for Mrs. Jones so if you see what I am getting at.

This thing with the hospital thing I am going to have—

ED HOWARD: Do you want to defer on that?

REED TUCKSON: Yes. Unfortunately, it will take like a year. So whoever asked me, grab me at the end here because I could not do it in the 13 seconds that Ed is going to give me.

ED HOWARD: Very good but Mary, you want to weigh in on this?

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MARY NAYLOR: I think it is really easy to go to payment reform but I do not think we should be going there first. We are not going to achieve the population health goals that we need without addressing this wonderful question about access and making sure that everyone in this country has access to insurance. The best primary care system is not going to happen unless people have access to that system.

Secondly, as a country, we have not at all paid attention to the population health opportunities. We have four or five major health risks in this country that result in the expression of six or seven thousands of diseases, obesity, tobacco, all of these issues. This is where our dollars, as a government, have the greatest potential to have impact.

Thirdly, we have not dealt with the realities here. There is a major shortage of nurses. There is a major shortage of primary care physicians. There is a major shortage of family caregivers on the horizon. The teams that we are thinking about building our future are not the same teams.

We cannot build health care reform on the same way we do business today. It has to really take into account, I think, players that we have not even considered in other countries and actually we do not have to go to other countries, communities have recognized the value of community workers in making sure

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that the health needs of individuals on their block and in their communities are addressed.

So my view is that we have to think, first and foremost, about the needs of people and how best to position our resources, finite as they are, to achieve those needs and goals and yes, I do believe in accountability and I think the only way we are going to get accountability is if we allow each of the professions in that redesign system to have full expression.

Currently, nurse practitioners are reimbursed by Medicare, Medicaid. We have three decades of evidence about their value in delivering primary care and yet we are going forward with a medical home model that says the physicians must lead it when we already have a system in place and we have total vacuums of people not getting primary care and nurse practitioners available to make it.

So I mean I think we need to take advantage of that which we have but let us think about how to re-envision a different future.

ED HOWARD: Okay. I just should warn you, we have far more cards up here than we are ever going to get to. So if you really want your question to be addressed, you better go to a microphone as you have.

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NANCY RIDENAUER: Hi, I am Dr. Nancy Ridenauer [misspelled?]. I am a family nurse practitioner and I am currently working as a Robert Wood Johnson Health Policy Fellow on the Ways and Means Committee and my question has expanded since I have been waiting because you have touched on several things that I am concerned about.

As a nurse, I know that nurses are all over access, cost, and quality, and certainly accountability and what I have experienced on the Hill is the nursing voice is not very present both in terms of nurses coming to the Hill but also in terms of using nursing research and all the data I know that is out there to inform policy.

And I would like some suggestions on how we can increase both the interest and awareness from the Hill but also for the profession to become more active as well.

ED HOWARD: And I do not know if this is your card up here but someone asked the question how do we get decision makers, on and off the Hill, to pay attention and replicate the successful nurse-led models we have heard about this afternoon.

MARY NAYLOR: Well I think nurses need to be much more visible. I think that they need to, I really think we have the best opportunity when we make the case through rigorous evidence about what it is that we can do and how it is that we can impact but that evidence is not enough.

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I mean we had evidence for many, many years in all of the right journals, et cetera. I think nurses need to be major ambassadors along with all of the other individuals that they represent patients and family caregivers, in change.

So it has not necessarily been part of our history to have a major place at all of these tables but I think we need to advocate for it. I think our professional organizations need to work as hard as they can to position nurses on all of the major policy making groups locally, state level, regionally, and nationally.

So we need to be willing to go the extra step not just do the teaching, not just doing the research but really translating what we do for major impact. So I am hoping that these opportunities and access to some of the staff members here gives you a chance. I think the Inquiry program is an exceptionally good opportunity here because now we have a real commitment to build the evidence and a real commitment to engage stakeholders for maximal impact. So thanks Nancy.

REED TUCKSON: And I would want to just quickly get in the brand name of raising the voice, Raise the Voice campaign of the American Academy of Nursing. And I think that what we are starting to see here is an important shift instead of it having to be where nurses pound on the table and get aggressive

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about make sure you include me, include us, include us, include us.

What you are hearing from the nursing representatives on this panel is that consistent, persistent theme of pay attention to the evidence. So what we are getting now is nurses saying look let us not get this into be a debate and a shrill fight, us against themism kind of nonsense. It is about here is information that transforms health care delivery.

We have got our act together in terms of recording that. The nurses that I mentioned at Evercare, at our company who again are responsible for 70-percent decrease in nursing home placement, 70-percent avoidability of emergency room and hospitalization. This is pretty significant, get down in granule level, this makes a difference stuff.

So when you bring that kind of data forward, this is not somebody being benevolent inviting you to the table. This is saying hey, anybody involved in redesign of the health care infrastructure needs to have, say how did you do that. Wait a minute, you did what? You come right over here and be co-equal.

So it is not a thing anymore where it is shrill. This is about science, evidence, documentation as opposed to playing the violin.

LISA SOMERS: My name is Lisa Somers. I am with the National Partnership for Women and Families and I just want to

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make a quick comment before I ask my question. I am a nurse midwife by training and I spent a dozen years in clinical practice, almost all of it in academic health centers where I was recruited primarily by maternal fetal medicine specialists who wanted midwives to be there to teach medical students normal labor and birth.

So my comment was just to underscore the importance not only of interdisciplinary education but having people like nurse midwives on medical school faculties teaching OBs but relative also to the discussion about payment reform. That is really been harder and harder to do in the last, I think it has 10, 12 years now since the teaching physicians regs, as we call them, which have made it very, very difficult for advanced practice nurses in medical schools to provide that care and get paid for it simply because of some regs that use the word physician when they really meant attending faculty in a school of medicine.

So sometimes one word in a regulation can create a tremendous barrier to what everybody here is agreeing that we should do. So anyway, long comment but my question, Mary Naylor actually sort of set up my question while I was waiting.

At the Partnership, we are doing a lot of work on the medical home issue talking to consumers about what do they want in a medical home and what are their needs, what they

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understand about a medical home and for a lot of women, not to minimize the importance of chronic disease but for a lot of women, what they need is pretty basic primary preventive care. They need family planning.

It is really pretty simple care that women need and sort of relative to the comment of Dr. Kellerman about being freed up to do what he was trained to do in medical school and the comment of Mary about nurse practitioners.

I was wondering if you can comment on sort of the difference between that national model with the PCPCC, which really underscores the physician leading the team and some of the states like Washington State that have clearly identified advanced practice nurses as providers of the medical home, if you could comment about that, any of you.

ED HOWARD: Either of you.

FEMALE SPEAKER: Well I did not know about Washington State. On the Chronic Care Commission in Pennsylvania and as we are rolling out a model of chronic care through the state, the way that the state has placed a premium on changing the scope of practice for all professionals to be able to operate within that which is they are prepared to do and assume accountability for. So one of the ways that we are doing a phased-in approach but in South Eastern Pennsylvania, we have kind of collaborated with the medical home and the work of the Chronic Care

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Commission and determined that we are going to allow and encourage nurse-led practices, the nursing centers are robust in our state, to participate in the demo as well as obviously primary care practices led by physicians.

I think this is exactly what we need to have happen. At the local level, taking full advantage of that, which we have, and then assessing the extent to which it is achieving the goals we hope to realize. SO I do not know, did that answer your question?

RICK KELLERMAN, MD: Okay. From my standpoint as a family physician, one of my concerns is, again, and I am on your side. I think you are exactly right and I think there are many people that have very basic health care needs. It is preventive health care services and that sort of thing.

As a family physician, I have trouble sorting out patients and saying well acute care goes over here and chronic care goes over here and end of life goes over here. To me, that fragments it even more. So what we have got to do is come up with a way where we decrease the fragmentation.

We have three family medicine residency programs. Each one has either nurse practitioners and/or PAs, work very well in our residency programs together. So I think it is that team concept we should get to.

ED HOWARD: Okay. Yes? Go right ahead.

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KAREN ROBINSON: I am Dr. Karen Robinson. I am the American Academy of Nursing Fellow working at AARP. I have a question related to the family caregiver. We have talked a lot about getting the nurse to the table. Along with that nurse is the importance of the family caregiver.

We focused on patient-centered a lot but that patient is connected to a wide network of family caregiver and family. So my question involves how do we get that family caregiver to the table along with the rest of the team and what model would you recommend best supports and educates that family caregiver?

MARY NAYLOR: Well I have had the great fortune to work, for the last couple of years, with United Hospital Fund on a major family care giving initiative and I know there are numbers of them across the country. That is exactly the work that they have done, which is to try to position health care systems to identify the family caregiver as a major partner, not a partner that you say okay, we are done now. You do it in terms of follow up but truly a partner in which their needs for knowledge and skills and support and their own health care needs are really taken into consideration.

So this particular initiative has paid really close attention to enlisting the family caregivers in identifying their needs and support, et cetera and a whole new program will

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be posted and available to family caregivers throughout the country starting in September or October but I totally agree.

I mean I think we are going to have to really recognize that it is not patient or person-centered. It has got to be relationship-centered. It has got to be the whole set of players, physicians and nurses and all providers and patients and family caregivers. We have to open our willingness to look even at policy level about how we can support the family caregiver because they have a major job and if we do not do it, we have a major impact.

I was at an Academy Health Session on presenteeism in which they showed family caregivers who are coming to work these days but who are the primary caregiver of people with chronic illnesses, there is Alzheimer's disease, the productivity is about 50-percent of that which it should be. So we lose, as a society, when we do not invest in this major, major team member.

RICK KELLERMAN, MD: I want to personalize that. My dad had a stroke, was sent home with my mother who was totally unprepared to take care of somebody with hemapoligie [misspelled?]. It was a disaster zone. My grandmother I think of her and how it was my aunt that was the caregiver.

Until you really experience some of this, that is an excellent question. We do a lousy job of involving the family

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and again, as I said at the beginning, patients do not experience illness in a vacuum. It affects them emotionally. It affects their families. It affects their entire communities and we have got to take a look at that. We have a long way to go on that.

ED HOWARD: Let me just say, as we move to the last few minutes of our Q&A, that I would love to have you fill out those blue evaluation forms as we wind down here. Give you a chance to say some nice things about whatever you think needs to have nice things said about it. Yes? Go right ahead.

FEMALE SPEAKER: I have one comment and then one question. My comment is that I am from Marymount University in Arlington, Virginia and I am from the school of nursing and we obtained a grant from a foundation and have established a nurse managed clinic and it is for the needs of the community especially those that are uninsured without access and it is for our nursing students so that they have exposure and experience in a community health setting.

My question is why are so many of the large medical practices resistant to e-mail communication? I happen to know that Kaiser Permanente has a secure e-mail communication system. To be personal, when my in-laws were hospitalized in another state, another part of the country but covered by the Mayo system and when we specifically requested e-mail access,

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we were told that the Mayo Clinic did not believe in that, that they could not be assured of privacy.

So we were deprived of timely communication as caregivers for parents in their 90s and have suffered as a result of that. So why are all of these large practices so resistant that they would prefer a telephone call, which takes up more time in a less well-managed way? Do you have any answers to that?

ED HOWARD: Reed?

REED TUCKSON: My experience is it is very variable, first of all, across the country. The different practices are adopting not only the use of health information technology in differential ways but also the specific e-mail stuff. Some of the challenges Dr. Kellerman had mentioned earlier are in reimbursement.

So what you are seeing is that there are a lot of us in the reimbursement side that are trying to figure out does the e-mail reimbursement, does that take away visits or increase costs? I mean which way does it move? Do you find that somebody e-mails and you want to reimburse the doc for that experience and, by the way, they are still coming in for the visit. So there are a lot of people trying to sift through some of that.

The privacy and confidentiality issues continue to worry a number of people and a number of patients and thank

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God, again, for you all up here on the Hill passing the GINA bill, which is, I think landmark and revolutionary for trying to take some of those worries about discrimination, of misuse of health information.

That is climate changing across the board. Some of it has to do with just the ability of the health information technology system to be integrated in the normal workflow of the doctors that a lot of times, what you are seeing is that depending on the systems that people are using, is that they are not easy in the sense of the flow and that it simply is another level of work as opposed to taking away work.

So different cultures are getting there but what I do not think you are seeing is, I would also by the way, the last part of that is I forgot, is generational. A lot of this is very much generational. The young students that are coming through are facile and used to it. Older physicians who may be in the group who may be the ones setting the culture and the tone in determining the course of events may be uncomfortable.

So you see in a variety of things in different places. So what I would conclude as I piece through your important question is I would not assume one size fits all. I would assume that there are lots of different innovations that is going on across the board that we are seeing a steady increase and it is not a heck no, I will not got resistance.

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I think we are at a pointing a curve that is moving forward. We have got to really take, though, a much better job of having, I will tell you it comes down to things like, I hope that you all up here will be attentive to the health information community successor of America, because we have got to really try to recognize it as long as the health information technology infrastructure is not a coordinated interoperable comprehensive thing.

But you have these piece things grafted on in willy nilly ways, you are not going to see the kind of movement you want because it is going to be inefficient from the point of view so many doctors so please pay attention to AHIC successor and let us have some interoperability standards.

Please worry about the privacy and security issues so we get that stuff done and then I think ultimately what is going to happen with the inevitable growth in technology and also the younger people coming into the field that we will see this move very rapidly in the days to come.

ED HOWARD: Yes and it is worth noting that the privacy concerns that Reed mentioned are, I think, in the minds of most people, the biggest single sticking point preventing Congress from coming to an agreement on IT legislation that people thought at the beginning of the Congress would be a slam-dunk

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within a matter of weeks. So it is not as if we do not have some work ahead of us to do that.

There are three questions addressed on one card to Audrey Nelson. So I figured we ought to subject her to a little rapid fire. I will hand you the card so you can follow along. I ought to read the first part of the card before I get to the questions because the person says thank you. It was an excellent presentation but what types of equipment did the VA purchase to assist in the no manual lifting policy especially with regard to the four-year return on investment.

Second, did VA see any injuries maneuvering patients into the lifts and if so, how many? Third, when a nurse does become injured, what does the VA do to coordinate the care and reintroduce the nurse to the working environment? Very practical.

AUDREY NELSON: Yes. I would say first of all, in terms of equipment, when we first started doing the research, we were actually importing equipment from other countries and the equipment that has had the biggest impact are sealing mounted patient lifts, which go over every bed. It reduces the amount of time it takes to do that task by four to six minutes because most of the time spent going room to room looking for the device and getting it to the bedside.

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Other types of devices are air-assisted lateral transfer friction-reducing devices, stand-assist lift, and height-adjustable exam tables for outpatient departments.

ED HOWARD: Would you write those down after the session and we will post them on the website because I did not catch them going by and I bet—

AUDREY NELSON: We have a technology resource guide on our website that has descriptions of all of that information. I would be happy to share. It is a lot more detail but there are right now, technology solutions for almost every high-risk nursing task that is provided with the exception of transferring a patient in the emergency room in and out of a car especially a critically ill patient.

There is not a really good device for that nor are the devices well accepted yet for repositioning in a bed side to side or pulling them up to the head of the bed. Those areas, there are still some gaps but the majority of high-risk tasks now have technology solutions.

In terms of were there injuries maneuvering patients into lifts, actually years ago, 10 years ago in the early protocols, you actually had to lift the patient up to put a sling under them so that you did not have to lift them. So it was sort of negating and nurses were not falling for it.

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So, of course, they were not being used. We were ordering equipment and having them stored in closets but in fact, the technology has really come a long way. You no longer need to lift the patient to use the device. So we really do not see those types of injuries or hazards anymore in the newest iteration.

Lastly, about returning to work in the workplace, there are all different programs that are available for that but I think the most exciting is, is that when you have the technology available, they would come back with a note saying they could lift up to 10 pounds or up to 20 and unless you work pediatrics, there really was not a lot you could do with those kinds of restrictions but with the technology, that mount of capability allows you to use all of the equipment and perform the tasks so they can re-enter the workforce much, much more quickly.

ED HOWARD: And did I hear you correctly? You said the average patient now weighed 250 pounds?

AUDREY NELSON: The 250 pounds is the average weight of the patient that is injuring a nurse but the weight, there is a wonderful CDC slideshow that is available on their website that shows the obesity problem in the United States and it goes up and it shows the average weight of a male and a female in the

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United States and it is absolutely phenomenal to see the change over the last decade.

If you just have a few minutes to look at that, it goes by state and by color of the average size of the individual and it is absolutely amazing the changes that are happening.

ED HOWARD: Wow, thank you. I have got one final question here that we are going to be able to get to. There are maybe a dozen cards, some with questions, some without outraged comments [laughter] about the scope of practice. It is kind of like the hospital payment question that I threw at Reed. I do not think we are going to be able to resolve that today but maybe that is an indication we ought to do a program on that.

In the absence of being able to get to those questions, let me try to pick one that actually gives you some, at least, some controversy and policy content to work with. This questioner wants to know what policy solutions are necessary to build and grow a nursing educator workforce to meet the current and future needs of the nursing workforce? I do not know what the statistics are but go right ahead.

AUDREY NELSON: Well I was going to say that the earlier question of why are nurses not actively involved in the political arena, the first thing that came to my mind is because there is not enough of them. They are taking care of patients. They are teaching students.

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I mean the demand is so intense and even in the schools of nursing, there is such a shortage of faculty and even more alarming, the faculty that are there, a huge proportion of those are due to retire in the next four to five years. So there is going to be even a larger gap. So I am not an expert on how to address it but I do recognize that it is a huge problem. Mary, do you have any suggestions?

MARY NAYLOR: I am also not an expert. I do not know if anybody from Pat wanted to speak to this, et cetera. I mean there are some initiatives obviously the Robert Wood Johnson Foundation has a major initiative to support the movement of junior faculty and to grow junior faculty and enable them to move quickly.

We have some fast-track programs going on right now, bachelors to Ph.D. because it is often, I think, graduating with your Ph.D. of Nursing, the average age is still over 40 because people are not going directly into that. So I know that both at a programmatic level and some national initiatives but I see Pat is coming to the—

FEMALE SPEAKER: And that is exactly what I would tell you and I am not an expert but I can tell you as being a nurse for over 30 years that the reason why I did not move into academia earlier was there was not any educational financial

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support. I could only have gone to graduate school if I had sacrificed and taken away from my family to attain that goal.

Now that I am an empty-nester, that is where I am going and that is why you have such an aging faculty because those that are in place now, many of them benefited from financial support from the government in the late 60s and early 70s and that was missing for over 20 years.

So we need the financial support from foundations and from the government to support nurse educators. We are starting to see that but we need that and we also need that for basic clinical practice nurses. They need the financial support so that they can attend schools of nursing. Thank you.

FEMALE SPEAKER: I would like to add one more piece. There is a growth of diversity. The demographics in the United States have changed tremendously and in nursing and in medicine and in all the health professions, we need to change the face of those professions to reflect the diversity of the populations, what will represent the diversity of the population.

And that continues to be an untapped resource that will help change the shortage that we are talking about.

ED HOWARD: We have one more.

PAT FORD-ROEGNER: Yes. Well hi. I am Pat Ford-Roegner the CEO of the Academy of Nursing and I, first of all, want to

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thank Ed and the Alliance and certainly Reed Tuckson for supporting this effort and just a couple of things in terms of Raise the Voice. These are two incredible presenters from what our list is of edge runners and I want to let you know if you do check out our website that you will see that we have a variety of edge runners on a variety of issues that we are facing in this country.

On the nursing faculty, the Robert Wood Johnson Foundation decided to take a different tact in terms of where would house an effort to deal with a nursing faculty shortage and the decision was to fund the Foundation at the AARP to build a coalition of consumers and providers, businesses and other to address this issue, not only at the federal level but also by providing and forming teams at the state level to look at what contributions nursing, economic contributions, nursing and nurse faculties make to the better living for all of us in each of our states.

Obviously, if you have schools of nursing, you have faculty, you have students, you have nurses. Any given community can have 8,000 nurses at a hospital. They are well paying jobs these days thank goodness and they offer local pay, local and state taxes so they bring a lot to their community in addition to the certainly the diversity of who they are.

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So we are very pleased to be part of them. Many of the nursing groups and other consumer groups and businesses have now joined with AARP and they have just picked 17 states where they are introducing state teams to really take a look at how to tackle those issues. The offices of the governors are involved; offices of the state legislators are involved as well.

So they are also testifying on the Hill in terms of the ongoing struggle for those few precious dollars that we all want for every single issue but what I think is new about this is engaging consumers because of what it means to them and we started out with a particularly AARP because as we have all noted, that it is an aging population and there is grave concern about who is going to be there for the rest of us, although we are forming co-ops, Mary, right?

So we will take care of each other but I really thank you all again and I really, this has been a great conversation. I do think there are others that have to happen around a lot of other issues that were raised here today but it is a good beginning.

ED HOWARD: Okay. That is a pretty good closing argument Pat. I incorporate in my remarks everything that she said. I just want to thank the Alliance staff for putting together a very good briefing, the Academy for its help in organizing

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this, certainly the United Health Foundation. I want to remind you that the op-ed of Reed is in the back if you want to grab a copy.

We have had a wonderful panel discussion but I just want to compliment those of you sitting out there because we had as many experts out there on all of these topics as we had up here certainly in the moderating anyway.

So thank you for your active participation in the discussion and I ask you to join me in thanking this incredibly rich panel discussion, for the panelists for this incredibly rich panel discussion [applause].

[END RECORDING]

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