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Alliance for Health Reform
Toward A High Performance Health System: Public-Private Efforts to Make Health Care Safer and More Effective
October 3, 2005

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ED HOWARD: Good afternoon. My name is Ed Howard. I am with the Alliance for Health Reform and on behalf of our Chairman, Jay Rockefeller, our Vice-Chairman, Bill Frist, the rest of our Board, I want to welcome you to this briefing on the pursuit of a high performance healthcare system.

The acoustics in this room are not great. It's our trick to make you pay very close attention to what people are saying, but we have installed some extra speakers and I hope it will work for you. We've tried, although you are somewhat cramped, to accommodate the overflow registration that we attracted with this topic, so bear with us. We are trying to give everybody a chance to get here. You'll notice that we don't have a whole lot more space up here than you have down there. It is the nature of the facility.

We are particularly glad to have this very good turnout today. I frankly was afraid that too many of you would conclude we already have a high performance healthcare system, so why worry about it? Why examine how to pursue one? But the fact is we know, as they say, better than we do in healthcare. So we are all expecting to learn something today.

Our partner in today's program is the Commonwealth Fund, which is a private foundation most of you are familiar with. Their work stresses the need for health system performance at a high level, especially for the most vulnerable

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segments in our society. We were expecting to have Karen Davis with us, the CEO of the Fund. If she is not here yet, she is on her way. We do have with us several key staff involved in their initiative relating to a high performance health system, including Anne Gauthier, who is the policy director for the Commission and she is based in D.C. If you don't know her from a previous incarnation, you should strike up a conversation.

A couple of logistical items before we get to our program. There are a lot of background materials in your packets, including extensive biographical information on our speakers. Also, by the end of today, you'll be able to watch a webcast of this program on kaisernetwork.org, already posted both there and on the Alliance website, at allhealth.org are most of the materials in your packets so you can send them to your colleagues or review them at your leisure by going there. And there will be a transcript available in a few days. You'll get an e-mail telling you the availability of that transcript.

And you will find in your packets a blue evaluation form that I hope you will fill out. We have been working with folks at the Commonwealth Fund to better standardize the language a little bit and hope that will help us make these programs better for you, and a green question card that you can use at the appropriate time. There are also microphones at either side. Some of you in the middle may have a little difficulty getting to those microphones. If you hold up your

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hand at the appropriate time, we have some handheld mics that we can get to you so you can be heard in the room.

We are very pleased to have one of the Commonwealth Fund's most key of their key staff on this topic with us today and he will be functioning both as speaker and as a co-moderator, Dr. Steve Schoenbaum. He is the executive vice-president of the Fund for program and he is the executive director of the Commonwealth Commission on a high performance health system, and somebody who has been directly involved in trying to forge high performance health systems for many years. So Steve, thanks for being here.

STEPHEN SCHOENBAUM: Thanks Ed and thank all of you for coming and joining us and we really appreciate that. I am going to give a brief introduction to the topic of performance, really a brief overview of performance in the United States. There is a somewhat longer, but still overview that's in the packet in the form of a chart book that Anne Gauthier and Michelle Serber [misspelled?] have put together. I also will not dwell on all of the slides, even that I have put together because you will have them for reference. I just want to use them as a way of triggering some thoughts in your minds or some facts about performance.

I will be followed by Jim Mongan, who is the president and CEO of Partners HealthCare in Boston. He also is the chair of the Commonwealth Fund's new Commission on the high

performance health system. And then by Gary Yates, who is the senior medical officer for Sentara Health in Virginia. And then we will turn it back to Ed, who will introduce our other speakers for today.

So with that, let me get into this brief overview. It will be a "big picture of you" and it will be American because we are talking about performance of our healthcare system primarily today. You have heard of the quality chasm and here are just a couple of illustrations of some of the issues that are involved in quality of care.

The work of Beth McGlynn at the RAND Corporation, now published about two year's ago when the New England Journal of Medicine showed that US adults receive only about 55 percent of recommended care. One of the things that isn't always emphasized is that this care varies by condition. It was as low in her study as 23 percent for adults who had hip fractures. And it also varies by geography, so we see here a set of Medicare quality indicators and their distribution by state and you can see that there is variation across the country in performance.

We do surveys each year, usually of five countries that have been English-speaking: Australia, New Zealand, Canada, United Kingdom and ourselves. This coming year, we are also surveying Germany. And one of the surveys that we've done has been to look at adults who have had contact with the healthcare

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system, significant contact, in the previous two years. This shows that more than one in six say that they've experienced a medication or medical error in that period of time that they think has caused serious consequences to their health. And that's obviously a large number. You can see as you compare it with other countries that no country is down near zero, so if you are into comparative performance, you can say that's not so bad. But one in six or more is still a significant number of people thinking that they've had a serious problem because of an error.

We also helped develop a set of quality indicators, international quality indicators, and there is now work going on at the OECD to extend this from the five original countries to the 30 OECD countries. And one of the results by the way, is that none of the countries that we looked at – none of the five – was the best or the worst. But here is an example from that where we look at colorectal cancer survival rates, and you can see that survival in the United States is a little bit better five-year survival than it is in the United Kingdom, but the Canada, Australia and New Zealand did considerably better than we did. We don't yet know why or how to fix this, but we are beginning to see these kinds of performance issues as we look across countries.

I will turn now to some of the coverage and access issues. I think you know that the number of uninsured in this

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country is large. It's now actually up to about 46 million and as one looks at the distribution, one discovers that about two-thirds of persons who are uninsured, who are non-elderly, are nonetheless adults, not children. I am sorry, about 80 percent are adults and about two-thirds are low-income.

There is again tremendous various by state and as you can see from this slide, the experience is increasing, that is of uninsurance, and the number of states with relatively high uninsurance rates has been growing. There are significant consequences of lacking health insurance for any period of time. It certainly threatens access to needed care, such as filling a prescription that's needed or seeing a specialist and so on and people who are uninsured, whether for a short period of time or a longer period of time, are less likely to have a regular place of care and it's one of the many instances in this country where one can see racial and ethnic disparities in access to care or in care that's provided.

Why don't we turn briefly to healthcare expenditures. Everyone knows that spending on healthcare in the United States is high and as you know, we spend a greater percentage of our GDP on healthcare than any other country in the world. The question really is, why are the costs so high? And there are several reasons. One is that we tend to have greater utilization of very expensive specialized procedures. Second is that we have higher prices per unit of care than other

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countries do, whether we are looking at hospital days or physician visits or pharmaceutical costs. And the third factor is that we have an enormous amount of administrative complexity and the administrative costs of our healthcare system have been rising at a faster rate than actually any of the other costs in the healthcare system.

Just brief illustration of some of these points – here is one relatively expensive and specialized procedure that we utilize to a much greater degree than in several other countries. Here you can see the relative expenditures for hospitals, for physician services, with the United States on the left in each of these, and for a group of commonly used pharmaceuticals. As an illustration of administrative complexity, this is a slide that was prepared by Senator Frist's office just showing that for one aspect of our care system – Medicaid. There is just an enormous number of different administrative systems one has to go through, depending on who one is and where one is.

This slide is called the "relationship between quality and cost," that relationship being what I think of as efficiency. The fact is that there isn't much of a relationship in this country and I will show you that in a series of slides, and I won't dwell on them because, again, they are in your handout, but if one looks at the center of this slide, the bar in yellow is the hospital in Pennsylvania -

and these were all relatively high volume hospitals with small numbers of transfers to other hospital – and the bar in the middle is the hospital with the lowest mortality rate. It is in the middle of the cost distribution, which as you can see, varies about eightfold from the lowest to the highest and this hospital is actually down closer to the lowest in terms of its cost. You are really looking at it as the median hospital. There also is, I believe, about a twofold difference in mortality rates among these hospitals.

Here we see some data from the Premier Hospital Network, showing no real relationship between cost and quality for coronary artery bypass graft surgery in a group of hospitals that were looked at. These are data from AHRQ, the Agency for Healthcare Research and Quality, which looked at HCUP data in 10 states and about 10 percent of hospitals were significantly lower in cost and higher in quality than the others. But basically what you see here is a scatterplot of cost versus quality. And I suspect many people have seen this slide, which purports actually to show a negative relationship between quality and cost. These are for Medicare data, such as I showed you arrayed by state before, versus cost to the Medicare program for caring for people in those various states.

The fact is that we would not want to fill in the Grand Canyon, which is the picture I showed you at the beginning, but we need to fill in this performance gap or chasm or whatever

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you want to call it. And the big question is, how are we going to get from where we are to where we could be and fortunately I get to turn over the microphone to Jim Mongan to begin us in that discussion. Thank you.

JAMES MONGAN, M.D.: Steve, thank you very much. It is always a pleasure for me to be back here on Capitol Hill where I began my own career 35 year's ago working for seven years as a staffer for the Senate Finance Committee. I am deeply respectful of the work that you all do.

Many of you may recall that Charles Dickens classic novel of the French Revolution, *The Tale of Two Cities*, opens with the often quoted line, "It was the best of times. It was the worst of times." It is a description that with some modification, could apply to today's United States healthcare system.

People often say that the United States has the best healthcare in the world, and in a sense we do. Leaders from government and business from across the globe beat a path to the doors of our hospitals seeking treatment for serious conditions. And to pass almost completely one way, very few Americans seek treatment abroad. So in one demonstrable sense, we indeed provide the best healthcare in the world. But that is not the whole story.

The US healthcare system underperforms on any number of measures, as Steve has gone through. By WHO statistics, we

rank well below 20 other nations in attainment of key health objectives.

Look within our own country and you will see great disparities among races with an infant mortality rate of 13.3 per thousand, or black babies more than double the rate for white babies. Look further at the numbers and you will see that we are the most costly system in the world, with 15 percent of our GDP going to healthcare in 2003, well ahead of our closest competitor, Switzerland, at 11.5 percent and the European median of 8.6 percent. And in terms of access, the US is practically the only nation without universal coverage.

Some will take issue with these criticisms, saying we are a less homogenous society than others or that we are more insistent consumers of high cost services or that comparisons inevitably have some elements of apples and oranges to them. But nearly everyone in healthcare knows one simple truth – we could do so much better and if we can do better, we should do better.

With advances in medical science and the aging of the population, health costs will continue to go up. There will be even more pressure as this happens to address one of the greatest challenges that our health system faces – the disconnect between people wanting the new things that medical science can produce, yet not being sure that they are willing or able to pay for all of these things. This disconnect will

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lead in turn to war of a focus on the value equation in healthcare and a more of a focus on the question of what is a high performing health system.

So how do we create a high performing health system? How do we deliver care that is high quality, efficient and effective? First, a word about each of those parameters. We focus on issues of quality and safety and in particular, reliability. Medical professionals all know that they gap between what we know and what we do in medicine is too large, even within our best systems. To take a well known example, too many heart attack patients don't receive aspirin and beta-blockers. We must work to close such gaps.

As recently as 15 or 20 year's ago, people rarely spoke of safety in healthcare. It was just assumed to be a part of good care. But in fact, ensuring safety demands a special focus on such issues as reporting errors and near misses. In addition to quality and safety, a high performing system should be focused on efficiency and effectiveness, both of which impact heavily on costs. With regard to efficiency, are we staffing correctly, purchasing correctly, designing workflow processes correctly?

Effectiveness is a less examined concept in medical care. It involves the question of whether or not every service provided has a positive impact on a patient's condition. We are a long way from answering this question. To begin, the

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evidence base underlying medical interventions and treatments, needs to be examined to distinguish effective from ineffective services.

And finally, a high performing system should provide access to all. Our shortcomings in health coverage are the most well known failing of our system and yet, they are very poorly understood. Most people know that there are millions of uninsured Americans, but most believe these individuals are able to access services when they need them. But many studies show that although the uninsured do usually receive needed acute care services, they do not receive much needed care for life-threatening chronic conditions. And even if everyone were covered, we don't have adequate personnel and facilities in inner cities and rural areas to provide care to all.

Now let me turn to what we are attempting to do to deal with these issues as Partners HealthCare in Boston. At Partners, we are convinced that value, which to my mind encompasses quality, safety, efficiency and effectiveness, is critical to our success over the next decade. In an era of increasing transparency, we cannot just assert that we provide value to our healthcare consumers and payers, we have to demonstrate it. And to do that, we have adopted five signature initiatives.

Our first and most important initiative is to link our increasingly integrated health system with a sophisticated

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information system. We want to give all our physicians electronic medical records and in particular, records which have built-in clinical decision support, which allows us to help guide the physician in appropriate directions. This will strengthen our ability to disseminate and support best practices and evidence-based medicine across our entire system.

Our second initiative is to improve patient safety. And here, we are focusing on improving electronic inpatient drug ordering and administration systems. We want to have fail-safe systems for drug medication error prevention.

Our third initiative aims to ensure the reliability of care across our system. We are tracking our care with the help of the electronic records against optimal treatment protocols for three conditions: Heart attack, congestive failure and diabetes. And measuring ourselves against the 90th percentile of performance standards, we are meeting this high standard in the great majority of instances.

Our fourth initiative is to employ disease management strategies. Many of you may know that disease management has earned a bad name over the past decade and often has been a surrogate term for payer's simple refusal to reimburse certain services. Yet you can't escape the number, the 10 percent of the people account for 70 percent of health costs and just one percent account for 30 percent of health costs. It is clear that real care management for these very sick patients can

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provide greater effectiveness as well as greater efficiency.

To begin, we have expanded a congestive heart failure management program, which in a pilot test has shown a 20 percent reduction in readmissions. We also have identified the 1,000 of our sickest and most expensive Medicaid patients and created a special nurse call center to provide them with extra support.

Our fifth initiative is to manage the utilization of services and specifically, the utilization of outpatient drugs and high cost imaging procedures. These are the two areas of fastest growth and the areas that were of most concern to our payers. Here, by using electronic prescribing systems and monitoring prescribing patterns, we have already beaten the local and national trends in the rate of increase in outpatient drug costs by more than 40 percent.

To manage radiology services, we are implementing decision support software for ordering high cost diagnostic tests. Now not surprisingly, this strategy has been controversial within our organization because any savings here come right off of our bottom line. But we are convinced that it is the right thing to do and we built it into our pay-for-performance contracts.

Through these five initiatives, we hope to become a concrete demonstration of how to improve the healthcare system by linking integrated delivery systems with advanced clinical

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information in order to create what I call a clinically coherent framework for care. One of the engines that will drive us forward is the pay-for-performance contracts we have negotiated with our local payers, which parallel and reinforce the goals of our signature initiatives.

Typically the problem of the uninsured is not discussed in the same conversation as our problems of healthcare quality, safety and effectiveness. In fact, even here on Capitol Hill, they are often handled by different committees working in different rooms. But in fact, these are all inseparable elements of a high performing health system.

Shame on us if we were to improve the system for the 85 percent of the population with coverage and leave the other 45 million of our countrymen behind. Health plans, like Partners, can help move us towards a high performing health system. But to increase access to care, the government must play a lead role.

Why are coverage issues so important? The primary reason is because the poor do not receive all the care they need. The Institute of Medicine Committee on the Consequences of Uninsurance, on which I serve, documented that the uninsured are far less likely than the insured to have seen a physician in the past year, far more likely to postpone or go without care and far less likely to receive preventative care. They are twice as likely to be hospitalized for complications of

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diabetes or hypertension. And the Committee estimated that in addition to a known burden of sickness and disability, there are an estimated 18,000 premature deaths a year as a result of uninsurance. This is about people's health.

Why are coverage issues so intractable? First, it is because they involve money. And to be a bit controversial, for the past 30 years, money has always trumped people's care as this issue has been considered on Capitol Hill. The Institute of Medicine's Subcommittee on the Societal Costs of Uninsured Populations, which I chaired in 2003, estimated that the price tag for services not received by the uninsured would range from 35 to 70 billion dollars a year, or about three to five percent of healthcare spending, less than each year's annual increase in spending.

Actual cost of any legislation would likely be higher from 70 to 100 billion dollars a year because most bills would provide either subsidies to employers who offer coverage or state fiscal relief or other support. In terms of aggregate health spending, these numbers are not really insurmountable. And according to our estimates, there would be a return to society as a result of improved health of 65 to 130 billion dollars a year.

So if the costs of covering the uninsured are less than each year's annual increase in health spending, and if the benefit to society would about equal the cost, why have we

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failed to act? Well first, as a nation, we get stuck on this issue because these returns would not directly benefit the taxpayers and employers who would be asked to pay to cover the uninsured. Healthcare financing at its heart, involves a huge income transfer, from the young to the old, the healthy to the sick, and the rich to the poor.

And second, we get stuck because on some level, we believe that we should be able to finance expanded coverage with savings from an efficient system. But this logic runs into at least two barriers. First, there may be no savings because any savings from greater efficiencies could easily be overwhelmed by the cost of new drugs and procedures for an ever-aging population.

Additionally, under the current system, any savings would revert to those who are paying the bill – the government, employers and employees- and would have to be taxed back to the health system. So in the end, the coverage issues come down to the need for additional taxes or employer mandates to finance additional coverage. This need runs directly into the teeth of the strongest force of the last 30 years in our political culture – the antitax movement, which has pushed federal taxes to their lowest levels in many years.

Tax levels in the 1990s, which drove one of the most productive economic eras we have ever seen, averaged 18.5 percent of GDP. Returning to those levels would yield more

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than 125 billion dollars of additional revenue in 2005 and almost 2.2 trillion dollars over the next decade.

Progress and the struggle to finance universal coverage will not come easily. In fact, I believe progress on health insurance will come only when we as a nation answer the question of what happened to social justice as a moral value? Justice will not be well served if all of us in this room go about our important work on costs, quality and health information technology while leaving 45 million of our countrymen behind, stuck in the second city of United States healthcare, the city of second-class care that exists in cities across this country, the city that we all saw briefly exposed last month in New Orleans.

I will close as I opened with Dickens' *Tale of Two Cities* – and paraphrasing his concluding line and say that working to improve our healthcare system for all of our citizens, rich and poor alike, will be a far, far better thing we do than we have ever done before. Thank you for your attention. [Applause]

STEPHEN SCHOENBAUM: Now we will turn to Gary Yates.

GARY YATES, M.D.: Thank you. It is a pleasure to be here. I have been asked to share some of our experiences at Sentara Healthcare, trying to improve quality, efficiency and access.

A couple of words about Sentara – we are a regional

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not-for-profit health system headquartered in Norfolk, Virginia. Six hospitals, nursing homes, medical group and a health plan. We deal with over 2,500 community physicians in the areas that we serve.

Over the next several minutes, I would like to share some thoughts on strategy, a model for improving results and then give examples of five initiatives that are showing encouraging early results in improving quality, efficiency and our access. We believe that one of the characteristics that will distinguish the high performing healthcare organization is that it focuses on quality and patient safety as strategic aims. It views quality as a way to differentiate its services and it views quality as a key to long-term success. We also believe that the Institute of Medicine's six aims is a robust roadmap for focusing improvement efforts as we go forward.

This is the very simple framework that we use to guide our improvement efforts. We believe that in order to produce significant improvements in quality and patient safety, not just incremental improvement, we need to be working effectively in four different dimensions at the same time – not two of the four, not three of the four, but in all. We have to be introducing new technology that improves care at the bedside. We have to be creating highly reliable processes, delivering the best care all the time. We have to have the right people delivering the care and it has to be built on a solid culture

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that values patient safety and continuous improvement.

The first of the five examples that I would like to present is the EICU. Sentara was the first site of this system in the United States, although currently, there are 20 other healthcare systems using the system. Intensivists, who are physicians specially trained in the care of the critically ill – patients who are commonly found in ICUs, Intensive Care Units – several studies have been done that show that involving intensivists in the care of these patients dramatically improves their outcomes. One of the problems is that there are not enough intensivists in the United States to go around for all the ICUs that could use them.

The EICU presents one solution to leveraging this scarce resource. For example, right now in Norfolk, Virginia, an intensivist physician with two critical care nurses, is helping to monitor 95 ICU patients across five different hospitals.

They are using this using technology that allows them to teleconference with the patients, the nurses. They have data feeds from the patients and electronic medical records and smart alerts. This team doesn't replace the usual care that is going on at the bedside, it provides an additional layer of care over and above that – an additional set of eyes that help to spot patients at their earliest signs of deterioration so that action can be taken to prevent complications from

developing. We have had five years of experience with this system, and we are encouraged that we are still seeing about a 20 percent decrease in mortality for patients in these E-units, as compared to the baseline care. We think this translates to about 85 patients each year that leave our hospitals that would have not under the previous system of care.

We have also had a chance to look at the economics of this, with the help of Capgemini. We believe there is about 155 percent return on investment on this. Interestingly enough, there is no third party reimbursement for this system. And for our system and others that have implemented it, we rely on the cost savings that come from preventing costly complications from developing.

The second example I would like to present is improving the reliability of processes. I want to speak to one example presenting one particular complication, ventilator-associated pneumonia. Being placed on a ventilator can be a life-saving event for patients. It is a machine that helps to breath for the critically ill. At the same time, we know that there is a complication that can develop from being on a ventilator that is particularly devastating also, and this is a ventilator-associated pneumonia. Up to 20 percent of these patients die.

We also know that there are some things we can do to minimize the chance that this complication will occur. We call that a ventilator bundle, and it includes such simple things as

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keeping the head of the bed elevated while the patient is on the ventilator. We also know form looking across the country that in providing this ventilator bundle to these patients, that the performance is terribly variable. The object ought to be to do this on 100 percent of patients. It means we will have to develop highly reliable processes to make that happen.

On this chart, I am showing some of our encouraging experience, trying to deliver that ventilator bundle to 100 percent of these patients. Across 13 ICUs with 161 beds across six hospitals, we have seen about a 64 percent reduction in this complication over a three-year period. This represents 80 patients who have not come down with this particularly devastating complication.

We have also had a chance to look at the economic impact. We believe very conservatively speaking, this represents about 650,000 dollars to the bottom line. It also helps to free up ICU beds because these complications do not develop, which helps us offload patients from the emergency department and helps us provide better access to care in that area. Making our processes highly reliable works in other industries to improve quality and efficiency. It ought to work in healthcare too.

A third initiative is trying to create a stronger culture of safety. If you recall the diagram, it is the foundation. We have been doing some work with a group that has

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had a successful track record improving safety in the nuclear power industry. What does nuclear power and healthcare have in common? We think there is more than we might initially suspect. By trying to take some strategies, which have been successful in that industry, and applying to our setting, we are encouraged that we are seeing about a 47 percent reduction in serious patient safety events across our hospitals over a two-year period. Initiatives that can encourage healthcare organizations to share with each other innovative approaches and especially those that encourage healthcare organizations to get outside our industry, might be very helpful in moving the entire industry forward.

Improving chronic care is an important issue for all of us, especially with the aging of the population. To echo some of Dr. Mongan's comments, disease management is something that some of the results we are seeing are encouraging. This is where we provide and try to coordinate care over and above just the usual physician's visit. A couple of examples where we are seeing some important successes in asthma, keeping children out of the hospital, out of the emergency department, in the school, at home where they belong, also brings about a 35 percent total cost reduction. We are seeing improvement in the care of diabetics and in one area where we are particularly encouraged and a new project, trying to impact the care of patients with sickle-cell disease.

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By providing expanded home healthcare coverage in case management, we can often take care of these patients' crises in their home and prevent them from having to go to the emergency department, having to go into the hospital and in two years, we have seen about a 65 percent decrease in a pilot project that we are running.

Palliative care is another initiative that can help improve the care of the chronically ill. Palliative care is a multidisciplinary approach that deals not just with end-of-life issues and the terminally ill, but also with other chronically ill patients, especially those with complex symptom complexes. This group has the time to really dig in and to get to the root causes. Our experience is that we have seen a tremendously improved patient and family satisfaction, as well as reduction direct cost and length of stay. We believe palliative care is better care with a business case.

The final example I would like to address is what we call our e-care initiative. In this, we are offering an office-based electronic medical record to all of our physicians in the community at a fair price. We are also going to be offering an electronic personal health record for patients and consumers, linking this back to the hospital information systems. This is not inexpensive, but we feel that this is going to be critical if we are going to enable true patient center care in our community.

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Let me finish by offering just two observations. The first is that the one thing that these five examples I have presented today share in common, is that probably none of them are adequately reimbursed currently by either government or commercial payers. We are concerned that for systems hospitals that may not have either the financial resources or the wear-with-all to get through the implementation phase of the initiatives, their communities and patients may not be able to derive the benefits that come from them without some significant modification of the current reimbursement system.

And the final comment, to echo Dr. Mongan, is it is hard to imagine how we are going to create a high performing healthcare system for the entire United States without dealing with the issue of universal healthcare coverage. Thank you. [Applause]

ED HOWARD: Thank you Dr. Yates. We have asked two key congressional staff members to help put the discussion of a high performance health system into a legislative context. We are going to hear first from Madeleine Smith, who is on the majority professional staff at the House Ways and Means Health subcommittee. She is a veteran of more than a decade of service with CRS as well. And from Dora Hughes, health and education advisor to Senator Barack Obama, who before that was the deputy director for health on the democratic staff of the Senate Help Committee under Senator Kennedy. She is a board

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certified internist as well. Madeleine thanks for being with us.

MADELEINE SMITH: Thank you Ed. I want to thank the Commonwealth Fund and the Alliance for holding this session and for inviting me to participate. I must say that my comments however have to be off the record.

ED HOWARD: So put those pencils down. [Laughter]

MADELEINE SMITH: It is just not retribution. I work for Chairman Bill Thomas of the Ways and Means Committee and also work very closely with Nancy Johnson, who is the chair of the health subcommittee.

I would like to start with two examples that I find illustrate the performance question, not only in the private sector, but also in Medicare. The first is a research study that was done at Duke. The researchers asked 315 hospitals to report on data for nine drugs that everybody agrees should be provided to heart attack patients. These are things like aspirin upon arrival to the hospital, whether they got a statin to lower cholesterol when they left the hospital. Did they get a beta-blocker – things that are well accepted medical procedures, with a lot of evidence behind them.

The researchers collected the performance of the hospitals on these measures of these nine drugs and reported the scores back to the hospitals. They did nothing else. The did not encourage them, they did not interfere in any way. But

over the next year, they collected data over time. And what they found was that the hospitals that improved on these measures saw their patient mortality from all causes, not just from heart attacks, fall by 40 percent, which is remarkable – 40 percent reduction in their mortality rates. Those where compliance on the nine drugs did not change, saw no change in the mortality rate.

And the hospitals that actually performed worse on the second go-round saw their mortality rates increase. The beautiful study showing what can happen if hospitals are given information about the quality of care that they are providing and how just that shining a light on the quality can improve performance if acted upon by the hospital.

The second example study information piece that I would like to share with you is a result of a Harris Interactive survey of 2,000 adults that we're questioning the adults about their attitude toward healthcare. And this I think is a compelling example of the lack of information about costs and efficiency that we as consumers have. Consumers can guess the price of a new Honda within about 300 dollars, which is very good. When they were asked to guess the price of a four-day hospital stay, they were off by 8,100 dollars.

In addition to that fact, 63 percent of those who had received medical care in the last two years did not know the cost of the treatment until the bill arrived, and 10 percent

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reported that they never knew the costs. So the one example tells us what can happen if we have quality measured and reported at least to the provider, let alone to the consumer of healthcare. And the second illustrates the lack of information that people have about the cost of care that they are accessing.

In order to address these issues and other issues as well, Mrs. Johnson has introduced a Medicare value-based Purchasing for Physician Services Act to improve healthcare quality, efficiency and safety by altering the physician payment system under the Medicare program. And I will just briefly outline the major features of this legislation, which is what I was asked to do.

The first is that this legislation would repeal the sustainable growth rate formula, the formula that is used to determine what physician updates will be on an annual basis and would replace that with a stable and predictable annual update based on the changes in the cost of providing medical care, which is known as the Medicare Economic Index in the Medicare program.

The second major change that this legislation would implement is that it would link payment updates to healthcare quality and efficiency. No longer would the Medicare program be paying all providers the same rate, regardless of the quality of care that they are providing to Medicare

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beneficiaries.

The update formula would be changed and Medicare practitioners, physicians and other providers paid under the Part B fee schedule would receive a 1.5 percent update in 2006. Under current law, they are scheduled to get a 4.4 percent decrease. They also are scheduled to receive decreases for the next six years, totaling about a cumulative 26 percent reduction in the payment rates they receive under Medicare. I think everybody agrees that that kind of a reduction in payments is unsustainable.

Beginning in 2007, all providers would continue to receive positive payment updates. In 2007 and 2008, practitioners would be required to report on quality measures to receive an update equal to the Medicare Economic Index. Those that do not choose to report on these quality indicators would receive a lower update, the Medicare Economic Index minus one percent. This is similar to how we are paying hospitals to participate in Medicare. Hospitals who report on 10 quality indicators get a higher payment update under current law.

Beginning in 2009, after a two-year phase-in period, practitioners who meet pre-established thresholds of care or who show pre-established improvement in the care that they are providing would receive a payment update equal to the MEI and those who do not meet those thresholds or do not show improvement would receive and MEI minus one percentage point.

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The legislation is not overly prescriptive, it attempts to outline a value-based purchasing program that CMS would implement and it would be robust over time. It does however include certain legislative language about the characteristics of measures that would be included in this value-based purchasing system. They would include a mixture of outcome, process and structural measures. They would include efficiency measures related to clinical care. They would be required to be evidence-based. They pertain to clinical care and they are also required to include measures that assess the relative use of resources, services or expenditures.

Very important for both the provider and consumer population is a guarantee of fairness, or at least a push to make the program as fair as possible. The value-based purchasing system would include measures that adjust for the patient population that the provider is seeing, caring for very sick patients and for those who do not normally comply with physician directives has to be taken into account when providers are assessed on their quality and efficiency. It is very important that the value-based purchasing system that is implemented not provide either for patient selection or for patient de-selection.

The legislation also outlines a process for selecting the measures. It would involve the practitioners directly with determining the measures used for gaging their performance.

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Practitioners themselves, or their representatives, would submit measures for clinical care to a consensus-building organization like the National Quality Forum. This consensus-building organization would make recommendations to CMS. CMS would then select among those recommendations the measures that it would implement. CMS would also have the authority however to identify other measures not related to clinical care or to supplement measures that go through this process if the ones that came out in the end were not deemed sufficient through the rulemaking process.

Finally, the legislation would require CMS to analyze volume and spending growth annually and to make recommendations on regulatory and legislative changes that would be needed to respond to inappropriate growth. The MedPAC would be required to review this reported recommendations and changes to the system would then take place.

And in a nutshell, that is the outlines of the legislation that Ms. Johnson introduced. She held a hearing on this legislation last Thursday. We heard from CMS, from Mark McClellan, about the steps that CMS is taking to implement a quality reporting system perhaps as early as January 2006 and we applaud their efforts to do that and are working closely with CMS with the provider community to move the system forward to get first quality reporting and then pay-for-performance into the Medicare payment system as rapidly as possible to

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avoid the kinds of lack of information about quality, lack of information about costs, that we find prevalent in both the private and public sector today. Thank you.

ED HOWARD: Thanks very much Madeleine. [Applause] Dora?

DORA HUGHES: Good afternoon. I also want to give my thanks for inviting me to participate to the Commonwealth Fund and the Alliance. I was asked to speak for a few minutes about efforts relating to quality and health IT in the Senate.

I will start by saying that certainly progress has been slow, but at the same time, progress has been made. I would point to the recently passed patient safety bill as one example of our success in this area. As a former Kennedy staffer, of course I have to note that Senator Kennedy has had a longstanding interest in the area of quality in IT. His interest from his convictions that as we reduce the cost of medicine, increase efficiency, we will be able to reinvest the savings and expand coverage for a greater number of Americans. Certainly Senator Kennedy is not alone in this regard. A number of other senators have examined the issue and reached similar conclusions and I think underscores the point that we were able to find common ground and negotiate and draft the Wired for Healthcare Quality Act, which I was asked to spend a few minutes discussing today.

The sticking points, if you use that phrase, certainly

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has centered on what is the role of the government and how and where can it be most effective? Related to that is, what is the appropriate level of investment for the government and how can it coordinate its efforts with the private sector, which in many ways, is far ahead of similar efforts in the public sector. And finally, on a more appropriate level, certainly there has been some discussion over who has responsibility for quality initiatives here of quality legislation here in the Senate, whether that's the Health Committee domain or if that's within the Finance Committee domain, and all of these questions we continue to grapple with as we try to move forward and pass this legislation.

Just to give you a few of the highlights, the Wired for Healthcare Quality Act did codify the Office of the National Coordinator for HIT. It also established the American Health Information collaborative. Very important, it would develop and promulgate the standards that would ensure the nationwide interoperable health IT infrastructure that we are desperately needing right now.

It has an ambitious grants section. There are grants provided for individual providers and health systems to acquire the equipment and services that it needs. It helps establish the state loan program and it requires their participants in the state loan program to adopt the government's IT standards as well as to link to local or regional health IT networks. I

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thought it was interesting that we were able to get a preference for states that implement some type of value-based purchasing system as well as part of the effort.

There is another grant program that would facilitate the development implementation of health IT networks, which again we are starting to see a number of efforts on the private sector now and I think this is a very promising area that we need to help to do more in. And it also provides grants that help healthcare providers, individual practitioners, learn how to practice medicine in this new era of health IT electronic systems.

The bill also looks at licensure issues. Many of you here would have heard that some states have varying requirements across states that could impede use of IT. For example, for radiologists, you may be reading films from one state for another state, that type of thing. And there is a resource center.

I would like to mention that also, very importantly, note that there must be a connection between quality in IT and it instructs the Secretary with the advice and expert guidance of a number of outside entities to develop and implement a quality measurement system and it builds upon many of the quality domains developed by the IOM.

I just want to end with a few general comments. Many people have criticized legislation that it is not far-reaching

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enough. There is not enough attention to Stark clause for example or the authorization levels are too low or perhaps we should have more focus on disease management programs for example. But I think most of us would agree that this is an important piece of legislation. We hope to get it passed. It will do a great deal to help improve quality and increase efficiency once implemented.

Personally I think one of the more exciting, or more important focuses of this legislation is the focus on networks. Many provisions have weaved in incentives for establishment of networks of care at the regional level or the local level. And I think as we focus on networks, this will help the medical community provide its focus more on systems-based care, focus more not just on the individual patient populations of patients, but I think increasing the quality of care, but also increasing the accountability for populations of care. Many would argue this is what helped the VA be such a champion and leader in this area.

I think this helps to also address Dr. Mongan's point that if we have networks assistance of care, we can more directly make sure that the savings are reinvested into the healthcare for these beneficiaries and not have to be re-taxed at the government level.

And finally, my hope is that if as we move towards this more network or populations-based care, it will also help us

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not forget that this legislation and other similar legislation has not addressed how we should be working to promote the conditions that will allow Americans to live more healthy, to avoid disease in the very beginning. We have address the chicken but not the egg or vice versa, I am not sure how to best phrase that. But those would be my brief comments and I will turn it back to Dr. Schoenbaum at this point.

ED HOWARD: Thanks very much Nora. You now have the chance to ask your questions. You have a green card, fill it up, hold it up and someone will grab it. Some of you have already done it, how wonderful. There are, as I said, microphones at either side. If they are convenient, if you want to ask a question verbally and you can't get to one of those microphones, raise your hand without a card in it, and someone will try to get you a microphone.

While you are doing that, let me just take the prerogative here and we had some questions, as you know, submitted in advance and let me try one. This one is directed at Dr. Schoenbaum and/or Dr. Mongan. The thrust of it is both of you have talked I guess about public and private efforts to make healthcare safer and more effective. And the question is, what do you mean, in this context, by public-private partnerships?

JAMES MONGAN, M.D.: Well I think it is a good question because the term "public-private partnership" is often used as

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a cliché across many fields and that could happen in medicine if we are not careful. But I think if you think about it, there is some real meaning to public-private partnership. We already have of course a significant partnership in that government is paying half of the bill for healthcare. So there is already a kind of a payer-provider sort of relationship that's a public-private partnership of some importance.

I think going beyond that and building on that, the role of the private sector in working on a lot of these safety and quality initiatives, as I outlined, is fairly clear. The government role, I think, should be to be as supportive of that as possible through such things like the pay-for-performance initiatives and the IT support legislation and of course, I have already reference my feeling that the government has to play the lead role with respect to the issue of access and the uninsured.

STEPHEN SCHOENBAUM: We have some examples of public-private partnerships. The National Quality Forum, which you have heard mentioned is one such and actually grew out of the President's Quality of Care Commission back in the late 1990s. We have had other examples of things that have started in the private sector that have gone on and involved the public sector, HEDIS measurement was one of those and the current Ambulatory Quality Alliance and the Hospital Quality Alliances are ones that again have tended to start with the private side

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and then move on and include very important government participation.

So I think that there are examples. There are questions of, I think, what else can be done and also is the fact that government is so well positioned; it is the best positioned player, if you will, to take a leading role in making order out of the healthcare system without nationalizing the healthcare system. We just have a situation I think where there are so many different players in our highly individualistic healthcare system that when you start trying to grapple with these issues of cost and quality and safety and efficiency and coverage and so on of care, that everybody sort of looks for the other party to do something.

I personally picture government as playing the major role in coordinating these efforts, but I do not see it in a country where we have had a long tradition and distinct advantages to the private side of our healthcare system. I do not see us going all the way over and in fact that is at the crux of this notion of public-private partnerships.

ED HOWARD: I don't see anyone lined up at the microphones. If you held you hand up wanting to ask a question verbally... Go ahead. Would you identify yourself please?

MICHAEL ZAMOORE: Sure. Michael Zamoore [misspelled?] with Congressman Patrick Kennedy. I was curious for both Gary Yates and James Mongan about whether your organizations have

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had conversations with payers about creative payment mechanisms to support your efforts to add value to raise the performance level of your systems. And if so, what the upshot has been and where this conversation would be going.

JAMES MONGAN, M.D.: Thank you. I could not go into everything in the brief time available, but indeed in Boston, we have three major payers – Blue Cross, Harvard Pilgrim and Tufts Health Plan – and we have negotiated within the last five years pay-for-performance contracts with each of those three payers. The performance standards that we are required to meet quite closely mirror the initiatives that I have laid out before you, so I think it has gone a long way towards aligning our interest with that of the payers and towards having the reimbursement system support the direction of our initiatives.

I think I indicated in my remarks the one area where that does not hold, and that is the area of high-cost imaging, where it still would be to our financial advantage to do more and more and more MRIs, but in fact, we have worked into the pay-for-performance contract a higher payment for reducing the number of MRIs. So we do have pay-for-performance contracts with all three of the local payers. It has been very helpful in supporting our work in the initiatives.

GARY YATES, M.D.: Our experience in Virginia has been that this progress has been somewhat more limited. There is interest, but in actually getting to those sorts of measures

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which will move things forward, we have had limited success. Certainly at the level of CMS, clear investment and demonstration projects – again, sometimes those take awhile to yield the conclusion of results that meet whether or not it makes sense to change some of the policy.

There are some interesting things going around the country, both the pay-for-performance – something which particularly interests us out of Michigan, which is pay-for-participation being driven by Blue Cross-Blue Shield there. The idea that there are certain things that providers could be working on that seem to make sense either in terms of implementing specific care processes or collaborating around a new set of measures, we are hoping it might be some combination of pay-for-performance, pay-for-participation that may lead us forward and maybe pick up the progress.

ED HOWARD: I have got questions that if taken together I think have a nice sequence to them. There is one for Dora, one for Madeleine and one for both. Dora, can you tell us about the new Clinton-Obama patient safety legislation and how it differs from Public Law 10941?

Madeleine, about representative Johnson's legislation, what is the best estimate of physician compliance/achievement by 2009 participated in the one percent bonus above the Medicare Index? And for both of you, what is the prognosis for passing any HIT legislation this year, or I would add, this

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Congress? Dora?

DORA HUGHES: I will start. Starting with the last question first, I think the possibility of passing the health IT legislation is pretty good. The level of interest is high, the commitment, both at the staff level and at the Senator's level is also very high, and also the administration certainly has weighed in on the legislation and I think it helps to bolster some of their priority areas as well. I don't know what the final package may contain, but I do expect that there will be a robust legislative package that will eventually pass the House and the Senate.

With regard to the Clinton-Obama bill, how it differs – it builds upon the former Patient Safety Bill. It was drafted in a way that it completely comports with what passed in law, but it does take the next step forward. It creates an office of patient safety and healthcare quality at the office of the Secretary, JCAHO in its recommendation repeatedly said that it needs to be a very high level person who is committed and will champion this issue within HHS and across the nation.

It also creates a national patient safety database that will allow this director to both monitor the trends as well as to conduct the analysis that are needed to understand how best we can intervene. "We" being loosely defined and what is working and what is not working. It also provides an incentive

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for hospitals that are really doing quite a bit in this area by creating an early disclosure and compensation model. This model is being used at a number of topnotch health systems and hospitals already across the nation. It also has been legislated and passed into law in a number of states, including Illinois. What it essentially says is that it provides support for hospitals that are aggressively monitoring patient safety concerns in their hospital and taking the steps to aggressively investigate and do root cause analyses and to disclose these areas to the patient and kind of facilitates their very open communication between doctors, but also between doctors and patients. And then it allows them to engage in negotiation with patients to make sure that they receive a fair and reasonable level of compensation.

Obviously, we focus quite a bit on medical malpractice here in the Senate across the nation. We think that with the focus squarely on patient safety, that this is at least one way to address some of the medical malpractice concerns, particularly the costs. So that is a very quick and dirty summary of what we are hoping to do.

MADELEINE SMITH: I would like to answer first the question about the incentive to physicians and projections of participation and the differential in payment of one percent. We have no estimate of the participation of physicians. We have a variety of facts to consider. One is that the hospital

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update payment differential is .4 percent. And the participation by hospital at a .4 percent differential was extremely high – 98 percent of hospitals reporting on the 10 indicators in order to get the higher update. One percent on physicians, given that outcome seems like a lot.

On the other hand, one percent of a two hundred dollar procedure is two dollars. One percent of a hundred dollar procedure is one dollar. The physician could forego involvement with CMS in this type of activity, see another patient during the week and probably get the money. So one thing we are quite interested in and a question I would love to discuss with the panelists is the size of the incentive that they have found is necessary in order to get physicians to engage in quality reporting and behavioral change.

As far as an IT bill is concerned, the House is also very interested in this issue. Mrs. Johnson has not introduced yet, but has sent around for comment specs on an IT bill that would also codify the Office of the National Coordinator for Health IT, but would make other changes that are unique on the House side to the process going on. One would be to have statutory exceptions to this Stark self-referral and anti-kickback laws for hospitals and physicians to coordinate their activities on IT.

There also is a requirement that the Secretary conduct a study of various state privacy laws and transaction standards

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to see what may be standing in the way of electronic medical records and health IT and data sharing. It also would require the Secretary to adopt the ICD-10 coding system and finally, I think is similar to the Senate bill, has a provision about the health information community. We are hoping that something is done in the House as well and we can get to conference with the Senate on that issue.

ED HOWARD: Thanks Madeleine. Is there anybody on the panel who would like to respond to Madeleine's request for technical assistance?

STEPHEN SCHOENBAUM: I would like to speak only of the pay-for-performance part. I think we have a lot to learn about just what kinds of incentives some of us who are physicians respond to. And we know that pay-for-performance programs in this country, while there are a large number of them, are in a sense in their infancy and they are just beginning to be evaluated. I think, again, a role, while I certainly wish you all well in enacting this legislation, I think the real role of research to find out just how physicians are going to behave, we just do not know yet.

There is a very interesting experiment that has just finished its first year in the United Kingdom and the British general practitioners contract offered physicians, GPs, in the UK 30 percent new money for performance. There were well over 100 different items of performance that got scored in this and

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the results just became public a little over a month ago. And while the British government had estimated that performance would probably be about 70 percent of maximum achievable - and that is all they budgeted by the way – performance in fact was something like 91 percent of maximum achievable with that 30 percent pot of money sitting on the table. We know that at least if you put enough, there is a lot of performance by physicians, we just do not know how little is still enough.

ED HOWARD: Gary?

GARY YATES, M.D.: I guess just one other comment. Our experience is the percentage is highly variable. It is not clear exactly how much. One thing which interests us is a number of the pay-for-performance programs have either been focused on physicians in their offices or on hospitals. And we are particularly interested because we feel in order to reach the kind of extremely high levels of compliance performance we are going to need to have in hospitals, we are going to need to find a better way to align the physicians' interest with the hospitals. Clearly there are issues with inurnment. Jim and his system have come up with some innovative ways to really pull the physicians and align them with the systems. But hopefully there is room as we go forward to let both sides both participate and benefit by providing perhaps unheard of levels of quality.

ED HOWARD: Inurnment in this context means the Stark

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anti-kickback rules? Okay, thank you.

CHRIS MITCHELL: Hi. I am Chris Mitchell [misspelled?] with the Association of American Medical Colleges. And along the line of this discussion on Stark and anti-kickback obstacles, I am curious to know how Sentara is dealing with that issue as it works to build IT partnerships with community-based physicians. I am curious to know whether addressing Stark and anti-kickback rules would expedite the creation of those partnerships. I am also wondering how many physicians you are reaching out to and at what cost to your organization?

GARY YATES, M.D.: Great question. First of all, in terms of providing the system, we are keeping a number of very bright legal minds occupied. The bottom line is we are offering at fair market value and to be sure we have the documentation behind that. The cost for us – our board recently authorized 67 million dollars in capital expenditures. We believe the 10-year cost of ownership, total cost of ownership, will be over 230 million dollars, but we think it is the right thing to do.

One of the reasons we think, whether it is government or other payer help can be here, is to get over that implementation hurdle. One of the issues especially dealing with physicians and their offices is that the benefits of the system do not necessarily accrue back to the physician or to the office. They accrue to employers and payers.

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The other thing is that our understanding is that the key to a successful implementation is not so much the software or the hardware, it is the process redesign that you do to reorganize the workflows and that is what helps to be bring the benefits back. But there is not a lot of discussion about that going forward. We are thinking that as something that is a system we can also help to bring to hopefully make these successful implementation as opposed to the other kind. Thank you.

JAMES MONGAN, M.D.: Ed, if I could add, I would like to make a few very candid comments about the national ambivalence and schizophrenia regarding how we deal with health IT because you all are caught up in this every single day I think in working in this era.

I am going to touch on four points. The overall ambivalence about health IT comes down to this better medical care versus privacy. That is a terrible algorithm to have to deal with, but that is a little bit where we are. I am convinced we are going to get better medical care, but it does raise some significant privacy issues and that is tough to sort through.

Then I think in terms of the things you would like to do to encourage health IT, we again run into ambivalence. In my mind, one of the first of those would be to relax the Stark rules because I believe deeply that the only way we are going

to get health IT disseminated is through large systems. Look who leads the country in doing this, the VA, Kaiser, Partners, Sentara – it is not small community hospitals and individual physicians. So in fact, I think you should allow those systems to have a safe harbor from the Stark provision so that they could disseminate these systems.

But that runs into our national concern on the anti-trust area, where we are not sure we want large health systems. It sounds a bit self-serving. I think we are better served by a number of large health systems that can do this than by a very fragmented system. But we are ambivalent there. And that area where we are ambivalent has to do with interoperability. This should be an area for federal action. Look what we did with railroads, look what we did with time zones, can we make these systems interoperable across the country? But again we run into ourselves, can the public sector do that better or should it give the private sector a little more time to sort out whether VHS or betamax is the best format. So we have got a third conundrum there.

And then finally, if that is not enough, I think if you really wanted to do this, one way to do it would be a Hill-Burton type model, where you actually substantially fund health information technology systems. But there, we run into our at least current kind of small government feeling that we do not want a large federal program of that sort. So there are a

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bunch of levels of ambivalence that you all have to sort through in dealing with this problem and I wish you great success because it is an extraordinarily important thing for us to accomplish if we are going to move these quality and safety issues forward.

ED HOWARD: That actually raises a couple of related points. Gary Yates was talking about offering the physician decision support software and other tools at a fair price. And the federal government is about to distribute VA's VistA system at a fair price that is probably a whole lot fairer than the price you are offering your physicians. Is that a good thing? Are we running up against the problem that Jim was touching on that we are afraid that the government is going to preempt the field? What do you think?

GARY YATES, M.D.: It is an interesting question. It is one that we have debated. Part of the question is when can you deliver the technical solution that is actually going to work and break through and of course there have been some delays in getting the VistA software out. In our community, some physicians may wait for that. Our hope is that the ability to really link the hospital, the physicians and the consumers in our area may be hopefully something that adds enough value that our community as a whole will go that way.

Clearly there are issues with the development of RIOs [misspelled?] and other sorts of things across the country. I

think to Dr. Mongan's point, a lot of healthcare systems and others are waiting for the other to act. And our sense is acting hopefully in a prudent way now may be the way to move the whole thing forward. It may be a place for VistA for others as we get to issues of interoperability and things. But also to sort of reinforce and build on Dr. Mongan's comment that if we could work through this ambiguity, this inability to step forward, I think it really could benefit the health of our community.

JAMES MONGAN, M.D.: There is an incredibly important cultural issue here and again we should spend a minute on it. I will go all the way back to 1970 when I was working here. Many of you may have forgotten or not know, you know the first line of the Medicare law, and it remains today, is "Nothing in this Act shall interfere with the practice of medicine." It sounds a little quaint, but that is what it says.

I remember when we were working on the first peer review legislation and we got enormous opposition from the medical societies, "This is cookbook medicine." "It is the wrong path." We are going to really have to cross that cultural hurdle when we move forward with health IT because the underlying issue is, who is responsible for the decision support, for guiding medicine, for which tests are right, for which medications are right, which patterns of care? Is each health system going to have its own decision support? Are

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local medical societies going to have their decision support? Is the government going to have a big decision support system? That is an important cultural issue and I think a bridge that we are going to have to cross as we go into the next decade.

ED HOWARD: Do our congressional staffers have a policy/political slant on this in picking up any residents on this issue?

DORA HUGHES: I think on the clinical stance, certainly those who champion universal healthcare have a much easier time supporting some of the changes that Dr. Mongan has outlined. I think many would argue that, yes, we should have a systems-based approach. Yes, the government should play a greater role in establishing standards and the measures and so forth. And so on the democratic side, I would say that we would actually be in favor – and I don't know if Madeleine would have a differing view on that or not.

ED HOWARD: That is the republican view of interoperability. [Laughter]

MADELEINE SMITH: Got me. I would like to add in relationship to what I heard the question to be, that we all recognize the geographic differentials that were illustrated in one of the earlier slides that showed how the practice of medicine is quite variable in our country and some of the most interesting findings are that the high cost areas are not the best quality areas. And to try to get a handle on that, we

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have to start collecting the information about the quality of care being provided. And eventually, we will have information about the outcome, we will have information about the costs and we can put the two together to determine what indeed is the best practice.

Recognizing however that there are differences in how medical care is delivered in this country, one provision in the Johnson legislation says okay, the first comparisons will be made on a regional basis, so that quality providers are not all identified in the same area of the country. But over time, the shift would be from a regional to a national basis in setting thresholds for quality, thresholds for improvement, but recognizing today that there is a wide variability.

ED HOWARD: Once again, I do not want to preclude people from asking questions from the floor, if you want to raise your hand. Also, we only have about 15 minutes or so left, so if you have to leave, make sure that you fill out that blue evaluation form.

We have got a couple of questions that are related that have to do with prevention. One of them says, "We heard a lot about managing care once people are sick. What kind of health system can deal with questions like obesity, smoking and mental health that cause costly chronic disease by a prevention strategy?" And related to that, a question directed to Dr. Hughes, "Can you say more about the need to help Americans

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remain healthy outside the healthcare system? And has anybody quantified the overall savings if you could do that?"

DORA HUGHES: I am not sure I fully understood the second part of the question. With regard to prevention, I would just say again, it points to the need for a more systems-based or population-based perspective and increased level of accountability for not just the individual patient, but the groups of patients, whether it be at the local systems level or the state level or regional level. And there is a huge disconnect right now between prevention. I would say that most, if not all, the major prevention legislative packages have been stalled in the Senate under the concerns that this falls within the realm of personal responsibility and so forth.

But at the same time, even prevention within the healthcare system, how do you insure that people are able to get that annual physical or whatever the necessary screens for whatever age or gender group, that that conversation is not happening. There is no dialogue right now and that is a primary concern for Senator Obama and certainly Senator Harkin and a number of other senators here and I am not sure what the best answer is to that question. This is for the second part – I do not know if that really answers some of the issues.

ED HOWARD: I think actually the second part was also connected to prevention. They used the euphemism outside of the healthcare system. But prevention I think was addressed.

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DORA HUGHES: Right because I think certainly the uninsured are not receiving preventive care. I think we are depending quite a bit on the community health centers to reach out or a number of the dish hospitals or other hospitals to provide that care and in fact, I think most of us would agree that it is not happening.

MADELEINE SMITH: I would like to add that as part of the Medicare Modernization Act, disease management program were implemented on a demonstration basis in Medicare and the Congressional Budget Office said that there would be no savings by providing disease management for the Medicare population. And if you have any evidence to the contrary, we would certainly welcome it in our annual fights with the Congressional Budget Office to demonstrate that these programs are important and are the way to go to help control the cost especially among the very high-cost cases.

The second thing I would like to add is that many of the indicators, the quality indicators, the starter set that the Ambulatory Care Quality Alliance put forth for quality measures include specific measures about preventive care. So I do believe that there is attention being paid to the provision of preventive care benefits to the population.

The third thing I would like to say is that Medicare also is beginning to address prevention in a more coherent way through it's Welcome to Medicare physical, where beneficiaries

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upon entering into the program are given a physical, told about the preventive care benefits that are available in Medicare and urged to receive those services in a timely fashion.

ED HOWARD: We have time for just a couple more of these questions on the cards that we have. "What measures can government or the medical profession encourage – I do not say require – to encourage patients to be hice [misspelled?] conscious and make individual and institutional providers more competitive?" And I guess I would add, what else besides price should you be thinking of?

JAMES MONGAN, M.D.: I will take a stab at a couple of things – three things I guess that people talk about. One is obviously transparency. I think there are a growing number of initiatives and calls for increasing transparency. You heard some conversation earlier from the panel about the relative lack of understanding of prices, many of the payers are pushing for increased transparency and pricing data on websites and things of that sort. And in general, I would say that I think that is a positive and necessary trend.

Obviously for decades, people have looked at deductibles and co-payments as a way to deal with consumer demand. There, I would just make the obvious statement that as in so many things in life, balance is important here. I think anybody who argues against any deductibles and co-payments is probably missing an important facet of human nature, but I

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think anybody who pushes too far on that string, runs the risk of deterring not only the use of unnecessary services, but also the use of necessary services. There is good data from Karen's folks at Commonwealth Foundation that can show the impact on people not filling their hypertension prescriptions as co-payments go up. So I think balance is very important in that area.

And then I think that pay-for-performance is an important indirect way to get increased consumer involvement because they can be tracking who is meeting performance standards and who is not meeting those standards.

STEPHEN SCHOENBAUM: I would mostly like to second what Jim said and cost-consciousness is certainly something that is likely. It is something that Madeleine referred to in one of her examples, which is that we do not have it to a great degree and partly that is because in fact we have not made obvious to the public and often not to providers either, what the costs of care are. There are some real technical issues in that, which is that it is not just the unit cost, it is how they aggregate across an episode of care and are there more efficient ways of putting together the components of care to get a high quality outcome as another major issue that needs to be looked into.

Pay-for-performance is clearly heading towards rewarding lower cost providers as well, I hope, as higher quality providers. And another way that this is being dealt

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with as we speak is with the development of tiered networks, which is yet another approach to this problem. So I think there have been several, but we can do much more.

DORA HUGHES: The only thing I would add is that as we focus on patient providers, I do think that is where the majority of our focus should be, but there are others outside of the direct medical community, that we should also include, for example, in terms of direct to consumer drug advertising, which we know how that certainly increases the number of patients who ask for X, Y and Z drugs that providers subscribe. I think it has to, whatever the solution is, has to include focus in a variety of different areas to make sure we are successful.

ED HOWARD: Let me just maybe take advantage of a previously submitted question to give people a chance to make final comments because it is actually another opportunity to give technical assistance to our congressional panelists. The question is, what can Congress do to move us toward a high performance healthcare system after all of this discussion? Anybody like to take a crack at that?

JAMES MONGAN, M.D.: I will take a first crack. I think I am probably repeating some points I made earlier, but Congress obviously has control of the ball with respect to the access and coverage issue and I hope people do not forget that ball. With respect to the quality and safety issues and

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effectiveness efficiency, I would say two things, one of which we talked about, the IT – any of these things to encourage IT, whether that is some direct support, some waiver of Stark provisions or some further work on interoperability. I think those are all positive things.

I think something we have not talked about here today, but it is very important, I mentioned in my remarks the importance of effectiveness and how little we know about what services are really effective and which are not effective. So I think support for research in this area, effectiveness-based research, would be a very important role for the government to play in this area.

ED HOWARD: Gary?

GARY YATES, M.D.: Yes, just a couple things I would add to Jim's comments. First of all, help in moving forward around the IT issues is key. Again, this ambiguity that is the sense that we are just not ready to go forward with extent concrete steps can take place there, would be very, very helpful.

Again, the idea of being able to align the various constituencies and both programs and things both through CMS and others to help to align the interest of physicians and nurses, other systems in moving forward. Another thought is that there are other innovative models in finding ways to support them will be helpful. For example, as we try to

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confront this aging population and at least some predictions that the demand for care may outstrip the caregivers, if you will, there are interesting things going on out there, for example, around using e-mail and e-mail visits. There are group visits. There are things around self-care that are probably going to be key to population management as we go forward, things that can come to help to encourage both those sorts of experiments and then to broadening those out into reimbursement would also be helpful.

STEPHEN SCHOENBAUM: I will try not to reiterate some of the points that have been made, although I happen to agree with essentially all of them. I think there are some other areas that Congress can work on as well. One of the missing links for us is technical assistance. You heard today about some of the things that are happening at Sentara or at Partners, but I guarantee you that there are large numbers of healthcare deliverers around this country who haven't a clue about the same things that you have heard about. And those practices need to be spread. If you get into the diffusion literature, you will discover I think that a lot of it started with looks at the spread of new and better agricultural practices and techniques in this country and was intimately related to things like the agricultural extension services that are around the country. And yet, we do not have that kind of technical assistance in healthcare for making sure that people

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really know what it is that can be done and how best to do it.

I think there are other things that can be done. I understand the demonstrations mean different things to different people, but I tend to think of them – or at least the form in which I am going to mention them – is very carefully designed evaluations of potentially better policies and practices. We know that primary care plays a major role in developing better care in other countries. We have not yet carefully evaluated how we might enhance the primary care system in this country, which is relatively stunted compared to what it is in other countries.

We know that there are some promising techniques for coordinating care and indeed, some of these are being studied in ongoing demonstrations and evaluations. But again, it is another area that we could focus on. And not to reiterate too much of what Jim Mongan was talking about, but to emphasize his point, that we know relatively little about what is effective or efficient care. Part of the reason is that we have not devoted a huge amount of our research dollars to in fact developing better information on effective and efficient practices. And so I think that is an area that people in this part of the world can strongly help us with.

I think my concluding comment would be that I am very fond of the framework, at least in quality of care and I, again, agree with all the comments that were made earlier about

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coverage and access being extraordinarily important and integral. Indeed, one of the things that we had in mind as we were starting this commission on a high performance health system was putting all of these things together in one package and not leaving them in silos, so that people would think about the tradeoffs between quality and efficiency and coverage and access and so on.

But if I can now focus just for one second on the quality area, it is not just about acute care, it is not just about chronic care – one of the frameworks that was developed by the Foundation for Accountability some year's ago for the IOM, who in turn were developing it for the Agency for Healthcare Research and Quality, was to look at the care that is delivered by care deliverers as being prevention, acute care, chronic care and end of life care. And all of those are important in all of the various other dimensions of quality such as safety and effectiveness and so on. We certainly did not mean this to be an exclusive discussion of any one of those areas.

ED HOWARD: Thank you Steve, very good concluding thought. I would like to take a moment to reiterate our thanks to the Commonwealth Fund. Also, we have not really talked about it, but buried in your materials is a chart book that has never been seen before this very day, so I want to commend it to you. Anne Gauthier and Michelle Serber oversaw the putting

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together of that document, which I found compelling just because it took a lot of things from a lot of different places and put them in easy reach of those of us who are concerned about these issues.

Karen Davis indeed did make an appearance and we are very pleased to have her with us, the president of the Commonwealth Fund. Commonwealth has been deeply involved in this area and will continue to be. I want to thank you for coming and I will thank you even more if you fill out this blue evaluation form. And I ask you to join me in thanking our panel for an extremely useful discussion. [Applause] See you next time.

[END RECORDING]

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