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National Scorecard on U.S. Health System Performance Press Briefing
Moderator: Karen Davis
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Karen Davis: [The Commission's] first major report which we call the "Framework report" is in your packets, and it was issued in August. And in it, the Commission described the attributes of a high-performance health system, and it laid out the keys for moving the U.S. in the right direction. Today it fulfilled another of its goals, reporting the results of a comprehensive, integrated check-up of health care in America that we believe will help lead us to sound policy recommendations in the near future. This report, "Why Not the Best?" is also in your packets, and it is being released today simultaneously with publication of a Web Exclusive article in the journal *Health Affairs*, the nation's leading policy journal, which you also have in your packets.

In a moment you'll hear the results from the lead author of the *Health Affairs* article, Cathy Schoen. But first I'd like to say why I think this scorecard is so urgently needed. The fact is that the US spends 16 percent of its gross domestic product on health care. That's more than twice the average of industrialized nations. But as several studies have shown over the past several years, and as our ever-growing uninsured rates underscore, we are not getting good value for that investment. In fact, 40 percent of Americans in a recent Commission study said they had experienced inefficient, uncoordinated, or unsafe care over the past three years. And yet recommendations to reform the system, when they've come at all, have tended to be incremental, lots of proposals but no real plan, and worse sometimes even, at least in the views of some, steps in the wrong direction.

So the scorecard comes at a time when the need is great and leadership is urgently required. And it provides us not only with information on what to improve, but also with clues as to how to improve by highlighting those regions and organizations that are already achieving benchmark performance. And the baselines give us the information we need to continually monitor our progress toward achieving these examples of excellence, these benchmarks. The Commission will follow the release of the scorecard with reports over the next several years, covering the keys to higher performance laid out in the framework report, and the scorecard will be updated annually.

Before starting, I just want to take a moment to thank everyone who has played a part in this undertaking. Particular thanks go to the staff and editors at *Health Affairs* who reviewed and prepared the publication of this article in breathtaking time. For any academics in the room, you would be amazed. [I'd like to thank] this illustrious panel that you see here today. I'd

also like to thank Dr. Jim Mongan, the chairman of the Commission and the members of the Commission, as well as Commonwealth Fund staff. And I'd just like to particularly recognize Cathy Schoen, the fund's Senior Vice President for Research and Evaluation, Sabrina How—Sabrina, wave. Everybody knows there's somebody who really puts out an enormous amount of work to get something like this accomplished. As well as the entire communication and publishing team.

So I'd like to turn the podium over to Cathy Schoen to present the results. As I said, she's the Senior Vice President for Research and Evaluation at The Commonwealth Fund and serves as our research director. Following Cathy we'll have Dr. Jim Mongan who is President and Chief Executive Officer of Partners HealthCare in Boston and a professor of health care policy and a professor of social medicine at Harvard Medical School. He also, I should say, serves on the board of directors of The Commonwealth Fund and is Chair of the Commission on a High Performance Health System. He'll be providing the Commission perspective as well as his own views as physician leader. And we'll take some questions for Cathy and Dr. Mongan after their remarks, including [from] those of you who are joining us by phone. And then we'll turn to a panel of reactors, chaired, moderated by Dr. Steve Schoenbaum. Dr. Schoenbaum is Executive Vice President for Programs at The Commonwealth Fund. He serves as Executive Director of the Commission on a High Performance Health System. I think many of you in the room know him, but he has had experience in the past as medical director and been president of Harvard Pilgrim Health Care of New England, a mixed model HMO delivery system in Providence, Rhode Island. And he's joined by Maureen Bisognano, who's the Executive Vice President and Chief Operating Officer of the Institute for Health Care Improvement. I think some of you have heard of the 100,000 Lives campaign that IHI [managed]. She oversees all operations, program development and strategic planning for the Institute, and in doing so she advises health care leaders around the world. She's an unrelenting advocate for the needs of patients and a passionate crusader for change. You'll also hear from Dr. Christine Cassel who is the President and Chief Executive Officer of the American Board of Internal Medicine and the ABIM Foundation in Philadelphia. We're particularly grateful for the endorsement by ABIM of the work that you'll hear today. She's the former Dean of the School of Medicine and Vice-President for Medical Affairs at Oregon Health and Science University in Portland, Oregon, leading expert in geriatric medicine, medical ethics and quality of care. In the late '90s she served on the President's advisory commission on consumer protection and quality in the health care industry, which I think really ignited the nation's concern and action on quality of care. She was formerly Chair of the Department of Geriatrics and Adult Development, professor of geriatrics in medicine at the Mount Sinai School of Medicine in New York. And the last member of our panelists and the newest member of The Commonwealth Fund Commission on a High Performance Health System is Dr. Robert Galvin, Director of Global Health care for General Electric. He oversees the design and performance of GE's health program, which include the management of GE's $3 billion annual health expenses, so he knows up front and personal problems of health care costs. He also oversees employee medical services, which encompasses over 220 medical clinics in more than 20 countries. So very experienced with health care around the world. And in his current role, Dr. Galvin has focused on issues of market-based policy and financing with special interest in quality [management], payment reform and the assessment and coverage of new technologies. He's a cofounder of the Leap Frog Group and the founder of Bridges to Excellence. He's on the Board of Directors of the National Committee for Quality Assurance, and he's a member of the Hospital Quality Alliance. It's been a great pleasure to serve with him on the Institute of Medicine committee, looking at issues of performance measurement and pay for performance. And I think he's in town for the release of that report tomorrow as well, which many of you may find of interest.

So at that point, I'd like to turn it over to Cathy Schoen.

Cathy Schoen: Thank you, Karen. [indiscernible] I could get the first slide. I'm delighted to be here today to present the first edition of the Commission's scorecard. Karen acknowledged an array of people, but inside your various reports you'll see this really is a product of a lot of experts contributing their time and thought, including new indicators. The scorecard—excuse me, I'm just making this move forward. The scorecard provides a unique look, a unique whole-system look that spans across five core domains of the U.S. health care system: health outcomes, quality, access, efficiency, and equity. This is one of the first times we've looked across all of them and really taken a focused look at how these core domains interact with each other. We compared the U.S. national averages to benchmarks of high performance drawn from within the U.S. borders. The top 10 percent of hospitals, health plans, states, regions. Benchmarks where we can see high performance inside our own borders as well as internationally where other countries are compared on similar domains.

The scorecard in total includes about 37 indicators that are scored. The scores are very simple ratios. They compare the U.S. national average to the benchmark of high performance. And I want to stress throughout this, these are benchmarks of achieved performance. We didn't set a goal of perfection, but we were looking for models of excellence that we could see and we could learn from. It's designed to track and monitor change over time. We will be producing annual reports. All of the information that's in this scorecard is currently available from national data sources with a potential of trends. As new information becomes available, we will be adding it and scoring it.

Overall you will see from the various charts and reports that the U.S. scores poorly, an overall score of 66 out of a possible score of 100. These low scores are reflections of the gaps between national averages and benchmarks of high performance. We find significant missed opportunities to do better, examples of excellence within our own border, as well as significant opportunities to improve. These gaps cut across all the core domains of performance, health outcomes all the way over to efficiency. The consequences of these are not just numbers, are not just these statistics. But we have lives at stake, both in terms of mortality statistics but quality of life, and we are also wasting resources. We could be getting more value out of our investment or getting the same quality for lower cost. Across the indicators that are included in the scorecard, we estimate that as many as 150,000 lives per year could be saved by achieving benchmark rates, and up to $100 billion annually. And this does not count productivity: sick loss days, people not showing up for work, participation. The Institute of Medicine estimates that by covering the uninsured, the nation could save as much as $130 billion annually in productivity.

Given that the U.S. spends more than any other country, as Karen has mentioned, we should expect to be doing better. We should expect to be a leader. We should expect higher value in return. And as you will see as I go through some of the indicators, there's an urgency to action. Coverage and costs are moving in the wrong direction. To secure a healthy nation we really need to take a coherent strategy toward change.

As I mentioned, across all domains we see gaps. These are average ratio scores within each domain that we averaged out then for the total score. But as you will see, efficiency has a particularly low score. Evidence of excess cost, duplication, waste, but also the higher cost of poor access, poor quality. Quality and cost variations that together say we could both save lives and move to better, more efficient cost systems if we would move to regional examples of excellence. And we also have very high overhead costs to run our insurance system.

I want to go through just a few highlights today of indicators that are in the scorecard. Karen mentioned a series of reports that are available to you in your folders. On the desk outside you also have a complete chartpack of all the indicators included in this scorecard that shows you the variations and where we are, both on equity indicators and within the borders across national comparisons. Within health outcomes we've looked at opportunities to improve health, lives and productivity in our indicators. A global indicator that is broadly used in Europe is [death amenable] from causes amenable to more effective and timely health care. These are diseases where we know something to do—we can do something about. This is a composite indicator. The U.S. ranks 15 out of 19 countries on this indicator with results that are one-third worse than the top three countries. As you can see on the chart, we have evidence within the United States, and there's a steady theme of places that are doing better. We can be benchmarking either to other countries or within our borders. Some states achieve rates that are near the top international rates. On healthy outcomes in your booklets you will see we do [poorly] both at the beginning of life and at the end of life. We are ranked near the bottom on healthy life expectancy at birth or at 60, and we are last on infant mortality with substantial variations on disability.

When we turn to quality of care, we've looked at four priority areas: getting the right care or effective care, getting coordinated care, safe care, and patient-centered care. To give a few examples from each area, within right care, we took the U.S. task force on preventative care's recommended guidelines and said, "How many adults are getting basic preventive and screening care? All the care they're supposed to get based on their age and sex [and] intervals." And these are based on patient interviews. And we find barely half of adults get all recommended care. There are wide gaps by income and insurance, but I think what's notable here is that even high-income, well-insured people are barely getting above half. On this one we selected a stretch benchmark of at least 80 percent because within the variations we can't identify high performance at the national level.

Chronic care is not what it could be. We have diseases that are not well controlled, and we picked two diseases, diabetes and hypertension, and I'm just highlighting one. We can see the national average of all adults is well below rates of control for diabetes achieved by the top plans reporting to the National Quality for—the National Committee for Quality Assurance. These are managed care plans, but I think what's notable is even within these plans that are willing to voluntarily, publicly report, there's extraordinary variation that the top groups achieve rates of control well above the bottom. [Based on] NCQA estimates for both diabetes and hypertension, if we could move to the benchmarks of higher performance we could save up to $2 billion a year in health care expenditures, up to 40,000 lives. And this doesn't count millions of sick days and productivity impact.

Turning to coordinated care. Within coordination we are increasingly seeing in the United States that [failures] to coordinate care drive up costs due to duplication. They put patients at risk due to safety and medical errors as people move across sites of care. And we miss opportunities to deliver the right care. So coordination is a critical aspect of patient-centered, coordinated, efficient, and effective care. We know that vulnerable patients—when they leave the hospital—should have follow-up care, discharge instructions on what to do next, symptoms to look for. On one indicator that is now being regularly collected at the federal level, hospitals have agreed to report it, we see that barely half of congestive heart failure patients receive any kind of written discharge instructions, and there are extraordinary variations between the very high rates achieved by the top 10 percent of hospitals where nearly 90 percent of patients receive discharge instructions and not even 10 at the bottom of the distribution. A steady theme of the scorecard is that if we could move the bottom up even to average, we would dramatically improve the average performance in the United States.

This extends to various other indicators of transition care. Within long-term care we see that care within nursing homes is not what it—always what it could be in terms of keeping patients well, maintaining their health, resulting in admissions to hospitals. But there's also discharge to nursing homes and readmission 90 days later, a churning that goes on as care is not well coordinated when people move across sites of care. Our payment incentives often encourage this kind of churning as everyone makes out well when people move in and out of these different sectors.

On safe care, despite seven years being passed since the Institute of Medicine published *To Err is Human*, we still lack good global indicators across the United States on safety, whether in the community or in hospital. The indicators we have for the community are all moving up in the wrong direction, more safety incidents especially on adverse drug events. And these amount to considerable preventative cost. Estimates are as high as two and a half billion dollars for preventable adverse drug events. Within the hospital sector, we selected an indicator of mortality that expected rates of mortality compared to actual, given the health mix of patients within hospitals. And we see wide variations across the country, with benchmarks of excellence who achieve much lower rates than expected. The Institute for Health Care Improvement—and Maureen can talk about this later—has included this as a target indicator for their 100,000 Lives campaign because we know by addressing infections in hospital, teamwork, drug reconciliation, we can do a lot better on hospital safety and move the entire distribution toward higher performance.

Turning to patient-centered care, we have several indicators that look at timely access and not getting access quickly to primary care resulting in emergency room use, not having access, after-hours care compared to other countries. But even when we get into care, patients are often not engaged with patient-centered care. We have a newly emerging indicator available to the United States that will allow us to compare hospitals, thanks to a public effort to have patient-reported surveys of what happens to them. And this is the first pilot [set] of 250 hospitals. As you can see on both self-managed, of management of pain, of responding when you're in need of help, getting someone to come, understanding the medications you're on and side effects, there are wide variations even in this pilot sample. As Steve Schoenbaum likes to say when he looks at this, "But we also see examples of excellence." There are hospitals that are getting to 100 percent patients saying that they did receive this type of patient-centered care. So we have models of places that we know can do better.

Turning to access, we have an epidemic on our hands as you can see from the annual surveys of the percent uninsured. The number of uninsured is up 6 million over the last five years. All this increase has been in working-age adults. We've done pretty well in protecting kids, so the scorecard is focused on adults. As you look across the states, we are losing states with low rates uninsured, and the number of states with 23 percent [or more] adults is now up to 12, up from 4 just five years ago. This is moving across the country, and it gets worse every year.

Our indicator of coverage also includes the adequacy of coverage. Are patient well insured, protected against high costs relative to their income? So we're looking both at uninsured and underinsured rates. About a third of adults are either uninsured or underinsured. This amounts to 61 million adults. These are very big numbers. And those costs amount to access barriers, delays in getting needed care because you can't afford it.

Affordability is another dimension we look at within access. Can you afford medical care when you do get it? We have about a third of the adult population saying they can't afford to

pay their medical bills and in debt paying off costs over time. These costs are particularly high, these burdens are particularly high among the low income population, both because of high uninsured rates and gaps in adequacy of health coverage. As you'll see in your packet, we are also looking at premiums relative to median incomes, and we're losing the number of states where the premium is a modest share of income over time as premiums far outstrip the median household income of the under-65 population.

Turning to efficiency, Karen mentioned at the outset that we are an outlier on one statistic. We are by far and away the leader on costs, whether you measure it as costs per person or as a percent of national income. We've put on this chart the next highest country, some of the next highest countries. And one of the things that you'll see is that internationally countries are all talking about getting more value for their investment. And some countries are starting to hold the line. So the gap between us and them has started to spread. On efficiency indicators we have several sets, some of which look at overuse, misuse. We also are trying to look at the connection between poor access and poor quality and higher cost. These are indeed connected, as an example of this is the 30-day readmission rate to the hospitals among Medicare patients. That congestive heart failure discharge data I showed you earlier on quality is part of a symptom of when we don't do well on transitions in care, when we don't do well in that initial admission, in the hand-off to primary care, we get higher than expected hospital readmission rates. People come back. There are wide variations as you look across the country, with about 50 percent higher rates in the highest readmission rate compared to lowest readmission rate, which were our benchmark for this indicator.

We also see wide variations in both quality and cost. This indicator was developed for us by Dr. Elliott Fisher and his team at Dartmouth Medical School, and it looks at one-year mortality rates for heart attacks, colon cancer, and hip fracture as a global quality indicator—this is after the initial hospitalization—and one-year costs of care for those indicators. The top left-hand quadrant over here is where we would like to be, which is better survival rates and lower costs. We have regions that achieve both: do better on lives, do better on costs. If we could move the nation toward those higher performing regions, we will do well on both.

I didn't put up an indicator that is in your packet on chronic care. On chronic care for three diseases, diabetes, congestive heart failure, and chronic lung disease, costs are highly concentrated among Medicare patients. These are the patients where we can really make a difference, both in the community and hospital. The cost average for that group about $32,000 a year, but there's a two-fold variation across the country. The steady theme of quality and cost.

When we look at insurance costs, our administrative costs for running our insurance system, particularly the private-sector side of running the insurance system, is a dramatically higher percentage of national health expenditures than other countries. About triple the rate of the lowest [indiscernible]. But if you look on this slide you'll see it's also much higher than Germany and Switzerland, which have complex public and private systems. These costs amount to substantially billions of dollars because remember they are also on a base that starts out much higher. Our per capita health care expenditures are much higher. We should be able to achieve administrative efficiencies and lower this overhead cost.

We also don't do well on information systems which are critical both for quality, for coordinating care, for avoiding duplication. We lag well behind on the use of electronic medical records among physicians. The statistic in the U.S. has moved up, but we're only at about a quarter of doctors still reporting any kind of electronic medical record compared to 80 percent or more in other countries, where they can find that they can free up doctor time and

start to focus on improvements that are more efficient care. We really have pioneer countries out there that we can learn from as they see what an information system can do for efforts to improve efficient and effective care.

On equity there are pervasive disparities across all the core domains that the scorecard covers. We have selected indicators in each. We looked at income differences, insurance differences and race/ethnic differences. As you will see on these global scores, the uninsured, and the low-income populations do particularly badly on equity indicators with rates about a third worse than their comparison groups. Hispanic rates and black rates are 20 to 24 percent worse than their comparison groups. One of the things that we've noticed in the scorecard, and we discuss it in the information that you have, is the relationship between not getting in, not having good access, and driving up costs. We often think of the uninsured as being particularly at risk of access and out-of-pocket medical bills, but they are also at very high risk of inefficient care, which we all end up paying for. Higher use of the emergency rooms. Duplicate tests. Test results that are never followed up. Turning up at the doctor's office and not having your records there. One indicator that picks a lot of this up is admission to the hospital for potentially preventable conditions if people had better access to primary care. Very high rates among minorities. Very high rates among low-income communities, and I've just shown you three of the conditions here on these conditions. This excess cost really mounts up to cost to the nation of not keeping people well.

There are six take-home messages, we think, from this scorecard as you look across the domains of care. The first that really jumps out at you is that we rank poorly. We should be doing better. We're an outlier on spending, but we are not getting value commensurate with these higher rates. These gaps are due in part to the wide variation within the United States. It's the variation that's pulling the average down. If we could move the distribution nearer to the benchmarks we can see and start using them as targets, we know we can do better. Guaranteeing affordable, high quality insurance is a critical piece to this puzzle of how to move the U.S. health care system. Poor access means poor quality. Poor quality drives up cost as well as puts patients at risk. These are inter-related. But beyond that, the churning that's going on in our insurance system means we can't track patients over their lifetime. We don't know what happens to them. We don't have data systems to follow a diabetic as they move in and out of care. So some basic tools are missing by not failing to close that participation gap. I seem to have lost my picture. OK, I'm at the end. So just going through the—I'm at the end, and that picture was supposed to stay up for the panels.

Quality and efficiency, a third take-home message. These are joint goals, not different goals. We see areas where we can improve both, and in fact working on quality often produces more efficient care. These wide variations can be reduced. We can see benchmarks of excellence. Better connected care appears throughout the scorecard as a goal we need to work for. Examples of coordination breakdown are across access, quality, safety measures. We're underinvesting in information systems and in research on system capacity to do better. We know we can do better on net gains in efficiency, and I think I'd like to close where I started. There's an urgency for action. A lot is at stake here as we look forward to how we continue to meet population needs. The security of a healthy nation is at stake. Action is urgently needed. Thank you very much.

Jim Mongan: Cathy, thanks for that very informative summary of the scorecard findings. It's not easy to cover that much material in so short a time, but Cathy, you did a great job at it. I'd also like to start by thanking Karen and all of the Fund staff who put so much energy and effort into this project over the past year. I think the results speak for themselves. And last but not least, I'd like to thank my fellow members of the Commission on a High Performance Health System,

thank them for contributing their time and effort and expertise to this critically important venture.

I'm pleased to be here this morning because I do believe that this scorecard is an unprecedented event in the evolution of efforts to improve the United States health care system. The scorecard marks the first time a report on our nation's health care system has addressed all of the key dimensions in performance: quality, access, equity, efficiency, and the system's capacity to improve. And it's the first time that a scorecard has compiled such a wealth of comparative performance data and benchmarks. That was purposeful. The Commission felt strongly that we in the nation needed a scorecard of this kind in order to establish a baseline across all of these indicators to provide us with the tools we need to target and to measure improvements going forward.

Now there can certainly be debate among reasonable people about exactly what this score of 66 means. Some might ask, "Is it a C or an F?" Well, we don't have exact data on how other countries would score on a similar scale or how our country would do if we were measuring education or housing in a similar fashion. But to me, and I think to other members of the Commission, the message from this report is very clear. We can do much better, and we need to do much better. And the scorecard presents the evidence for both of these statements. The benchmark data tells us that in some regions, states or organization within our own country, or in some instances abroad, higher levels of performance are already being achieved. So why not the best performance for all of our citizens? The analysis begins to show our opportunities to gain both in terms of quality life and national productivity through better coordinated, higher quality, and more efficient care.

So what do we do now? How do we start the work of improving? As a physician, I like to think of this scorecard as the diagnosis, and our Commission has already started to map out a treatment plan. In August the Commission released its framework for a high-performance health system for the United States in your packet, which laid out seven steps that we as providers of health care, policymakers, insurers, and employers can begin taking right now. The framework focuses on these seven areas, and I know that in the discussion that follows the question-and-answer period, Dr. Schoenbaum and the other panelists will touch on a number of them. The Commission has recommended that we should take these seven actions. Work towards encouraging larger and more organized delivery systems. Expand the use of information technology. Implement major quality and safety improvements. Guarantee affordable health insurance coverage. Reward performance for quality and efficiency. Increase transparency and reporting on quality and cost. And finally, encourage collaboration among stakeholders in the system.

Over the next three years, the Commission, with the support of the Commonwealth Fund leadership, will publish reports that provide more information and more detailed recommendations on all of these seven areas. And in addition, the foundation will support research and projects that will shed further light on each of these issues. Our country is undeniably the home of some of the best health care in the world. We should make every attempt to make that quality of care available to all, rich and poor, urban and rural, insured and uninsured, and across the length and breadth of this country. Our Commission hopes to show the way towards this goal which all Americans can and should support. And now I'll turn it back to Karen for the Q&A.

Karen Davis: Thank you, Jim and Cathy. In addition I should let you know that all of the materials that have been referenced today are available on the Commonwealth Fund Web site at cmwf.org. We're also launching today for the first time a feature on our web site called Chart Cart. So

you've seen a lot of charts. They're even more in the chart packet in your package. But if you want to tailor your own set of charts, you can click on the ones you want and create a file with that. So it's brand new. We hope you will find it useful to you, but also give us your feedback on ways we can improve it.

So I'm going to open it up for questions. I'd like to recognize first reporters— [operator interrupts]

Operator: Ladies and gentlemen, if you have a question or comment at this time, please press the "1" key on your touch-tone telephone. If your question has been answered or you wish to remove yourself from the queue, please press the "#" key. We do ask that if you are on a speaker-phone, please lift your handset before asking your question. Thank you.

Unknown Female: [indiscernible] problems, but it seems like since the big Clinton health care bill in '94, Congress is more inclined to go with incremental fixes. I don't know if you can comment on what incremental steps perhaps should come in what order that they could take to help fix some of the bigger problems you've cited here? Thank you.

Jim Mongan: Well, actually, while there are those who think the only approach to this that will work is a comprehensive solution, but I think many of us would not deny the point you've made with respect to the Congress' affinity for incremental action. So I think we should be prepared to deal in both worlds. I think we would like to put forward quite comprehensive suggestions to improve against the seven acts as I've mentioned, but in addition I think we'll work hard to try and put together detailed proposals in each of the seven areas I mentioned, detailed proposals to try and expand health coverage, to try and move us towards [indiscernible] performance, to move health IT forward, to encourage more organized delivery systems. So as our work goes forward over the next three years, I'd like to see us addressing those issues area by area so that people could put together either a more comprehensive or a more incremental set of packages.

Karen Davis: Other questions? Yes, if you'd identify yourself, please.

Todd Fullick: Hi, I'm Todd Fullick [ph]. I'm with Public Radio International and also WebMD. So just to boil this down, given the scores and the relation of the scores to other countries, if our lawmakers and our politicians continue to get on the floor of the Congress and on television and say, "We have the best health care system in the world in the United States," should we ignore them?

Jim Mongan: Well, I'd like to comment on that. I would never urge people to ignore our lawmakers and leaders, but I would urge you all to prod them with additional data. We do have this conundrum which I mentioned. Undeniably some of the best health care in the world exists in this country. After all, you see world leaders from other countries flying here for health care, not flying overseas. So it is undeniable that we do have some of the best health care. But you can run, but you can't hide from this mass of statistics that's been presented today, that taken as a whole we fall far short of having the best health care. And that should be pointed out to our leaders in every time that we're having commentary about this discussion, because it's a very important distinction.

Karen Davis: Yes? If you'd introduce yourself.

Nancy Ferris: Yes, I'm [inaudible]. I wanted to ask—I'm Nancy Ferris from Government Health IT. I wanted to ask about a sort of ambiguity, I think, in the findings. The percentage of national health expenditures spent on administration and insurance is very high in this country. But at

the same time you're urging more use of health IT which would be—which would add to that administrative cost. Can you tell me how we could resolve that?

Cathy Schoen: Is this on? I think first I should clarify that what is in that overhead chart that I showed you is the overhead of running our insurance system. If anything, those rates should have gone down because of IT. We could be moving to a paperless system. We aren't, when you think of what you do with your insurance card. None of us [indiscernible] insurance card that works by passing it through a scanner. My daughter actually asked me why her plastic card doesn't work that way, and I had to explain to her, "You just have to keep filling out the information at place after place." So that overhead cost has actually been rising faster than any other aspect of our national health expenditures, than drugs, than physicians, than hospital care. And I think we need to be questioning what we get for it. On the IT side of physician offices, that's where we do lag behind. We are starting to be able to look abroad and where there are potential efficiencies within physicians, within hospitals. And once they start to get physician support and interoperable systems where I can know information about a patient at the hospital level from the doctor, or the doctor can know what happened to the person in the hospital. We have countries that are starting to get there, and they are going to be able to report back to us on where there's avoiding duplication, freeing up doctors' time to spend time with patients, not searching for records, freeing up nurses' time to do nursing care. So I think there are potentials there, and we can start learning on where they are.

Karen Davis: Just to add to that…I think it is an issue we need to [know] more about. Does IT save money? Cost money? We are funding some work to get better answers on that. We have underway an evaluation of New York State's regional health information organization, RHIOs, in six areas of New York to see if the savings from reduced hospitalizations when people are seen in the emergency room by physicians who can now access your medical record, offset some of the cost, whether reduced drug interactions and other health benefits also offset the cost. So I think it's something we need to learn more about, but that's one example of work we have underway. Yes? If you would identify yourself, please.

Larry Wheeler: I'm Larry Wheeler with Gannett News Service. I'm guessing here that most folks who read our coverage of this event in tomorrow's paper or see it on the TV are going to want to know what hospitals are the best and the worst? What states are the best and the worst? Why isn't that part of your data, or is it? Where can we get it?

Karen Davis: Cathy, you want to—

Cathy Schoen: I'll do both in sequence. The hospital data is starting to be available on a regular, public level. And one of the things that we're finding interesting is the clinical indicators. I didn't put up the clinical indicator data set that's now required to get annual Medicare updates, payment updates. That increased voluntary participation dramatically when it was linked to getting your payment. They're expanding that indicator set. We're able to benchmark. Some hospitals do well on one set and not on another. So care can be variable within a hospital, and care for a heart attack versus care for pneumonia patients. And hospitals are now starting to be able to benchmark, and this information is increasingly publicly available. But equally important as feedback loops to hospitals, where are you doing not as well as a comparison peer group, and what are they doing that gets those? So on the state level we are planning a state scorecard that we hope to release by the end of the year. Cost is [indiscernible] on these types of indicators. We've been collecting them. We do not yet have that data available. Rank orders among states vary, depending on which indicator you're looking at and which set of indicators. So what we'd like to be able to do is a more comprehensive look to be saying, "Where are the quality variations, access variations, efficiency variations across states?" And

so you should be looking toward that to start saying, "Where are states doing relatively well? Relatively worse? About average?" And we will be putting that out.

Karen Davis: Again, just to plug a little bit the work of The Commonwealth Fund, we were pleased to support the work of Dr. Ashish Jha and Arnold Epstein at Harvard who published in *The New England Journal of Medicine* the Medicare quality indicators and what were the best regions and the worst regions. In addition we have a bimonthly newsletter called *Quality Matters*, and we listed the names of the top nine hospitals in the U.S. on those quality indicators and did a case study of the Number 1 hospital, which was Reid Hospital in Indiana, and how they managed to get the very best scores, sometimes 100 percent, on many of those Medicare quality indicators.

If we could take a question from somebody calling in on the phone. If you would identify yourself?

Operator: We do have one question. The first question or comment comes from [inaudible].

Karen Davis: If you could identify yourself, that would be great.

Operator: Our first question or comment comes from Kevin O'Reilly with *American Medical News*. Your line is open, Mr. O'Reilly.

Kevin O'Reilly: Hello. My question is isn't comparing or using the benchmarks of the highest performers kind of like looking at pro golfers and saying, "Well, everybody stinks compared to Tiger Woods, so we need to improve"? Or why is that analogy wrong? Shouldn't we expect that people aren't going to be as good as the highest performers?

Karen Davis: Dr. Mongan, I don't know whether you know the Tiger Woods of health care?

Jim Mongan: The reason I made my comment about how it's impossible to put a letter grade on this data flows in part from that point. Ideally in golf it would be nice to have everybody be the very best they can be. In medicine it's more critical we think that everybody perform as high as the highest performer. Will we ever get to 100? I have no expectation that we'll get to 100 soon, but we should certainly get higher than 66. And the important part of this scorecard effort in my mind is the ability to continue to track these going forward and to see how close we're all getting to becoming Tiger Woods. And I would say again it's more important in health care than it is in golf to narrow that gap and to work as hard as we can to narrow that gap, and that's what we're measuring going forward.

Karen Davis: Other questions? Yes. If you'd identify yourself? Yes, in the front there.

Unknown Female: I'm [inaudible] from the American [Nurses] Association, and I just bring to your attention that there's a coalition for patient rights that has been established to encourage the health care consumer an opportunity to choose their care provider. I'd also like to ask what's going on in relation to those of us who are paying out of pocket for alternative and complementary therapies far more money than is going into hospitalization [inaudible] environment. What's going to [inaudible] evaluate the outcome in relation to those people?

Karen Davis: Cathy?

Cathy Schoen: One of the areas that you'll see in the scorecard is something we call investing in the system's capacity to innovate and improve. I think we are way underinvested, and we give some

numbers on the level of federal or private investment [on] knowing what works well. Cost effective therapies, comparative therapies. Systems, which systems deliver more? And so one of the things we've called for is investing so we can start to know answers to those questions.

Karen Davis: Yes? There? I suspect we can hear you if you go ahead. Please identify yourself.

David Hogberg: David Hogberg, National Center for Public Policy Research. I just first of all want to commend you on putting together an awful lot of data that is going to be very good for a lot of discussion and debate. And I guess my question following on that, The Commonwealth Fund also has a project with the OECD looking at quality indicators across countries, and looking at that report I noted how difficult it was to come up with comparable measures across countries. Could you comment on that regarding some of the indicators that you've included here? How confident are you that the indicators across countries are all that comparable? Because we know that, for example, on life expectancies there's a lot of nations that don't use the OECD's definition—not life expectancy, infant mortality—do not use that definition. So I was just wondering could you discuss that a little bit?

Karen Davis: [indiscernible] and I know we have somebody here from the OECD project. If you want to add anything, feel free.

Cathy Schoen: I'd be happy to. We have selected indicators from international, and we did our best to make them totally comparable. The mortality amenable follows exactly the same methodology. And we did restrict it to the types of information where we're on more certain ground. The OECD effort has been to expand from the initial five countries to look at clinical process indicators to get more so that we can do more of this benchmarking internally and externally. And I might point out other countries are starting to do this a lot, saying, "I want to look inside as well as internationally for models of excellence." On the patient indicators that we included, The Commonwealth Fund has invested over the last several years in annual surveys with exactly the same questionnaire done in exactly the same way in each country so that we can get away with maybe this wasn't the same concept that people were answering. It's gone through a lot of expert review to even worry about the English-language speaking country: do the words mean the same thing? So many of our international comparisons in the patient-centered side and access side can now be drawn from international contrast where we are asking the same questions. Did this happen or did it not? How many days did you wait before it happened? So we're trying to enrich that database so the actual comparability is not the issue and we can say, "Where can we see models of different types of performance?"

Karen Davis: Mr. De La Mare, do you want to tell people where they can get that report? Anyone want to volunteer? I think it's OECD—we'll have to get that referenced for you, but I'm sure somebody—yes, in the back?

Unknown Male: [inaudible] all the work that you've been doing in terms of moving the envelope forward in terms of quality and health care performance in the country. I wanted to follow up on a question that was raised earlier in terms of state comparisons. Ms. Schoen referenced a few times the concept of value. And I'm curious to find out whether in the state report card that's going to be released toward the end of the year that she referenced, whether there will be indicators that look at quality as the numerator and cost as the denominator, and come up with some assessment in terms of the value of care being provided on a state-wide basis so we can look at that.

Cathy Schoen: For you looking for that overall indicator of cost and quality, I think what we're going to be looking at is areas where states are doing well on both, doing poorly on both, and a mixture, is what you're going to see. And again, one of the symptoms of performance failure in the United States is the paucity of indicators. As we go down to the state level, we lose some of these indicators. We have very few safety indicators at the state level, for example. They just don't exist. States are not getting them, collecting them at the federal level, either. But we will have quadrants that are similar to what I showed you from Dr. Elliott Fisher's where a state is doing fairly well on quality but is relatively high on cost, and we'll be able to say, "What lies underneath some of that? Is it higher readmission rates? Is it [indiscernible]-centered admission rates? Where are those higher costs coming from? Is it access gaps?" Which we believe drive up costs statewide.

Karen Davis: Well, thank you for these questions. At this point I think we're going to turn to our panel and turn it over to Dr. Schoenbaum.

Steve Schoenbaum: Thanks. This morning we've invited a group of panelists to help provide some additional perspective on the scorecard and its implications. All of them as you heard in the first introduction are members of The Commonwealth Fund's Commission on a High Performance Health Care System. And I'll just refresh you very briefly. Maureen Bisognano is the Executive Vice President and Chief Operating Officer of the Institute for Health Care Improvement in Cambridge, Mass. Dr. Christine Cassel is the President and Chief Executive Officer of the American Board of Internal Medicine and the American Board of Internal Medicine Foundation. And next to her is the newest member of the Commission, Dr. Robert Galvin, who is the Director of Global Health for General Electric. Now, you've heard that the scorecard was put together to help the Commission and the country know about the current performance of health care in this country and to begin to think about what might be done to achieve higher performance, and ultimately to begin to measure that progress. To date, the Commission has really discussed improved performance on a general level, has set out the framework for what it thinks might lead to a higher performance health system, has in fact been involved in the notion that we needed a scorecard and what it might consist of. But it's not really yet gotten into specific options for improvement. So what we'd like this morning is for each of the panelists, because each of them has her or himself had an intense interest in improving the performance and value of the health care system in the United States, to give their individual perspectives. And I'd like to start by asking each of the panelists to describe what their organizations are doing to try to achieve a higher performance health system. Maureen?

Maureen Bisognano: Thank you, Steve. The Institute for Health Care Improvement—can you hear OK? How about this? No, it's not on. Oh, here we go. OK. The Institute for Health Care Improvement in Cambridge was founded exactly for this purpose. The IHI has been working with providers, physicians, nurses, health care leaders for the last 15 years to identify the gaps in care and to close those gaps collaboratively across the country. On the one hand, we've seen dramatic innovation and dramatic improvement as both Jim Mongan and Cathy Schoen have described. But I guess the bottom line for me is our failure to be able to take those dramatic innovations and improvements and spread those reliably and consistently and quickly across the entire country. So the challenge I think is spread. It's a very fragmented system, and I think the challenge that we'll find with the report is can we come up with a small number of priorities for improving care and move those across the country quickly? The best example that we've had of this at IHI has been the 100,000 Lives campaign that was launched in December of 2004. We had six examples of evidence-based research that was known to help improve safety on behalf of patients, and yet those were variably adopted across the country. So we challenged ourselves to try and find about 2,000 hospitals that could pick up on those

six indicators, implement them reliably and then track progress on saving lives. To our amazement, having a small number of focused indicators, evidence-based ones that perhaps didn't cost a lot of money to implement, ones that were able to be accomplished at a microsystem level with frontline nurses and physicians, excited an enthusiasm across the country. And at my last count, over 3,100 hospitals had signed up for the campaign and had begun to implement those six changes.

So we think that the idea of having an aim that's important on behalf of patients can really galvanize the energy across the country, can vitalize, revitalize physicians and nurses who are working in fragmented and frustrated systems and given them the tools to share with one another best practices to make those changes visible on behalf of patients. I feel sure that if we can create a system of reliable spread, that we can get these kind of changes implemented much more quickly, much more reliably. And the end result is going to be wins not only for patients but also for providers and payers as well.

Steve Schoenbaum: Thanks, Maureen. Chris?

Christine Cassel: Thank you, Steve. First I want to also commend The Commonwealth Fund and the Commission on this report which I think really is an eye-opener. We all see lots of data, but presented in this way is I think as Maureen suggested, makes it possible [indiscernible].

Unknown Male: Is this on?

Christine Cassel: You want to try this one? Oh, that—is that better? OK. That shows you that the indicator isn't [indiscernible] patient safety. The indicator isn't always telling us the right thing. That my particular perspective on this and the ABIM's perspective on this is that of the individual physician. And Maureen mentioned how frustrating this is for doctors, and we certainly hear that all the time. ABIM provides the organization that creates board-certification processes and requirements for 200,000 internists in the United States, roughly 40 percent of American doctors, and includes the largest group of primary care physicians but also a whole range of subspecialists. So we have kind of this specialty medicine and generalist physicians within our group.

If you look at the main takeaways from this report of what's needed, what's needed is care coordination, the idea of teamwork, the idea of information freely available, the idea of a medical home that came out of a consumer survey earlier released from The Commonwealth Fund, and then you look at how physicians practice in the United States. Within internal medicine, 20 percent of internists are in solo practice. More than 60 percent are in practices of less than five people. And then you ask yourselves, "How can they provide these kind of integrated systems of care given that mode of practice?" So that's a huge challenge for how to take the system that we have and create what the Commission feels is the key missing factor, which is "systemness" to how physicians are able to practice care.

What my organization is doing to try to enhance this is first of all ensuring that the physicians who you see, who the public sees, have the knowledge of up-to-date medical evidence-based information to work on.

Secondly, and this is what's new, in order to maintain their board-certified status, internists are now required to evaluate their performance in practice. Not only what do they know, but what do they do when they take care of patients? And report to us a whole range of evaluations of performance on indicators related to the kinds of conditions that you see here. We also have Internet-based tools, which allow them not only to collect that information and

compare it with national benchmarks but also to develop improvement plans and ways of innovating in the microsystem of their office, as Maureen said, to develop targets and move towards improvement.

In order to make this more doable for physicians—because you can imagine in individual doctors' offices the kind of burden of all of this information gathering as we saw they mostly don't have electronic record systems; it has to happen from chart reviews—we've developed relationships with health plans and large medical groups which do collect clinical data and made it possible for physicians to get credit towards their improvement processes from these other data sources if the data is rigorous and valid.

The last point I wanted to make is that we are part of a family of certifying boards that represent all 24 recognized medical specialties. I just came from a meeting yesterday in Chicago of that group, where all four have now agreed to comparable standards for board certification, which include periodic reevaluation and performance assessment. And we're working very hard, particularly with some of the smaller boards, to help share some of the tools that we've been able to develop to make it possible for them to do that.

Steve Schoenbaum: Thanks. Bob?

Bob Galvin: I will speak on behalf of employers. And just as a little reminder, employers are kind of [accidentally] in this health care system in the U.S., but they're in accidentally in a big way. It's still through employers that 160 million people get covered, and about half of what's spent in this country comes through employers, both with employers and employees. And I think employers have—reaching a new sense of kind of frustration and looking for action. It's very interesting, a recent survey that was done through what's called the HRPA, or Human Resource Policy Association, which some of you might know. It's the group of senior vice presidents of HR. About 250 of them from the largest companies in the country, and about every year they survey them. HRPA's been focused on health care now for a couple of years, and the last survey done a few months ago was eye-opening, which is a great majority of these human resource people who are responsible for managing the health care in the company feel that we need a new direction in health care, and they are very disillusioned about whether any of the initiatives that we're undergoing today are going to get us to where they want to be. And so I think the best thing to call employers at this point is probably reluctant activists. And I think one of the kind of great benefits of the scorecard and this report—and I'm the newest member of the Commission. One of the reasons that I joined it and GE thought it was worth joining was kind of the courageous willingness to put forward these numbers, because it is now a substraight. It's kind of a [indiscernible] from which we can improve.

Now, the employers have been at this for a long time. Steve asked us to speak a little bit about what we do in our own areas. We have really been focused on moving away from just cost, and we try to define value as integrating quality into affordability. We've been very devoted to transparency. That's what the Leap Frog Group was all about. The Leap Frog Group was, to answer that gentleman's question who's no longer here who basically said, "We want to know what hospital and what doctor," that's what Leap Frog was all about. We have been really dedicated to driving more incentives for quality into the system. That's what Bridges to Excellence was about, which was really rewarding physicians for doing kind of the right kind of services.

And I think even with all that we're finding those were necessary and not sufficient. A big eye-opener for us was through this HRPA we tried to expand insurance coverage to the

working uninsured, which is the biggest bulk of the uninsured in the country, through a program called National Health Access. We had a press release a number of years ago. And we've had a lot of struggles with that. It's working very well for those who join, but what we found was one of the limiting steps was affordability, even if we could offer access. Affordability was a problem; people simply couldn't afford the insurance. The other lesson we learned, and I think it's going to come in—it's going to be a big deal on this Commission, is how important collaboration is. The reason Bridges to Excellence worked as well as it did is because we had government payers in on the Board from the very beginning. We designed the program so that it would work for small employers and government. In fact, Bridges to Excellence got integrated into the MMA bill a couple of years ago as one of the demonstrations. I think similarly what we found in trying to expand access, which we think is very important to affordability overall even for us who offer private insurance, is that we couldn't do it without collaborating across the system. And that's one of the things I think the Commission represents. So with that, Steve, [inaudible].

Steve Schoenbaum: Thanks very much. We've heard some examples, specific examples of excellence of best practice. But I thought I'd just ask the panelists if there were any particular ones that they might want to mention, not just one that their own organizations were necessarily involved in, that show great promise for improving access or equality or efficiency of health care and that they think might be spread more widely. Anyone want to pick that one up?

Christine Cassel: I will, Steve. I think if we—one of the advantages of having these kind of regional variation studies, which are really important, is I think to answer the question of the person who asked the Tiger Woods question, you know, we can't all be Tiger Woods. Well, but one of the things—and Jim Mongan I think correctly said, "Yeah, but health care is not golf." And I think that is important to point out. But it's also true that if we look at where the high performers are, we can look at how they're doing it and get into the actual nuts and bolts of what makes it better or what makes it possible to be better. So we've done that with the ABIM and with our foundation in looking at not just quality of care but also efficiency. What kind of physician practices are able to deliver a higher quality care more efficiently? These tend to be larger physician groups that have multiple specialists within a group and collaborate and coordinate around the care of patients, largely also patients where there's a defined population that you're caring for. So I think there's lots of variations for how those groups come about. But I think in general that's what we've seen in seeing the characteristics of the people who are able to get to higher quality and better efficiency.

Maureen Bisognano: A few thoughts. First, Tiger Woods does use improvement methods himself. He regularly reviews his own performance and uses Kaizen improvement cycles to drive his score down—

Unknown Female: [inaudible]

Maureen Bisognano He does. He watches films and he runs strict PDSA performance improvement cycles to drive his own score down. But if you do track that—and I do, because I'm a very bad golfer—he has actually taken the score of the entire PGA down. Because as he has dropped his scores, what's happened is that's put pressure on the other professionals, and they've started to adopt some of his methods and techniques. And that's exactly what we're after here, is can we work with a few to create profound performance change, make it very transparent, and then open up collaboration such that everybody can see both the performance change itself and the methodology behind that. The unfortunate legacy of competition in health care in the United States is that we haven't been so transparent. And that's what I'm so hopeful that we can change. Two very quick examples. One is the premier [CMS] demonstration project, the hospital analogous project to what Bob described with Bridges to Excellence. Two

hundred and sixty hospitals joined together with a very small financial incentive to try and see if they could improve performance in five diagnostic areas. Again, I think the key is focus, a doable project. Can we pick acute MI, congestive heart failure, community-acquired pneumonia, hip and knee replacement, and CABG surgery, and work quarter after quarter towards a goal? Again, transparent data and support across the system to make changes? And if you look at the results, it's dramatic. Of the 260 hospitals, almost every single one of them improved care quarter after quarter after quarter for three years now, and we're seeing major changes. Opening up the black box so that everybody can see what they did exactly I think is going to create a new standard. And one last example is we're working again in collaboration. We're using that word at multiple levels, but collaboration across facilities on improving perinatal care towards our problems with neonatality. And what we're seeing here is dramatic improvements now in decreasing birth injuries. We've got some hospitals across the country that have been able to go for more than a year with no birth trauma. And that's a result of collaboration at the frontline level. Doctors and nurses working together with evidence-based standards and implementing them reliably.

Robert Galvin: I don't want to play this golf analogy too much but the Ryder Cup is this weekend for the golf fans, pit Europe against the States.

Look, I think I'm speaking for the payor side because that's what I know. There has been a remarkable change in collaboration between, I think, the two parties on the payor side that matter most, and that's what's happening with CMS and what's happening with the private insurers who are essentially funded by the employers. And if you look back a decade the kind of philosophies, approaches to managing healthcare in the country, we're really quite different. But now across administrations on different sides of the isle, we have had CMS administrators and staff working very closely with the private sector around things like transparency and particularly now pay for performance. So I think that—Steve asked for examples of collaboration, I think on the national level the extent to which a gigantic payor like CMS, with its 40 million or 42 million covered lives, and enough of the private sector, which is 160 million covered lives, can give steady messages and steady incentives and reimbursement to the providers that are striving to improve, is going to make a big deal and there's a couple of bills right now that'll get settled that could make a big difference with that.

Steve Schoenbaum: Thanks. I think we've all been bitten by this Tiger Woods question, and I just thought I'd mention the specific example that I stumbled into a couple of weeks ago. I was asked to give a talk to medical students in Pittsburgh, and I had as one of my slides an example of the work or some of the—an illustration of the work that had been done by Dr. Richard Shannon [ph] who was at the time at Allegheny General Hospital. And back about three years ago he decided to tackle the problem of central line associated bloodstream infections. A very particular thing. And within a three-month period of time, achieved a 90 percent reduction in the occurrence of those in a couple of the intensive care units that were under his direct control within that hospital. Now there is such a thing as the Pittsburgh Regional Healthcare Initiative, which has been going on for several years and has been supported by the Jewish Healthcare Foundation in Pittsburgh, and that has, I believe, about 44 collaborating hospitals. When I sent my slides to the University of Pittsburgh Medical Center, the people who had invited me to give the talk to the medical students, they said, "Gee, this is very nice but you should see our slides on how we're doing on central line associated bloodstream infections!" And they sent me back their slides which in fact showed that they've achieved a 90 percent reduction in central line associated bloodstream infections over roughly about that same period of time. And by the way, they've been working on methicillan resistant staph aureus infections and getting down close to you know, a 90 percent reduction there, and ventilator associated pneumonias, and actually also for the entire Pittsburgh Regional Healthcare

Initiative across those 40-something hospitals I believe there's been, over this last couple of years, about a 60 percent or more decline in the occurrence of these specific infections.

So we may not all be Tiger Woods, but in fact we all, as Dr. Mongan pointed out, really can do better in this field, markedly better, and there are really examples out there. I think with that—

Christine Cassel: Can I just add one additional specific example and also put in a plug for a collaboration between The Commonwealth Fund and the ABIM Foundation around the Putting Quality Into Practice DVD which we can make available to you if—there's information I think at that handout desk and you can access our Web site and order this, and no cost. This is 35 small practices. I talked about how tough it is for the small physicians in small practices, but some of them actually are doing amazing things in measuring and improving their quality. And we went out and interviewed them and made this DVD that tells their stories. And some of them are truly remarkable where they really discover what they didn't know about shortfalls in their patient care that then they get busy trying to figure out how to improve it.

One of the most remarkable was a practice that took care of homeless patients in the Midwest, and that's where we always hear—Bob and I were joking you know, physicians always say, "Well, my patients are sicker; that's why I can't do better." Well, and everybody's got sicker patients. But these are the toughest patients you can imagine to take care of, and they were able to get their control of diabetes and hypertension, the two indicators that we looked at, to absolutely the best benchmarks by developing better microsystems of care, and understanding the patient's lives and where they came from. So it is possible, I think we need to look at those examples.

Steve Schoenbaum: OK, well, I think at this point then I'd like to again throw the discussion open to the audience and to people on the telephone. And please identify yourself when you get the microphone.

Rima Jolivet: Hi, I'm Rima Jolivet from the American College of Nurse Midwives, and I'm just very excited by [operator interrupts]

Operator: Once again, ladies and gentlemen, if you do have a question or comment at this time please press the "1" key on your touch-tone telephone.

Rima Jolivet: …centeredness and efficiencies, and I would like to just point out that certified nurse midwives are a group of providers with a long history of caring for underserved populations much as Christine was just talking about, populations that often have higher risk profiles for bad outcomes. But midwives care for them in ways that use really appropriate resource utilization, patient centeredness, and often demonstrate excellent outcomes that are better than national standards. So I like to joke that a pay-for-performance were [indiscernible] we'd be better paid. But I would like to advocate for the Commission to try to expand the perspective beyond a physician-centric perspective, to look really at team models and best models when they're looking for models of excellence, and I really commend this work, it's exciting. Thank you.

Steve Schoenbaum: Thank you very much for the comment and any [comments you have].

Christine Cassel: Well, I just couldn't agree more, as my own medical specialty is geriatric medicine and that's of course based entirely on this understanding of the team. The physician alone can do very little in the care of complex older people, particularly people with lots of disabilities or in long-term care. And so that's a model where teamwork is essential. And again, when we get

to the part about what—beyond diagnosis to treatment as Dr. Mongan said, I think one of the things we need to look at is ways that the payment system can better support teams of care.

David Helms: David Helms, Academy Health. I want to join in the chorus of commendation for this groundbreaking work and make a, I think, an excellent demonstration of the investment the country has already made in the health services research and pulling that together in a very effective way to show what we do know. I also want to commend you to Cathy's point that where we don't have evidence about what really works and what doesn't, this country has laid out a framework for beginning to do more in comparative effectiveness research and I hope this work will stimulate that need because we are going to need to know more about what really works.

I also, as you look forward to producing your state variation estimates, I do think we have to be sure to calibrate those in terms of the capacity of states to act. And we have a very unequal system of capacity from our sub-national government. So some states do very well with covering the uninsured but they do well because they have a very high proportion of employed people who have and offer health insurance, and they have tax capacities to fill in those gaps. So you're going to have to calibrate your state comparisons, and it's going to demonstrate, I think, that really addressing this issue is going to require some fundamental redistribution of the resources that the country will have to put to this task.

Steve Schoenbaum: Do you want to comment on the states?

Maureen Bisognano: No, well, I could just second David's point, but you know, as you start to look at some of what's going on in states, you also encounter a phenomenon of extraordinarily high premiums in low incomes states. In fact, you know, I was challenged once, well certainly it's cheaper to buy insurance in New Mexico than Massachusetts, and the answer is no. And so there are some state levels starting to look at what is actually going on to the provision of care. If you don't insure people, cover for primary care, you end up building up your emergency rooms and pushing people into acute and more fragmented care. So there is this whole system kind of approach that can potentially turn some of this down, and build capacity, rather than say we just don't have it.

Steve Schoenbaum: Thanks. I want to turn next to questions on the phone then we'll come back to the group here. First is Melanie Evans from *Modern Healthcare*. Is she on the phone?

Melanie Evans: Yes, thanks, can you hear me?

Operator: Ms. Evans, your line is open.

Melanie Evans: Hi. This is Melanie Evans from *Modern Healthcare*. I have a question for Ms. Bisognano. You described the industry's lack of transparency as healthcare competition's unfortunate legacy. Is there any initiative that you believe would reduce variation highlighted in the Commonwealth Fund's report, that must be tackled by the federal policymakers rather than the private market?

Maureen Bisognano: Could you repeat the question? You were breaking up a little bit.

Melanie Evans: Sure. You mentioned the lack of transparency as healthcare competition's unfortunate legacy. I'm wondering if there's any initiatives that you believe would reduce variations that must be tackled by federal policymakers rather than the private market?

Maureen Bisognano: I'm not sure that it must be federal. We're seeing some credible private initiatives. As an example in the State of Wisconsin, many of the hospitals have joined together to disclose their quality data. They created a Web site and they publish their data routinely. And they're using that within the state to visit one another, to find best practices within the state and to create a collaborative that's non-governmental and not mandatory. But that kind of initiative is, I think, tackling the issue from the spirit of professionalism and from the leadership positions within a group of folks in the state. So I'm not sure it has to be.

Bob, did you want to add to that?

Steve Schoenbaum: Okay. Let me turn next then to Kevin O'Reilly from *American Medical News*.

Kevin O'Reilly: Hi. A couple of folks have described this report as groundbreaking and giving you something new. I want to ask how it compares to—it seems as though there's another new scorecard report about healthcare quality in the country every week or every month. What briefly—perhaps Ms. Schoen would be best to answer this—sets this apart in your mind in terms of giving us a really good picture of where we're at on all these different dimensions of quality?

Cathy Schoen: I think there are two aspects that set it apart. One is that we tend to see the scorecards that come out and I agree more is better, but we often will see one on safety, we'll see one on quality, we'll see one on diabetes. We look at things in a very silo-ed way, one on insurance, one on disparities. We made an effort to look across all core domains and start looking at efficiency and developed about thirteen new indicators in here that would be cross-cutting, where you can see doing well on quality or poorly on quality, or access—directly affects cost performance. And I think we need to start thinking that way as a country to develop coherent policies so that we don't do something on the coverage side that hurts quality and access or cost, but really have a very coherent, strategic view. Other countries are starting to do this as well, to really ask this value question: what are we getting and where are there pockets where we can see doing better and not trying to take a silo'd approach, but say these are really quite interconnected. Not just hospitals, not just nursing homes, not just doctors, but really to say how do all these parts work together? So I think that's where we're unique. But we are certainly building on the groundbreaking work of AHRQ, of NCQA, of CMS. We wouldn't have a lot of this data if people hadn't put in a tremendous amount of work on trying to get us indicators for different aspects of care, and we really need that work to continue.

Bob Griss: Bob Griss with the Institute of Social Medicine and Community Health. I am very excited about the variation in quality that you [have] and [cost] that you've been able to demonstrate, but I'm looking for mechanisms of accountability at the community level, or even at the regional level, that would be possible to spread the costs, equalize the costs so that more of the best practices could actually be delivered to the total population within the area. It's one thing to find benchmarks for standards of excellence; it's another to develop a capacity at the community or regional level so that the entire system can utilize these best practices. And I'm not seeing that jump out in these comparisons and hope that at the state level you can begin to dig there, because there are mechanisms at the state level that are different than the silos that we have at the federal level. And I wonder if you could address, sort of, this set of gaps dealing with mechanisms for public accountability to deliver on these standards that you have so beautifully focused on?

Cathy Schoen: I'll take a quick attempt, but then I'd very much like the practitioners to jump in. This is a scorecard, so I think as Dr. Mongan said in his remarks, we're starting to do a diagnosis, not necessarily the treatment. We completely agree that there are strategies and that many of them can be done at the state level. There are levers that we can use to move system change.

We know that payment policies matter. When you look at nursing home care there are collaborative work that Medicare and Medicaid can do together to really be talking about quality of care. And so we will not just be looking at a scorecard set of reports, but as was mentioned right at the beginning, start to say, what are some of the policies and strategies that can move pieces in a more coherent way. So not just a little here, a little there, but act together. Some states are doing that and we're certainly looking for creative efforts on states and having states share what has worked well and what has not worked well, so that we can learn from each other.

Steve Schoenbaum: There's also an interaction, I think, between community accountability and just community improvements. So the example I gave you in Pittsburgh, where there is a collaborative working on a set of problems, has led, not necessarily to a lot of public reporting but to a lot of improvement. And the improvement has been reported. What I didn't mention, by the way, in relation to the scorecard, is that if you were to look at where Pittsburgh started on that particular issue, it started at the national average as tallied by the National Nosocomial Infection Surveillance System. So it's getting down to—across that whole area to a 60 percent reduction against the national average—which would be wonderful if it were to occur for other scorecard indicators. And then you have some examples where it's in fact down 90 percent. So I think there are different ways to skin this cat, if you will.

Gary Christopherson: Gary Christopherson. First just a loud applause line for Jim and Karen and the rest, in terms of the report. The idea of laying out both the framework and laying out the performance measures are key to making this all work. Through the whole presentation I've been nagged by number one on the list up there. And as near as I can indicate we're about a quarter higher on spending than most of the rest of the countries of the best, and we're about a quarter worse in terms of performance measures, the one there. And that's—I would characterize much less kindly than I think Karen and Jim maybe have done, to call it essentially a system failure. We also then say, if I were to look at the cause, I would say the cause is essentially human error because it's really us who have either made this or not made this.

So, a question to the group. It's a question I sort of posed to Karen earlier on. We've been down this road somewhat before. This is something which says we're going to do it systematically, we have a systematic problem and systematic sort of measures to go back [directly to] the problem. I'd be interested in what the systematic solution is in the approach we're going to take, to take for example, the six or seven strategies you have and how do we actually move that forward in a public/private sector kind of collaboration to finally really change the numbers.

Steve Schoenbaum: Jim?

Jim Mongan: Well, I went through in my commentary, the six or seven directions that we thought were important to move forward on. I think if you listened into the Commission discussions and deliberations, one of our major feelings is that we need, as Christine said, more "systemness" in terms of trying to help our health system. Now, I've been challenged by people who said, "You've got a hell of a public relations job trying to explain how the answer to our health system is you need more systemness. What does that mean?" And I think one analogy I've been playing with, in terms of trying to build a rebuilt and improved and reconstructed health system, you can't build a house out of gravel. You need to have bricks to build a house, or you need some kind of aggregation of the gravel to put the pieces together that will allow you to build the house. And I think that's one of the major themes the Commission is focused on, is how to get medical practice less fragmented, more into more organized groups which can then use IT effectively, adopt protocols for care, work against benchmarks more adequately.

So those are—that's one of the major directions we want to pursue and we want to look at the panoply of public and private reimbursement and regulatory policies which could make that kind of systemness and grouping easier as opposed to more difficult.

Now we recognize of course that in rural areas much of that would have to be virtual, but we think that also is achievable. So, Gary, I'd say, if there's a theme to our treatment plan, that's an important part of the theme.

Unknown Speaker: Just one quick follow up. [Indiscernible] my question still goes back to what [indiscernible] which is, how does it actually make this happen. I was just fortunate to be able to [play] together to both build this system, this house…

Jim Mongan: Well, we've all been involved in this. Making this happen is going to involve obviously cooperation between the public sector and the private sector on things such as regulatory policies, reimbursement policies, etc. It's going to take more cooperation within—people in the various health professions to grapple with this concept, see if they agree with that concept, and get kind of motivation from inside in addition to what outside payors and regulators are pushing. So I think we're going to have to be going down a broad path, the things from reimbursement and regulatory change all the way to kind of, self-driven cultural change, which I think is needed across this sector.

Christine Schoen: I think if I could just speak as a physician to this, I think that's why it's so important that this is, that we start with the right diagnosis. I think some of our previous efforts to try to fix the health care system have had ideological or theoretical or, you know, people have come down on various sides of what the right answer is, but without a really good diagnostic tool. That's what we really I think, are presenting to you here. The Commission has several more years of work, although this is not to say it is a leisurely process. But I think we are already taking this and trying to answer your questions.

Steve Schoenbaum: Question—yes.

Male Speaker: Yes, Steve, thank you. Christine, I'm Mike Parkinson with Luminos, which is a WellPoint company, and also the incoming president of the American College of Preventive Medicine. Formerly on the Board of Preventive Medicine as well, so I empathize with all of the challenges you have. A comment for anybody on the board to react to one way or another. My concern—this is an excellent report—but my concern is when it's titled "A National Scorecard of U.S. Health System Performance," that is evidenced by the work of Ken Thorpe and his study in *Health Affairs*, 62 percent of the rise in health care costs is due to personal risk factors, over the last five to ten years, that we've chosen to "medicalize". So it's sedentary lifestyle, it's tobacco and it's poor nutrition, which continue to get worse. I know you tell this audience that nine out of ten diabetics are due—they're Type 2, it's personal lifestyle. And no matter how well we do controlling the one out of ten that have the genetic defect, we're not going to get to the scorecard. So the omission that I see in our six take-homes is an awareness of, at least in the diagnosis, that it's a public health risk factor epidemic that has got to be addressed as part of the "health" system as opposed to "health care" system. I know that's an old [screed] but Karen, you know, from our background it's very important to get it in the diagnosis so that the Commission addresses it [in the treatment half].

The second piece is as I see the affordability index—clearly I'm now, I'm with WellPoint which is the nation's largest health insurer, and the affordability tracks to a lot of things. The epidemic of risk factors, whether or not we have business models that are efficient, administrative costs of health insurance—but I get a little troubled when I go to every

community in the country and the largest single growth engine in the community is the hospital building a new wing, with more technology, whether on bonds or whether on for profit health systems, and I wonder if as part of the Commission's work, you can look at something like a community medical expenditure health index. Is there a sweet spot for community expenditures on facilities, technologies, healthcare, number of people—because to some degree I think Wenburg's [ph] work misses this. It misses the community pros and cons. You saw the *Wall Street Journal* article three days ago saying that the country's entire economic engine appears to be funneled in the health care sector by growing employment that really comes from third party reimbursement. It's either tax dollars or tax credits. So this is a macroeconomic issue that I would propose maybe no one's looking at—perhaps the Commission and the Fund in uniquely poised to look at it. So two comments on excellent work, and thank you.

Steve Schoenbaum: Thanks. Anyone like to comment on those comments?

Jim Mongan: Well, you've covered a number of points in your commentary. I think they're all important and well taken, and we will be looking at the issues of the personal health habits, or lack of habits, and I think that's something that does kind of roll into all of these numbers.

With respect to the issue about expenditures, I think the country at the moment is still a long way from going back to the health planning era when they're going to take that kind of approach to those health expenditures, but I do think again, some transparency, some more data, some looking—I'm not sure Wenburg's work misses the mark, I don't think it necessarily misses the mark, as I do that people haven't taken that and then said, "What's going on here? Why is this vast difference between Minneapolis and Miami? Is it expenditures? Is it practice style? How much is it of each?" And we've got to grapple with those issues because that variation, that variance is at the core of this difference between average and best performance.

Steve Schoenbaum: Thanks. I have a question back here.

Sherry Bruner: Sherry Bruner from Bon Secours Health System. We're one of the few health systems that are actually in the CMS project. What I wanted--to first commend you for the report. You've set the baseline and we know where we need to go from there. But I think Maureen made a very good point, and I would ask this group to remember it, and to talk—as we talk about collaboration I think one of the things that we're struggling with as providers is, everyone is coming at us from a different perspective with a different set of indicators to track, and initiatives to undertake. And I think Maureen said it well when she said we've got to be focused and it's got to be doable. We're a health system, we have the assets, we have the support for management in our boards, but there's a lot of single hospitals out there that are struggling. And so the IHI's 100,000 Lives was something easy that the clinicians, physicians included, all bought into it quickly and they were things that we could get done and they could see some of those results right off the bat. So again, as you do more work along this line, you've got a lot of work ahead of you, just if you can talk about, be it joint commission with our national patient safety goals, or AHRQ, IHI, and others, the more you all come together and give us some next steps that we can focus on, and we're all focusing on them together, we can do it. We've seen major improvements in our CMS scores. And our board made a conscious decision that when we went into that project, everybody went in, even the facilities we thought wouldn't do real well because we felt it was important, and we have been able to do some of that knowledge transfer. So again, thank you very much, we know what we have to do now.

Steve Schoenbaum: Thanks. Anyone?

Christine Schoen: I would just endorse the idea that we need to as a nation, to agree not only on measures that we use that are evidence-based and valid and actionable, but also on goals and targets. And that's one of the reasons that the certifying boards, along with other stakeholders throughout the health system support, for example a process of the National Quality Forum, bringing groups of people together to say, let's all agree on a single set of measures and look critically at how we can use those. And why I think from the physician's perspective, the physicians are feeling the same thing and need to get out of feeling that everybody's you know, requiring different levels of reporting. If their patients have 12 or 18 different insurance companies, each one requiring something different, and then their board requiring something different, the state licensing board requiring something different. So I think what you're seeing now is people coming together and recognizing the need to harmonize those things.

Steve Schoenbaum: I think we have time for one last question if there is one.

And if there's not I will thank everybody for coming and participating and particularly like to thank the panelists and again, the people who did all the hard work on the scorecard, Cathy Schoen and Sabrina How particularly. Thank you very, very much.