Rewarding Quality Performance: The Multidisciplinary Approach
Alliance for Health Reform
May 12, 2006
ED HOWARD: On behalf of our chairman, Jay Rockefeller, and our vice chairman, Bill Frist, I want to welcome you to this program on the connection between the developing pay-for-performance phenomenon and the nursing workforce that has such a dramatic impact on the quality and the efficiency that the pay-for-performance initiatives are supposed to reward in the first place. Our partner is today’s program is the Robert Wood Johnson Foundation, the country’s largest philanthropy devoted exclusively to health and healthcare. We’re very happy to have Sue Hassmiller of the Foundation here today. Actually, we had John Lumpkin here for a second.

I guess pay-for-performance is the next big thing that US healthcare is coping with or blessed with. There are more than 100 P-for-P initiatives already operating in both the public and private sectors, aiming to do in healthcare what we do in every other part of our economy, and that is that we reward superior performance in the marketplace more than we reward mediocre performance in the marketplace. Entities like hospitals and physician practices and other healthcare institutions are going to have a hard time performing well in this P-for-P era without strong input from their nursing staff. Is that happening in some places? Can it happen in most places? Are there policies we need to put
in place to help that along? Those are a few of the questions that we hope to explore today, and what better way to mark National Nurses Week than to have this kind of discussion?

Let me just do a quick logistics review for those of you who haven’t been to a lot of these briefings. In your packets there is a lot of good background information, including the slides from the speakers from whom we got them in advance. The bios that are not more extensive, I’ll have time to give them. By tomorrow morning you’ll be able to watch a webcast of this session on KaiserNetwork.org, and in a few days there’ll be, on that web site and on ours at AllHealth.org, a transcript of the discussions, along with electronic copies of the materials that are in the kits that you have before you. You’ll also find a green question card and a blue evaluation form way at the back on the right-hand side of your kits; we hope that you will make use of both of them at the appropriate time.

As I noted, we have Sue Hassmiller of the Robert Wood Johnson Foundation with us today. She is senior program officer there and the team leader for their nursing team. RWJ, most of you know, has been extremely active in helping to shape nursing policy in this country, and Sue has been instrumental in shaping RWJ’s role, so we’re very pleased that she is able to join us. She is actually in town for
another meeting, but managed to free herself for participation here and we wouldn’t have had this briefing if she hadn’t pushed the folks up there very hard to put it together. Sue thanks for being here.

**SUE HASSMILLER, Ph.D., R.N.:** Thank you, Ed. I’m absolutely delighted to be here today and so happy that it’s a nice day our and you were able to walk over here to be with us. To the nurses in the audience and non-nurses alike, I do want to wish you a happy Nurses Week. It is Florence Nightingale’s birthday today, so this is a very nice event today.

I just wanted to let you know where the Robert Wood Johnson Foundation is coming from and why we are so happy to co-sponsor this event. As you know, we pay a great deal of attention to the important health issues that are shaping today’s society, and we’re very interested in whatever we can do, whatever policies, whatever strategies, whatever programs, that we can promote to improve the quality of patient care. As our president, Risa Lavizzo-Mourey, is so fond of saying, “We absolutely want to improve the quality of patient care, but you just ain’t gonna get there if you don’t have the nursing policies and the nursing workforce in place along the way.” We noticed, obviously, that pay-for-performance was a very, very important issue being talked

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about in many corners and auditoriums around the country and
even at our own Foundation. We really did notice as well
that many great administrators, physicians, and others are
being involved in some of the decision making in pay-for-
performance. At that point, we simply made the decision to
help co-sponsor this panel today to see what we could do to
ensure a multidisciplinary approach to pay-for-performance.
We simply believe that if all voices aren’t heard at the
quality table, the pay-for-performance table, that it would
indeed be a missed opportunity for our patients and America
today. With that I will ask you to introduce the panel Ed.

ED HOWARD: Great, thank very much. In case you
thought this was a flash-in-the-pan phenomenon, some of you
may have seen the story in yesterday’s Boston Globe that Blue
Cross and Blue Shield of Massachusetts has doubled the amount
of money that it is putting into a pay-for-performance
initiative to something like $189 million for the coming
year. There is a real financial stake that is being
developed in places all around the county in, as I said,
private and public payers to be able make this phenomenon
actually work to improve the quality of our healthcare
system. That goal is one that is the primary goal of our
first speaker. We’re going to hear first from Dr. Barry
Straube from the Centers on Medicare and Medicaid Services
where he is the director—note, no longer acting director; congratulations Barry—of the Office of Clinical Standards and Quality and the chief medical officer at CMS. He is, in other words, the quality go-to guy at that agency, both internally and in relationships with outside groups like the Joint Commission and the National Quality Forum. In his spare time, he draws on his background as a nephrologist to chair CMS’s end-stage renal disease activities and advise the agency on ESRD and transplantation issues. So the fact that he is here with us is great. We’re very pleased to have him lead off the discussion today. Barry?

BARRY STRAUBE, M.D.: Ed thanks very much, and Sue thank you also. Good afternoon to all of you. I’m seeing a lot of familiar faces and for those of you that I haven’t met yet, I hope to get to know each and every one of you at some point here over the next few years at least. What I wanted to do is to lead off the session here. I have far more slides than we could possibly cover in the entire session, let alone the 8 or 10 minutes that I have, but let me try to paint for you the imperative that I think is there for us to progress with pay-for-performance. As Ed mentioned, in terms of the some of the commercial payers putting large numbers of money on the table, I think a lot of people jumped to the conclusion that we’re doing pay-for-performance to save
money. I’d like to make a case that, although we do have an imperative as a nation to address the growing healthcare costs, we also have imperatives from the quality and efficiency standpoint that we have to address irrespective of the need to control costs. So I’m going to whiz through these.

First of all, we at CMS are operating more and more not just as a regulatory agency, but as what Mark McClellan, our administrator, likes to refer to as a public health agency. This is not functioning as an agency that sets up flu clinics and immunizations clinics and other preventive services, those are important, we are trying to use our influence with revenue spending with other activities that we do to join in partnership with Congress, with the Administration, and with other stakeholders in healthcare industry to try to improve quality of care. I’ve put for you some bullet points here. We intend to try and align beyond the Medicaid and Medicare programs, go beyond that, and address the entire healthcare system in terms of making our policies consistent with improving quality of care across the United States. We’re focusing on quality first and foremost, but increasingly we all need to talk about other terms such as value, efficiency and eventually, cost effectiveness, although that’s not our charge at CMS right now. I have a whole bunch of slides here we can’t go individually through,
but let me take you to the summary slide on these. That is these are the imperatives, I think, that are driving the discussions we’ll be having here this afternoon.

First of all, in the United States, we as a healthcare system spend more per capita on healthcare than any other country of the world. In spite of these expenditures, the quality of care, as measured by quality measures and outcomes here in the United States, is often inferior to those of other industrialized nations that spend far less money per capita than we do. Often the quality of care that we deliver does not meet national consensus-driven broad-based guidelines. In Beth McGlynn’s study, published in *The New England Journal of Medicine* three-and-a-half or four years ago, only 1 out of 2 patients coming to a physician’s offices gets the care that they should be getting according to national guidelines. In some conditions, it’s only 1 out of 4 or 1 out of 3. This is not acceptable and we have to improve on that. We definitely see nationally gross and market variations both in the quality of care that’s delivered in different parts of the country and even on a regional basis from city to city, from neighborhood to neighborhood. At the same time, we see market variation in the amount of expenditures that are being expended to get that care. To some extent, there is increasing evidence that there may be an inverse relationship between the amount of
money we spend on healthcare and the quality outcomes. By that I mean in areas where we spend the greatest number of dollars on healthcare, we see the worst quality of care. Conversely, the best quality of care is often associated with lower expenditures, as you’ll see today from the Premier hospitals as an example.

We’re responsible for the healthcare of a growing number of people; the Medicare program is growing exponentially now as Baby Boomers hit us, and so we feel that the imperative is that CMS, working in collaboration with other stakeholders, has to address these issues going forward. We’re going to do this through our quality roadmap; The Right Care for Every Person, Every Time is our vision. We can’t go into our strategies in much detail here, but the quality initiatives that CMS and the Department of Health and Human Services has initially chosen to focus on are in these regions, or these domains, or these silos: hospitals, nursing homes, home health agencies, dialysis facilities, and we’ve just embarked upon a focus on physician offices. Clearly, there are many, many other healthcare settings that we’ll be focusing on first and foremost in Medicare and Medicaid, but in concert with private sector commercial payers of healthcare in other areas also. This slide though, there is something important to see here. We have focuses as a nation on the silos of settings of care. We focus when

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people go into the hospital, but we forget that patients
don’t live their lives in just one of these silos. We have
to increasingly focus on what happens when a patient leaves
the hospital, whether they go home, to a nursing home, to a
home health agency, and so forth. We have to measuring the
quality of care and improving the quality of care across the
continuum in each and every one of these settings and as
patients navigate the different settings.

We have, in our Quality Initiative, several broad
themes, I’ve listed them here. First of all, we’re first and
foremost working through broad national quality alliances.
We’ve been very heavily focused on the Hospital Quality
Alliance and on the Ambulatory Quality Alliance, but there
are many, many other quality alliances that are forming,
including one we’ve just announced in the past several weeks,
the Pharmacy Quality Alliance. I’m involved with an End-
Stage Renal Disease Quality Alliance that’s been forming and
we will be involved with others, but we feel it’s very
important for broad-based, multiple-stakeholders to talk
about how we approach pay-for-performance and other quality
information. We also believe very firmly on the principle of
using quality data; if you can’t measure quality, you can’t
improve it. So we are heavily invested in developing quality
measures and publishing that data and allowing it to be very
translucid in alignment with the White House’s and the
secretary of HHS’s initiatives on transparency and using that information for quality improvement and performance.

And last but not least, we take all of these principles and we take the quality measures et cetera and we believe that what we’ve done so far, in terms of quality improvement efforts, have largely not been effective. We have too many gains that we need to make and the methods that we’ve been using up until now have not succeeded, so we have to think outside the box with new methods. At the moment, whether you think it’s a good idea or bad, the only one on the table really in pay-for-performance right now. We believe that it has great promise and merit if done properly, and you’ll be hearing about that during this panel discussion on ways that we think we can go forward.

We have a number of incentive initiatives, or pay-for-performance initiatives; we don’t have time to talk about all of these. By the way, we’ll make this available for you, too, after this presentation, for those of you who are rapidly writing notes, or you can E-mail me.

ED HOWARD: Barry, I should say also that we’ll make sure that it’s on our web site with the materials that are already there.
BARRY STRAUBE, M.D.: Thank you, Ed. But you’ll see here a great number of demonstrations, and these are only a partial listing, and they all have different tweaks, different approaches in terms of how we’re trying to approach so-called pay-for-performance. I think that the standard things that we’re doing in these initiatives are that the initiatives all are involved with development and implementation of standard performance measures in every setting and measures that can measure quality of care across these various settings. We’re increasingly focused not just on quality of care, but because of the expenditures that I mentioned earlier, on efficiency of care. So we want first and foremost for people to achieve a very high level of care, but once we can define what that level is, we want to reward people who are more efficient and can deliver that high level of care more efficiently than other providers can. We are developing pay-for-performance initiatives in all the areas that I mentioned. We just recently announced six pilot sites through the Ambulatory Care and Quality Alliance that will be doing collection, integration, and reporting of data along with pricing and cost reporting across the United States. They’ll be based in California, Arizona, Minnesota, Wisconsin, Indiana, and Massachusetts to start. The secretary of HHS is extremely interested in these pilots, and we hope to be able to very quickly expand the number of sites.
and expand the concept not just the physician offices, which we’re starting off in, but to include hospitals, to include cost and pricing performance measures also, more to come about that. But the themes that we use have to do with physician/patient partnerships; they have to do with the benefits of group practice and integrated practices; they do have to do with efficiency and value through coordinated care, through care management, through health information technology adoption and the use of evidence-based medicine. We’re focused on chronic illness. We’re focused on the benefits of prevention. We’re clearly looking, as I mentioned, at evidence-based guidelines being used. And last but not least, we clearly think the entire process should be very transparent, especially to the payers and consumers so that they can choose where they get their care and have some effect on the economic structure of how they get their care.

What I’d like to quickly do in the remaining minute or two here is tell you about three things. First of all, the Hospital Quality Initiative; we initially, four years ago, in concert with the other hospital organizations I listed here, announced a voluntary system where we hoped hospitals would voluntary report up to 10 quality metrics in the hospital arena through the Hospital Quality Alliance. After a year-and-a-half or two of a voluntary effort, only 30-percent of hospitals had agreed to voluntarily report. In
fact, only 10-percent were reporting 1 or more of those 10 measures. Congress enacted Medicare Modernization Act, Section 501b giving a 0.4-percent incentive to report this data. Within six months, we went from 10-percent reporting 1 or more to 98-percent of hospitals reporting all 10 measures or more. So for those of you working up on the Hill, money does talk and does give incentive to people to report and, I think you’ll find here in some of the example, to do better. These are the Hospital Quality Measures we used. We had the Premier Hospital Quality Demonstration, I won’t go into great detail on that because you’ll be hearing from other people participating in it, but basically this demonstration looks at 34 quality metrics in the hospital setting, voluntary participation, they’ll talk about the scoring system somewhat, but what I wanted to show to you was these five metrics. You’ll see the baseline in the blue-colored slide, the improvement or the second year of performance after interventions were made, and in all five areas of heart attack, congestive heart failure, pneumonia, coronary artery bypass grafting, and hip and knee surgery, there was significant improvement after one year of pay-for-performance models.

The final thing I’d like to do with you is something called PVRP, which is the Physician Voluntary Reporting Program. We just started this in January of this year.
We’re encouraging voluntarily again, although we anticipate to go the same route as the hospitals where we may have to pay for reporting, for physician offices to report quality measures by appending a G code to their normal claims submission for Medicare services. We will measure a whole series of quality metrics that I’ve listed here on these slides, a whole series of them, 16 basic core quality metrics, and we will be able to take that information, calculate results by individual physician offices, give them back to physician offices, and work with them to try to improve the quality of care. You’ll see here a potential timeline for physician offices where we may go. This year voluntary reporting; next year perhaps Congress will assist us in apportioning or appropriating some money to actual pay-for-reporting; in 2008 perhaps actual pay-for-performance in physician offices and so on, on the timeline.

Finally, I’ll end with those of you, again, on the Hill. The Deficit Reduction Act of 2005 has a number of pay-for-performance components. We’re responsible for delivering to Congress a plan for the hospital setting for a pay-for-performance program that might be implemented nationally by Congress, and we’re also charged with delivering to Congress a play for home health agencies. I would anticipate that, for the other three arenas that I mentioned to you earlier, we will also be charged with doing that in the very near
future. In addition, Congress have very wisely, I think, charged us with implementing a gain-sharing demonstration where hospitals, doctors, and other providers working all together in the hospital setting will be able to share in cost savings after they have delivered very high-level care, something that has not been allowed under the law previously. I think this will be a major contribution, pro or con, to determining where we go with pay-for-performance.

Last but no least, I’ll end on my focus of Care Across the Continuum. There’s an acute post-care payment reform demonstration that we will be enacting. We will develop a single, post-acute care assessment tool, which at the time of discharge from the hospital, patients will be able to be assessed, be determined what setting of care they should go to for their next level of care, and then continue to have quality measurement, regardless of the setting they’re in, probably linked to reimbursement at that point, too. So this, again, is a very, very quick overview. Here’s my contact information. Ed, I will turn it back over to you and I’ll be here to answer more detailed questions once we get into it.

ED HOWARD: Terrific; thanks very much Barry. That’s quite a lot of ground that you covered and quite a lot that’s going on within the agency. If I can ask our folks in the
audience, if you have not already done it, could you put your pagers and cell phones on vibrate or whatever it is you can do, that will be very helpful to the continuity of our conversation.

Next we’re going to here from Jack Needleman who is on the faculty at UCLA School of Public Health. When we felt the train rumble in below, he said he thought it was just another Southern California phenomenon [laughter] and wasn’t worried at all. Jack is also one of the country’s top health services researchers. He’s won, as David Helm pointed out to me, the AcademyHealth Health Services Impact Award. He leads the Robert Wood Johnson Foundation’s evaluation of Transforming Care at the Bedside initiative. His Health Affairs article on the business case for better nurse staffing is in your packets and I commend it to you. Jack, thanks for coming all this way and for being part of this discussion.

JACK NEEDLEMAN, Ph.D.: It is a pleasure to be here and a delight to talk to you. I’m going to try to keep my comments brief, which those who know me, know will be difficult, because I think the most important things we can get out of today are out of the Q&A.

There are really three points I want to make in this introductory presentation. The first is simple that nursing
matters for patients. I’m going to focus principally on hospitals, but research suggests in many other settings as well. The second is there is a business and social case for enhancing hospital nursing, and that may cost us a little bit more, but one can make a very strong argument that it is worth it. The third point is that the current pay-for-performance systems do a very poor job of targeting improvements in hospitals in the core work that nurses do.

Let me start with the first point that nursing matters. Over the last decade, there has been a growing body of evidence that nurse staffing and hospitals makes a difference in patient outcomes in very significant ways. Lots of different ways of measuring nurse staffing in hospitals, the who measures that have been most commonly used in the literature are some measure of nursing hours per patient day and the skill mix of the nurses, the proportion of the nursing staff that are registered nurses. When you look at either of those and you look at the research that is there, outcome after outcome after outcome is sensitive to those measures in hospitals. Mortality is probably the one that has been least demonstrated to be related to nursing, the one with the most mixed evidence. But mortality in hospitals happens for many, many reasons and it was simply trying to capture a very noisy phenomenon looking at only one of the things that might affect it. When we actually look at
a narrower range of deaths, which are in the literature characterized as “failure to rescue,” patients who begin developing complications that need to be treated in a timely and appropriate fashion, things that nurses are critical and central to, we see more evidence for nurses’ impact on mortality. When we look at other measures, length of stay and overall measure of the efficiency with which care is delivered and the reduction in complications that keep people in the hospital longer, nursing is very clearly associated with reducing length of stay. Pneumonia, urinary tract infections, other kinds of hospital-acquired infections, pressure ulcers, deep vein thromboses, bleeding, shock, cardiac arrest, medication errors, falls, the whole list of evidence that we have as study after study comes in shows that the quality of the nursing staff and the amount of time that staff has to work with patients make a difference in patient outcomes and patient experience in the hospitals. So nursing clearly matters.

Nurses’ work is at the core of what hospitals do. We have outpatient surgery, outpatient physician visits, outpatient imaging; God knows if you go into the Virginia suburbs you can’t go more than two or three blocks without seeing and MRI center. We have outpatient imaging, outpatient therapy, outpatient lab testing. There is only one reason for a patient to spend a night in a hospital, and
that is because they need nursing care. The range of outcomes that we see influenced by nurse staffing reflects the range of work nurses do. Yes, the standard image is of the nurses taking the doctors’ orders and doing what they’ve been asked to do is certainly part of that work, but so is the assessment and monitoring of patients, so is the development and the identification of the need for and the beginning of timely and appropriate intervention and pain management, so are patient education activities, discharge planning; there is a whole range of things that represent some of the core functions that nurses do. The whole list shows that the amount of the nursing staff, the quality of the nursing staff, and the way the nursing staff is organized in hospitals makes a difference in the ability of the hospital to carry out that work. We tried estimating, in the Health Affairs article that Ed alluded to, how much it would cost hospitals to increase nurse staffing and whether the improvements in the care, the reduced number of days, the reduced adverse consequences, the reduced deaths would basically pay for themselves. Clearly, the impact of improving nursing is substantial. We estimated, if the three-quarters of the hospitals that were below the top quarter of hospitals just raised their nurse staffing up to that level that we see in the top quarter, how much it would cost, how care would change, and how much would be saved.

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These are the numbers from that estimate in terms of the impact. If you raise both of the staffing measures that I mentioned before, there would be 4 million fewer days in the hospital or roughly 1-percent; 70,000 avoided events of those events we looked at, and we did not look at all the things that nurses affect; 6,700 fewer deaths. Would the savings from these things pay for themselves? Well, probably increasing the skill mix in nursing, increasing the proportion of registered nurses in the hospital staff would pay for itself, which was one of our conclusions. However, increasing the hours, which have major consequences on days and deaths, would not pay for itself; you would have to pay more for that. But we have an estimate of how much and depending on how you dealt with the fixed cost in hospitals, whether you think that in the long run that those can get adjusted as the other care changes. The estimated cost of getting those full sets of improvements that we modeled were somewhere between 0.5-percent of what we spend on hospitals today and 1.5-percent. To put that number in context, hospital costs have been increasing every year by about 5-percent. So we’re talking about one-tenth to one-third of one year’s increase to get those benefits. The business case is iffy in the sense of relying upon the savings to pay for themselves. The social case, that this is care worth paying for and is affordable, I think, is much
stronger. If we’re talking about pay-for-performance, we might be talking about creating incentive for hospitals to actually spend that additional money to bring the nurse staffing up with the value it brings to patients. One of the problems we see, however, is that current pay-for-performance systems do a poor job of targeting improvements in the core work of nursing. Pay-for-performance usually looks at processes, with a focus on whether specific processes have been completed. On the list that Barry Straube pointed out before on heart attacks, a patient coming into the hospital with a heart attack, did they get an aspirin when they came in? Did they get beta blockers when they went out? If they needed catheterization, did they get it within two hours of the time that they came in the door? If you’re looking at diabetes, did they get appropriate blood tests, eye tests, and foot exams? But nursing processes are hard to measure; nurses are everywhere doing everything and they are multitasking as they go from patient to patient. They are tailoring the care that they do to specific patients, so quite appropriately, every patient does not get the same process of care. To understand a lot of what nurses do, say with pain management, you need to look at the documentation not for a one-time event, but for things that are happening over and over again through the whole admission process. Keeping track of that kind of documentation is very, very
hard to do and very expensive to pull together in the kinds of systems that pay-for-performance relies upon.

I went to the CMS hospital compare site, which contains many of the metrics for hospitals that Barry Straube mentioned, looking for some of the measures that seem most closely related to nurses’ work. I happened to miss the falls measure; I’m not sure it’s actually on the hospital compare site. But here are the ones I came up with that were nursing related. The PCI within 120 minutes, not because nurses are core to that, because that’s a team effort and nurses are certainly parts of those teams. Whether of not patients leave the hospital having been assessed for their needs for pneumococcal vaccine and whether they got it is the second measure. The third measure is smoking cessation counseling for patients that come in with conditions that suggest it ought to be looked at; heart attacks, pneumonia, and heart failure. Finally, discharge instructions after heart failure. These were the five measures that I could find that were nursing related. As you look at this chart, I think one should draw two conclusions from it. The first is that our hospitals are doing a crummy job; they’re doing a mediocre job at best. We’re looking at rates here between 50-percent and 78 or 79-percent. So that’s the first thing one should conclude. Of the things we can measure about the functions that nurses do in hospitals, hospitals aren’t doing
so well. The second conclusion one should draw from this chart is that these don’t look like the core functions of hospital nursing. They don’t involve the pain management; they don’t involve the assessment of patients for risk of complications, for risk of dying, for the various and important things that nurses do. This is not core activity to nursing. The problems that you have creating these are not unique to CMS; this is actually the state-of-the-art. When the National Quality Forum went to develop a set of nursing performance measures for hospitals, after looking at scores of measures, well over 100 and I think I’m underestimating substantially, they came up with 15 measures that they thought were documented and in the public domain. Eight of them were outcome measures; four of them were structural measures like how many staff and what their turnover was; only three were process measures. The problem for finding good measures for process is not unique to CMS. The three process measures that came are in the CMS compare data that I just showed you. So this is not a problem that is unique to nursing. I mentioned diabetes before and all the process stuff; did you get this test or that test, did you get that exam? But other activities that are central to actually helping diabetics actually live with their disease and improve their functioning, things like education and other kinds of dietary interventions are also not in these
systems. It’s not a unique problem to nursing. It is, however, a problem for nursing. If we want hospitals to improve their core functions, in terms of delivering higher-quality to patients, nursing is central to that and we are going to need to find better ways to measure the core activities that nurses do and bring them into these systems.

**ED HOWARD:** Thank you so much, Jack, that was very helpful in moving this discussion along. Now that you have the policy background that you need, we’re going to look at the view from the front lines. I think we have gathered representatives of two hospitals who are definitely not, as Jack used the term, crummy. [Laughter] In fact, they are exemplars of high quality. First up in that category is Rob Colones who is the president and CEO of McLeod Health, which is a non-profit health system in Northeast South Carolina. He has been a member of the McLeod management team for many years; he has been president and CEO for the last four. He is a winner himself of the Milliken Medal of Quality, one of several South Carolina-specific rewards based on the Malcolm Quality Aware Criteria. The McLeod system, four hospitals and associated units, has been one of the top performers in what you’ve been hearing a little bit about, the CMS Premier Quality Demonstration. So we’re very pleased to have a non-crummy, non-mediocre [laughter].

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ROB COLONES: Thank you. And thank you, Sue, for inviting us to be here today; we appreciate the opportunity. I’m just going to talk for a minute about the hospital and the organization that I work in. You’ll probably note some institutional pride in my conversation, but my reason for mentioning it to you and the work that you do is that we are a hospital in average America. In fact, we’re in a poor and rural part of South Carolina. If we can take knowledge that is readily available in the literature and apply it in a reliable and consistent manner, dramatic improvement can occur both in the quality for patients and in cost. So our effort in the demonstration project, I think, proves that this can happen anywhere in America at any of the 5,000 hospitals that are functioning today.

Let me talk just for a minute about McLeod. McLeod serves a 12-county area in Northeastern South Carolina. We’re four hospitals in that particular area of South Carolina. We serve, with our tertiary services, about a million people. The mission of McLeod is to improve the health and well-being of people living in this region. It is our goal to reduce the burdens that are associated with illness and injury to people who need our services. We are a non-for-profit private organization and last year we provided
$135 million in uncompensated care to patients who needed the specialized services of McLeod Health.

It is a privilege to be here today for several reasons. One, this marks our 100 years of service to our community; this is our centennial celebration all year long at McLeod and today we’re celebrating Nurses Week, and it’s good to be here with you on that as well. McLeod was founded in 1906 by Dr. F.H. McLeod to be a general hospital and a training school for nursing. We’ve had nursing education as part of our mission for a number of years. Later today, at 2 o’clock in Florence, about 150 former graduates of our nursing school will have a reunion this afternoon as part of both in celebration of our 100 years and in celebration of Nurses Week. The tradition, the richness and the history that’s there in our organization has allowed us to achieve recently some success. I’ll just mention a couple of things. Two of our four hospitals in our system have received the South Carolina Governor’s Quality Award. That is an award given in South Carolina to any corporation that achieves that status based on the Malcolm Baldrige Criteria. So we competed with manufacturing and other service organizations to receive that distinction. We received a Nation Award in 2003 with Premier; we received their quality award and a variety of their other awards that are listed there. One that we’re very proud of that really leveraged our work much

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more than the previous year’s was the Pursuing Perfection Grant. We were one of seven organizations selected by the Robert Wood Johnson Foundation to try to raise the bar in performance in healthcare. The work that we did during those two or three years with the other hospitals and health organizations dramatically improved our organization.

We are also participants in the CMS demonstration project, and let me just share with you some results. As noted in the earlier presentation, there are certain evidence-based standards that hospitals have difficulty meeting; 50 or 60-percent of the time on a given night, evidence-based standards are able to be delivered. It has to do with complexity; it has to do with specialization; it has to do with a lot of different issues. But the scorecard across America is not very good. The CMS demonstration project picks five clinical focus areas, and there are 4 to 7 evidence-based standards within each of those 5 categories. So if you can’t score a 100 in all 7, you don’t get credit for 5 out of 7 or 6 out of 7; you only get credit when you can deliver all evidence-based standards for every patient within those particular clinical areas of focus. Nationwide that number would be 60-percent or less. In our work in the demonstration project, we were top decile in the four of the clinical focus areas and second decile in one of them, and we missed that one by only two-tenths of a percent. So the
demonstration project and the work that we’ve done based on our quality effort is something that can be achieved throughout the country. This shows our mortality declining by 25 to 30-percent over that time period as well. Our key design principles in our quality work are physician leadership, data-driven decisions, and evidence-based medicine; we use that to direct us in our work.

I’d like to pick out several core successive actors for our quality work; I’d like to walk you through these six just briefly. I also want to highlight for you the role that nursing plays in our organization in helping us achieve this quality work that physician-led, data-driven, and evidence-based.

At the top right, quality is a core value of our organization. We have four values, and quality is a core value that we teach, train, and remind ourselves about consistently throughout the organization. Next May I need to be a better president than I was this May. I need to understand my weaknesses, I need to get education, and I need to improve as an individual. We expect that of our radiology department and our emergency room. We expect not only individuals, but departments in the hospital to honestly look at their data, their comparative data, and then work using our methodology to improve as an organization. So quality is a key value of our organization and is one of our core

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success factors. Prioritization and data-driven decisions, we are a partner with Premier; we’ve used the Perspective Plus Data System for a number of years. It gives us information in several key areas to find gaps such as how we performed taking care of pediatric asthma patients this year and links the stay and mortality, complications, cost, readmissions compared to other hospitals in that database. Where there’s a gap, we put a team of our people together to work on that and apply the evidence-based measures.

Improvement methodology; in 1994 Jack Welch visited Florence, South Carolina. He brought the board of General Electric to Florence; not to visit us, but to visit the GE plant in Florence where 51-percent of the world’s magnets for MR machines are shipped off the loading dock in Florence, South Carolina. He came to recognize that plant for their quality improvement efforts and their teamwork. We took note of that, went out and understood what they were doing, used their trainers and training materials, and adopted that methodology into our organization. We have a methodology that’s based on Deming’s [ph] work that helps us improve the organization that we use each and every time we find areas of opportunity to work on.

We’ve worked on change theory; many of you may have read Cotter’s Model of Change. But in other words, we have a methodology we use to help people cope and understand the
various steps in change and how to go about changing a very complicated and specialized environment. We have physician and executive engagement. We have over 200 physicians who have participated in three-month quality improvement projects, not only receiving education, but helping to lead that effort. We have senior leadership engaged in that as well. Every morning at all of our hospitals, the first 30 minutes are spent visiting patients to try to understand what’s going on with them and what quality opportunities there would be available to us. Many of our senior leaders are nurses by training. Our chief information officer is a master’s nurse. Our vice presidents of patient services, several of them are master’s prepared nurses. Our chief quality officer is a master’s prepared nurse, as is our vice president of human resources in training. So we have allowed nurses to come in to the board room table and lead the effort within the organization.

The reliability theory, all of these are a mile deep; we could take a week on each one of them. Learning how to prevent errors before they occur, learning how to identify and mitigate errors as they are occurring so there isn’t harm, and learning how to redesign whole systems so that they’re more reliable and consistent. This is just a close-up example of one of our teams. It lists the number of people who were involved in an ICU redesign project; you

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certainly can see the physicians who are listed there. There are several key nursing positions that are listed there. We have learned to put an implementer on every team so that during the three months of their work, they hear the various solutions that are generated and they can help people understand what might be implemented and what might not work. We have a nurse educator on those teams, we have a nurse champion on those teams, and we have a nurse implementer working on those teams. This is a graphic of our Medication Safety Project, which was one of our Robert Wood Johnson Pursuing Perfection grants, and it shows a significant reduction in medication errors over the term of that project and we continue to maintain less than a 0.5 per 1,000 rate of harm for medication errors.

Ventilated-required pneumonia is recent work out of the 100,000 Lives Campaign with the IHI. We’ve now gone 22 months without any patient developing pneumonia on a ventilator in our intensive care units, and all of that is based on quality work from those committees for that redesign team that I shared with you.

Does it work? It certainly works for us in the demonstration project. This is a listing of the top most expensive hospitals in the state of South Carolina. There are about 65 hospitals in the state of South Carolina. We’re the fourth largest in terms of budget, people, programs, and

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services; yet we’re number 38 on that list with regard to cost. So we believe our quality efforts over the last couple of years have had dramatic improvement. We have been able to reduce costs. Just for example, the ventilator-acquired pneumonia adds $40,000 to the cost of taking care of that patient. So if you can prevent that patient who is on a ventilator from developing pneumonia, you have the opportunity to reduce length of stay, reduce costs, and improve the mortality opportunity for that patient. Thank you.

ED HOWARD: Thank you so much, Rob. Our last, but not least speaker, as they say, is Regina Berman who heads up Performance Improvement Services for the Hackensack, New Jersey University Medical Center. She is a nurse by profession and training herself. She has been at the Medical Center for seven years and has steered it to Quality New Jersey Governor’s Awards, also based on the Baldrige criteria and, like McLeod, an award for RWJ for the Pursuing Perfection initiative. Hackensack, with Regina’s leadership, is another big winner; in fact, maybe the biggest winner in the CMS Premier Demonstration Project, so we’re very pleased to have her with us.
REGINA BERMAN, R.N.: Thank you very much. I’d love to just piggyback on some of Rob’s comment, because I think that a lot of the outcomes that we have both been able to enjoy really did start with an early work and commitment through the Pursuing Perfection grant and the Robert Wood Johnson Foundation’s capability there. Thank you.

The underlying concept as part of that grant was to transform healthcare, which was quite a large order, but also to look at really making the commitment to defect-free care. I think when we do that in the environment of applying evidence consistently, which Rob so nicely described, you start to lay the foundation for your stability in your publically reported outcomes and those things that have been selected for pay-for-performance. So I think the link of those activities is very important, and the trajectory of how that occurred is very important.

For Hackensack, there are just a couple of items I’d like to tell you about us. We’re currently a 781-bed facility that grew from a 12-bed facility. So we all have our origins and most of them are very humble. Right now we’re the largest provider of healthcare services in Bergen County, New Jersey. We’re just 10 miles outside of New York City, so our largest competitor groups, if you will, from a market share standpoint are the large academic medical centers in New York City: Columbia, New York, Cornell, Mount...
Sinai, NYU, et cetera. So we are not the only player in town, if you will, so our CEO, John Ferguson, who has been at Hackensack for 20 years, made a commitment many, many years ago that quality would be a distinguishing factor for the organization, and I think every decision made throughout those 20 years has really looked at service and quality as a distinguishing factor. The point I’m trying to make is that it’s not something you start when you’re forced to do it, but its part of your leadership model, and I think that’s a very important distinction. I think, very consistent with a lot of the Baldrige work, that we make reference to the Malcolm Baldrige program which is, as you know, a government-based program. Leadership, development of leadership strategy is the primary initiative of those developments. If you live with them, you then go down to the impact on the workforce and ultimately on your results. They cannot be separated. We do enjoy 90-percent of our medical staff being board certified. I think that is a very important and compelling piece of our success. We’re the second organization in the country to be provided with the Magnet Distinction for Nursing and have been re-certified three times since. That, we think, has been a long-standing success factor in our retention efforts for nursing and some of the autonomy that nursing has had in Hackensack for a long period of time.
Rob showed you the CMS Demo results for the first year; I thought I would add for you the second-year preliminary results that we have. Again, based on the preliminary results, we have achieved top decile in 4 out of 5 case types, hip and knee being a little bit of our nemesis, but I think the important piece of this slide is to see, if you would just look at hip and knee, the first year second-decile performance was achievement of a rate of 93.85; that was our rate. We did not make top. That’s a pretty good number. Most people would be happy with 90 or better, but that in no way was top decile performance. For year two, we’re once again second decile, and I think we missed it by about 0.1-percent or something. But at a rate of 98.09-percent we are still second decile. When you talk about moving the bar and raising the bar, this is what’s happening in this project; everyone is getting better. That’s the good news. I think the bad news is that you become obsessed with defect. That may not be bad news totally, but sometimes you can get distracted by them also. We just need to realize that this is not a fixed number that you try to achieve and once you arrive, you’ve been there; this is a moving scenario. I think improvement across the nation needs to include some type of moving scenario and the bar always being raised. The other numbers we have on here, Rob mentioned reliability, I think both organizations are very committed to
looking at reliable systems and processes and 10 to the -2 basically is about 2 defects per 100; 10 to the -3 would be 2 defects per 1000. It’s sort of a modified Six Sigma. In all the reports that we give to our staff, to our board or anyone, we include those numbers so we can say, “Yes, we have a high grade, but our process still is not highly reliable.” Or, “It is getting highly reliable.” I think that’s a very important distinction to consider because it’s not only the number. What we’ve tried to avoid as part of our approach is chasing the number, but instead really understanding where we are at any point in time and keeping in mind that defect-free care is our overriding principle. It’s very important for the workforce to understand that you’re not chasing a number for the money, and you’re not chasing a number for the wrong reason, and that you’re not chasing the number, but that you’re trying to do what’s appropriate. There are times when withholding an intervention might be more appropriate than providing it and there needs to always be a balance in that regard.

I have here for you a couple of slides about different paradigms in quality because I think it gets confusing when people talk about the concepts of misuse, overuse or underuse versus outcome process structure. I think we’ve heard references to each of them today. Then of course with the IOM reports the dimensions of care: safety,
efficacy, patient centered, and timely. What I think you need to do is look across those and horizontally take the most important components of them. I will go quickly, but I think that’s an important foundation. I don’t think there is cookie-cutter approach that you can apply; we have to see what works. We began with structure and creating a very important infrastructure in the organization that supported quality initiatives. It began with the use of small multidisciplinary expert teams, a rapid-cycle approach, which was a baseline Deming. But I think the most important piece that was a breakthrough for us was creating multidisciplinary rounds where you really had partnerships at the unit level among all caregivers, be they physicians, nurses, or ancillary providers. You have to have a common lexicon and a common way to align your care on any given day that then includes the patient’s component of that care.

Moving along, one of the things that we found was important was developing unit-based score cards and having line-of-sight for the staff so that they knew at any particular point in time where they were. I think the constant learning from failures and allowing an environment—

Oh, I’m sorry this slide did get it. We thought this was the one that was absent. That’s just an example of as you do your interventions; the staff gets to see each intervention, what the plan to check that cycle was, and what impact it
had. I’ll show you some examples later of those tools.

Learning from failures, I think from this slide the most important piece is that we do expect the staff to constantly use tools and methods that help to promote quality and that you need to have an environment of safety briefing and safe ability to say what did not go right so that you can then correct it. I think that has been a major breakthrough.

The next slide, basically you’ll all recognize this from Crossing the Quality Chasm and the Simple Rules Through the 21st Century, I put in because under the new rules, those highlighted areas are some of the aspects that we focused on in order to get started. Customizing care, which I think Jack referenced, is a double-edged sword because it takes tremendous resources to do that, but it’s also an important pivotal component for the social aspects, as well as the efficacy.

The next couple of slides show you examples of how we integrated in those IOM dimensions, our aim or promise to the patient and then how we planned to try to focus across the continuum of care. Just to go to some of the previous comments made, on this particular example, access to care for chronic conditions and ensuring that patients understand what happens post hence and self empowerment so that they know what to do when they leave the hospital, who to call, and how to have easy access; those are very important components. So
while we are an acute care facility, the rest of the aspects are really that much more important. The MDR rounds, to go back to that for a second, I listed for you the goals. Basically, again, our model was to integrate in the IOM dimensions, thinking that those are the components for the 21st century and that we really have to find models to live with through them. We did a little bit of an internal study. As we deployed MDR rounds, we did find there was variability at the round level and we found that there was variability in the outcomes, and we tried to study that to find out what the difference was because the model was the same. What we found based on the CMS Demo measures and the unit-based score cards where we were looking at where defects occurred and why the occurred was that those units that were really the best performers and had the lowest levels of variances were mostly clustered units where they had a homogenous patient type, such as cardiac, they constantly saw cardiac patients, therefore they were able to take care of them very efficiently as a second nature, and intuitive sense was applied very quickly. A failure-to-rescue scenario was rarely occurring because you could see a problem coming and intervene very quickly. So early recognition and early intervention was what was promoted in those clusters. When we got down to the mixed Medicaid-surg units, we found that because there was an infrequency of any particular case type,
the workforce was unable to organize around all case types so
they needed additional and different tools and techniques.
We actually created tool kits for those units. If you have a
patient with an MI, here’s your order set and here’s what you
need to do. You have to do different things in different
places, and I think that was some of the learning.

The elephant in the room, if you’ll indulge me for
this next room, is a very important concept. I think it’s
greatly misunderstood. You hear it chronically referenced
that the documentation wasn’t there, or the documentation
wasn’t good, or it’s not a quality issue, it’s a
documentation issue. I think there is a lot of confusion and
a lot of concern. I think the point that we have to
understand is that since almost all of this reporting is
based on clinical documentation and often on abstracted data
and administrative data sets, you have to realize that the
physicians and the nurses write in clinical terms and they
have an algorithm in their mind that they are describing and
writing to. The coding staff, who are working with a set of
principles, but not necessarily the same, are really
extracting that information in diagnostic terms; they don’t
always match. The algorithms, the mental models don’t always
match, so what you do wind up with are sometimes elements
that are just disconnected. As we expand for pay-for-
performance, we do have to work on the lexicon and bridging
some of those gaps if we’re going to stay with some of these rankings. If we’re going to look instead at individual thresholds, I think we can get someplace else. So one of the approaches we committed to was accurate capture and exchange of information at all portals. Regardless of what your job is, it became everyone’s accountable situation to make sure that we had the most complete and accurate information. We’ve put forth a lot of alignment programs according to documentation and coding.

The next one, and I know we’re just about out of time, is the data distinctions. I think this is an important one for policy going forward. If you look at the right lower corner, if you really want to improve, you really need prospective information or information that is readily available to you so that you can act and react to it, especially the staff. But the price of getting that is high. If you want to have real-time information available to you, it’s a high price; however, the upside is that you have a lot of accuracy and reliability and you can tend to deal with disconnects in a more real-time manner and avoid a lot of the back-end rework that usually occurs. I think this is important because many of the models that we’ve been told have failed in the past tended to use either the completely retrospective model, post-hoc analysis where you’re really trying to understand something that happened a long time ago,
and it just doesn’t necessarily have the analytics or the relevance that one would need. So I just offer that as a concept. The next slide, of course, just basically reinforces that if you want to improve, you need to have real-time notion of where you are at any given point in time.

Horizontal integration, I think, is very important. This is mortality, referred to earlier as the ultimate clinical outcomes, and I just want you all to have access to this to realize that we use the AHRQ indicators for patient safety to monitor much of this, and I think if you are not looking across scenarios for those multiple tasks that Jack referenced that the nurses have to look at, you have to have some sort of visual model or context for them to work within; otherwise it’s just one more number, one more topic, one more scenario. I think if we furnish the appropriate tools and analytic capability at the front end, we have found most of our success is that the staff has what they need in order to make the next right decisions.

The next few slides are just examples for you about what those analytical tools look like. Finally, the most important one from my standpoint is these, which are the current public reporting initiatives that we are involved in. One of the dilemmas we have is that the board will say, because they all have different comparators and different pools of data, “Well, are we good or not?” Because in some

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we’re the top decile, in some we’re the top quartile, and in some we might be at the mean or the median. It’s very dependent on the comparative group you’re using. In the state, for example, the more locally you get when you’re dealing with low volume, high volume, et cetera, we might be in the median of a particular therapy, as opposed to like hospitals. So I think there are just some cautions that have to be understood about what we select, how we compare it, and then what we’re reporting because if we want the boards fully engaged, we need to give them something to react to in a simplified manner. I think we can end with that. Thank you.

ED HOWARD: Thank you, Regina. We are now in Q&A mode. I would invite any of our panelists, if have a comment in response to something they’ve heard since they spoke, to throw in at this point. They’d be welcome to do that. I want to make sure that Sue is involved in this as well. You, of course, have access to microphones in either half of the room and the green question cards that you can use to write the question and hold it up, and someone from the staff will grab it from you and bring it forward. We have somebody at a microphone that is prepared to ask a question. I’d ask you to identify yourself, and I’d ask all of our questioners to be as brief as possible so that we can get as many questions covered as we can.
BEVERLY COLEMAN-MILLER, M.D.: My name is Dr. Beverly Coleman-Miller. I am an internal medicine physician and a bachelor’s degree nurse. I am curious about Six Sigma; I heard it mentioned in passing and I’m just wondering, as I look at them transform their quality assurance from the Jack Welsh [inaudible] into the healthcare arena, whether any of you have approached it or whether you’ve approached it and negated it as quality assurance that’s not appropriate? I have a real quick second question. It sounds like Medicare and Medicaid just kind of thought about nurses after the fact; we’ve been multitasking for 1,000 years and I’m wondering whether that can’t be part of our measurements. Multitasking is the natural order for nurses.

ROB COLONES: About GE’s methodology, which was the precursor to Six Sigma, many of the statistical tools that are in Six Sigma are also in what we use currently. It worked for us, so we stuck with it. We are also using lean principles and learning more about that as well. So I think its several tools in the toolkit that broadens our understanding of what to apply, whether we’re working to prevent an error, whether we’re working to identify and mitigate, or whether we’re working to totally redesign a system. I think, in my opinion, neither one of them is more
important. They’re all important as tools to use in the toolkit.

**ED HOWARD:** Jack, do you have a comment?

**JACK NEEDLEMAN, Ph.D.:** Yes. When we looked at the hospitals and the Transforming Care at the Bedside initiative, which is a funded project by Robert Wood Johnson Foundation to try to improve the performance of med-surg nursing units and improve the work environment for the staff including nurses in those units. We’ve got a number of different hospitals, and they’re using a variety of different methods, Six Sigma and some lean methodology. I think the critical thing here goes back to something that Regina alluded to, people need to have a common way of talking about their common problems and whatever methodology people adopt is a vehicle for giving them a common way of talking about what problem we’re trying to solve and what our tools are for achieving that. It’s a teamwork-building component and has been very valuable in terms of allowing for the multidisciplinary work that nurses, physicians, the unit clerks, and the housekeeping staff together are trying to do on these units.
BARRY STRAUBE, M.D.: My reaction, too, is in prior lives I’ve been involved with Six Sigma as one of multiple parts of the toolkit, as Rob was alluding to. I think at CMS we’re not so focused quite yet on the methods in the toolkit. We are involved with that through our Quality Improvement Organization Program where we’re trying to bring different methodologies to various providers that they can use. I still think our main problem is that the healthcare industry is still not used to measuring quality of care. So before we jump into how we fix it, we still have to answer some very basic questions about how we measure the quality of care, how we do it with the least amount of burden and the least amount of resource use in order to get that information. How valid is it and to whom does it apply? There is a long, long list of questions that we still haven’t fully answered, but the biggest hurdle that we’ve started to jump, I think, is that people are finally starting to collect, analyze, and report data. That’s the most important thing to us. It’s been a pet peeve, I suppose, of mine that in any setting that I’ve been at, hospital or physician level, health plan, I was a vice president for quality improvement for a large national HMO, and now at the federal level for the major federal payer of healthcare, nursing gets kind of forgotten and put off to the side. Yet, it’s key and core to all of the settings that I mentioned up there just as much as physicians, if not more.
so. Part of this gets back to the payments systems we have and how we’re going to develop these pay-for-performance programs given the payment systems we have. Right now we, in Medicare, recognize that our payment system is one of the most perverse, if you will, in terms of alignment of payment for reward. We reward a doctor or a nurse or whoever who does very, very good care and keeps people out of the hospital, yet the patient who comes in who has a very, very long hospital stay with many complication, premature discharge, readmission to the hospital, we pay for all of that in spades. The people who work in those settings don’t always share in the cost savings. So as we reform the payments system in each of the settings, we also have to figure out how we can incent people who are on the cutting-edge line but aren’t getting the payments that we’re getting; we have to maybe insist that it be passed onto other people. So a lot of questions to answer.

SUE HASSMILLER, Ph.D., R.N.: We have some questions from the audience with the nursing themes. I think, Barry, you answered one of the questions that has to do with CMS and nursing integration.

BARRY STRAUBE, M.D.: Sue, if I could just add on nursing and this supplements what Jack said; we’re very
Concerned about staffing, particularly in the nursing staffing area. We haven’t really gotten our arms around that or addressed it adequately, but we do have a number of special projects that are being done through the QIO program looking at staffing turnover at hospital and nursing homes in particular. I think we need to increasingly look at that.

**SUE HASSMILLER, Ph.D., R.N.:** Okay, and that’s what the cards would indicate. So this question is for Rob. It’s probably a two-part, and I’m going to try to integrate a couple of these questions here. I think in the diagram that you showed, your key principles, if nursing is so important to the multidisciplinary team and leadership, why isn’t nursing leadership one of those key design principles? What changes, if any, were made in regard to nurse staffing as you addressed quality in your own organization?

**ROB COLONES:** Each of those six core processes that we think are important are a mile deep, and you could take a week on each one. When we talk about improvement methodology, when we talk about prioritization, when we talk about executive leadership, nursing is at the table with us making those decisions. Each Tuesday, we spend about four hours with a variety of people. Most of the room is nursing helping us look at the data, analyze the data, and pick the
opportunities for improvement. It’s just hard in just a few minutes to explain that; but if you were in our shop, you would see a significant amount of nursing involvement in that whole prioritization and project selection. And then in the actual three-month cycles that we run, we have a care manager, a master’s prepared clinical nurse specialist, who is our black belt, our content expert, in our quality methodology and he or she, as a nurse, helps that physician leader drive that three-month cycle all the way through.

SUE HASSMILLER, Ph.D., R.N.: And what kind of retention efforts are going on inside your hospital that you might relate to quality improvement?

ROB COLONES: In South Carolina, we have about a 13 or 14-percent nurse vacancy rate. At McLeod we’re about 2-percent. So we’re doing much better than the state average. Nursing retention was one of our quality efforts in our ways that we worked on and made some significant improvements in keeping it [inaudible].

JOSH SEIDMAN, Ph.D.: Mine falls onto this question, so it fits right in. I’m Josh Seidman from the Center for Information Therapy. Given Dr. Needleman’s comments for the third point that current pay-for-performance systems do a

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poor job of targeting improvements in the core work of nursing and also the work that RWJ sponsored at Wagner in the chronic care model that demonstrates the critical importance of engaging patients as partners in care, I’m wondering what measures you think pay-for-performance systems should use to reward nursing impact on patient engagement? And sort of as a followup to that, what are the data sources that we need for that, which I think is a question about the use of patient-reported data?

JACK NEEDLEMAN, Ph.D.: I was afraid I was going to get that question. It’s easy to criticize; it’s hard to design. I think there are a couple of basic principles. One is as I noted, a lot of measures that we have that we associate with measures of nursing performance are outcome measures. For a variety of reasons, we might want to think about including some of those in the measurement set. The big challenge for doing that is risk adjustment. The advantage of process measures is that the patient who needed it either go it didn’t, and there is no risk adjustment involved. So we have to think about what kind of mix of outcome and process measures we want to use in adjusting our payment systems. In terms of nursing process, clearly there are other measures that we need. When I mentioned the National Quality Forum Initiative, one of the big missing
gaps that the NQF committee felt was there was pain management. I think if we could develop a good process measure for pain management, which would require looking day after day at the needs of patients about whether it’s assessed and whether it’s controlled, we would get a long way to measuring how much time and attention nurses are able to deliver to patients not just for pain, but across the variety of tasks that nurses have to do for individual patients. If we take that as an example, one of the real challenges is the ability to access the day-after-day records from processes. I think one of the things that’s going to make a big improvement in our ability to measure what has to be measured is the development and extension of electronic health records, electronic medical records, in hospitals where we can begin using them as databases to compile detailed information on the whole process of care, not just fixed endpoints.

REGINA BERMAN, R.N.: I’d like to just add to that.

I referenced the AHRQ patient safety indicators, for which there are very, very clear technical specifications, and we are able to get them out of our clinical data systems, so we look at decubiti, nosocomial decubiti, falls, failure to rescue, some of those things that Jack referred to in his research that really are directly related and nursing teams,
as well as the multidisciplinary teams, respond to that data constantly.

JACK NEEDLEMAN, Ph.D.: Regina’s comment just reminded me of something. She noted that she and other people in her hospital were putting together flow sheets and check sheets around specific conditions. Those check sheets become the vehicle for monitoring what care was needed and what care was delivered. You can integrate both whether care was delivered with a common order set of what care might be appropriate for this patient. So I think in the short run, we have some paper-based systems that will allow us both to improve care and can serve as a vehicle for monitoring whether or not care is at the level where we want it.

BARRY STRAUBE, M.D.: From the federal perspective to your question, I have already alluded a little bit, on nursing incentives, since we don’t pay nurses directly under Medicaid or Medicare, nor do commercial payers generally, except in some circumstances, we probably have less impact right now. But that’s something that I think people who pay salaries and bonuses to nursing staff ought to be thinking about. I think, however, to address this from the patient perspective, this is a very important area. A couple of things, you may remember that on the slides that I put up...
earlier one of the key components of many of our demonstrations has to do with trying to reenergize the concept of doctors, nurses, and clinicians working with patients as a partnership and as a team. As an extension of that, there are ways that we can potentially incent or involve patients with this whole pay-for-performance process. One is, first of all, in our development of the structure of premiums, deductibles and co-payments. I know this is happening in the private sector, and we’ve talked a little bit about ways we might do it in the Medicare and Medicaid programs. But there are some private payers and PPO programs in particular who are waiving co-payments or reducing co-payments or deductibles for those patients who actually adhere to certain treatment regimens and other advice that their clinicians are giving to them. That’s one way of doing it. Another indirect way, and again, this is all emanating from the White House, the secretary of HHS and Mark McClellan, our administer, is this transparency approach. We’re making all of this information on quality and cost and pricing available to all of us and then able to use that information. One example would be where we go to get our care. So if you have a bad-quality provider and patients know about it, they don’t go there; they go to somebody else. Volume and the revenue stream can indirectly drive or promote quality in that way. Of course there are other things; all
of you who are involved with statute development and policy development, which is going to be debated and discussed very much this year, is the Administration’s proposal to promote health savings accounts. Whether you agree or disagree with the general concept, the general concept would be trying to put money in consumers’ hands, give them information to make choices about how that money is spent on healthcare, and empower those people to change healthcare by putting their dollars where they think the best care is given. So those are three examples.

**SUE HASSMILLER, Ph.D., R.N.:** This question is from a member of news organization and I guess it’s for the panel. If more expensive, more well-trained nurses and more of them curtail adverse outcomes, that is, cut business, why would a for-profit hospital even invest in more and better nursing? [Laughter] For the news media.

**BARRY STRAUBE, M.D.:** It all depends on how you’re paid. If you’re paid per admission, as CMS does, and those better-trained nurses are shortening length of stay and the payers don’t come back and try to recapture the savings of the shortened lengths of stay by cutting the rates, than the hospital has gained the funds. If you’re paid per day, as many smaller insurance plans are still paying hospitals, and

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you cut the length of stay, than the insurer gains that money and the hospital has to go negotiate back with the insurer on why they should get paid more per day since they have been instituting plans that save money. This issue of incentive alignment is a central one in any of these systems and it needs to be examined and kept in mind closely.

REGINA BERMAN, R.N.: I will say that that’s the business case for quality; do you, by putting more resources and a rigorous program in place, give yourself the yield you need? When we looked at that, we tend to run a very, very high census. We have in the past month been at 99-percent, which is almost impossible to manage. But one of things we did is we know that we replace those patients; we’re not out recruiting them, but people come. More people come so efficiency has not hurt us in any way. Efficiency has helped us. We applied APN, Advanced Practice Nurses, as part of this work to work with disease-specific categories of patients such as cardiac, heart failure, pneumonia and some of these issues where we actually had people looking across the organization, licensed independent practitioners who either had a collaborative agreement with physicians or functioned as an augmented resource to the nursing staff with the idea of helping to spread the knowledge. What we found is that it’s an expensive part of the workforce; they’re

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highly skilled, licensed practitioners. Some of them can bill for their work. We mostly did not take that tact because we used them as part of the workforce instead, and we did not want the physicians feeling as though they were competing with their payment options, so we just kept it as part of the salary expense. But what we found was that the efficiencies were 10-fold, that the return on that investment was great, that we were able to get into some of those patient-centered approaches, we were able to work on the self empowerment pieces for the patients so that when they got outside, they knew much more about self management, readmissions went down dramatically in heart failure, and the length of stay and cost per case went down dramatically. So I think there is a business case that’s supportive. It tends to be very clear in the chronic care model, but I’m not sure we have the answer across the board.

BARRY STRAUBE, M.D.: I was just going to take this one step further. We’ve talked an awful lot about the measure that we will reward in pay-for-performance and whether or not they’re nursing sensitive, but Jack’s observation about the need for payment alignment would lead one to examine what kind of payment mechanisms there are in these various initiatives, including the ones at CMS and Premier, and how they’re structured in a way that does or

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does not make them sensitive to the criteria that you’re developing that would be sensitive to nursing inputs.

**ED HOWARD:** Here’s what you’re measuring and rewarding and how you can structure the reward. Med PAC says that 2-percent should be a pretty good incentive for hospitals to change their behavior. The National Health System in Great Britain has followed a reward for general practitioners of 30-percent total compensation. Somewhere in that range there is a mechanism that would be ideal for helping us target the nurse-sensitive measures.

**BARRY STRAUBE, M.D.:** I’ll take a stab at that. To be honest, we have not focused on nursing up front. I’ve listed the five areas we’ve focused on at CMS in the Medicare and Medicaid programs, and I think to a large extent for the commercial payers it’s been the same way. So I think we have to address that and there are many other clinicians involved including physician’s assistants, technicians and all sorts of other people who are part of this system that we probably ought to be thinking about. I think your question, though, does raise some other things we haven’t talked about in pay-for-performance considerations. First of all, do you pay for the top performers as we’re doing currently in Premier Hospital Demonstration? Or do you pay for anybody who makes
a significant improvement over their baseline? The argument, if we just do the top performers, is that there may be some people because of geographic location, their own business case situation in a local area, or commitment to their administration, who will never be to get in the top 1 or 2 or 10 or even 20-percent of performers. But they may go from being in the bottom decile to the fifth decile; that’s a significant improvement. Should that be rewarded or not? I think that’s important. I think the other thing has to do with amount. But I’ve already mentioned that in the hospital setting 0.4-percent took us from 10-percent to 98-percent, at least in terms of reporting, so small amounts do make a difference. In the Premier Hospital Demonstration $8.85 million in the first year was paid out. That may be a lot of money, but when spread out over a lot of hospitals, it’s not such a large amount. So what’s the right incentive amount? Some people do say numbers, particularly for physician offices, you might have to get up in the 20-percent range in terms of an incentive to make a change. I think we have to struggle with all of these issues.

Finally, in terms of the methods, regardless of the amount, in our demonstrations we have a variety of methods. It can be a straightforward bonus, as in the Premier Demonstration, where if you get in a certain range, we will pay you a bonus on top of your base payment. Other ones are...
set to a capitation method where you pay a flat fee and if you have savings, you get to keep those savings. Other methods where there’ll be populations treated, there are cost savings, and the people involved may be able to share a percentage of the cost savings. So there are many, many ways to structure this. I think we still don’t know how to distribute it to all of the people involved, what the appropriate amount of incentive should be and what the vehicle is to do that, and how much it should be.

ROB COLONES: I think this is more about a beginning to the line incentives of different providers to come together to create standardization of care. This is not really about money. The raises next year in our system will be $9 to $12 million dollars; this is a 3 to 4-percent raise for people. The $200,000 to $500,000 from the Demonstration Project doesn’t make it available to distribute and even put a dent in that $9 to $12 million raise, but what it does begin to do is it begins to allow us to standardize. We’re talking about 13 orthopedic surgeons who trained in 13 different places and have 13 different ways of doing something and trained across 30 different years; it’s maddening for the nurse to implement 13 different protocols to take care of her patients. Standardization would help greatly. There are many benefits beyond just the actual
funds received. The issues with flow and the peaks and valleys in demand are big stressors on nurses. If we can attack that issue through performance improvement, we can make a big difference. The goal is to begin to align incentives and get people to make the real changes that are needed. I don’t think any of us think that a lot of money is going to be coming from Washington to pay everybody a lot more money; it’s about redistributing what is available.

LISA SUMMERS, CNM, DRPH: My name is Lisa Summers. I’m with the American College of Nurse-Midwives. I actually came to the microphone when the comment was made that CMS doesn’t directly reimburse nurses which, of course, generally is true when you’re talking about hospital-based nurses, but I wanted to make the point that CMS does directly reimburse advanced-practice nurses, nurse-midwives, nurse practitioners, nurse anesthetists. Regina’s comment about the APNs in her institution to some degree answered my question about how you see the role of APNs and their value in the system. I really appreciate her comments. But I also wanted to point out, with regard to CMS, that in the very early days of discussions about pay-for-performance I know many of the groups of APNs, the MPs, the CNMs, the CRNAs, very much wanted to be a part of that discussion. I would just encourage you as you continue to develop this to think
beyond the role that physicians play because that group of providers is playing an increasingly important role in healthcare and I think has proven to be a very cost-effective group of providers.

BARRY STRAUBE, M.D.: I’ll respond. Again, I hope I’ve made it clear that my own personal feeling is that I’ve relied on nurses my whole entire career; I couldn’t have survived in my career without nurses, not only as assistants, but as educators to me when I was a medical student and so forth. We do pay nurses. I think we’re struggling with limited resources; we have to start in big dollar areas, but can’t forget the nursing piece.

BOB GRIST [ph]: Bob Grist with the Institute of Social Medicine and Community Health. We’ve been talking about quality as if hospitals all have the same level of resources, technical skills, uncompensated care and all the things that we know vary tremendously within our healthcare system. How does the pay-for-performance methodology address the inequalities that the hospitals bring to the table when they’re trying to improve quality?

BARRY STRAUBE, M.D.: I’m not sure I get the question entirely? Could you just talk about little bit more?
BOB GRIST: I was reacting to the fact that even in the IOM report on To Err is Human, it didn’t focus on inequalities among hospitals that contribute to the variation in quality. By bringing the best examples of hospitals to our panel here and saying, “Look, we can even improve over what we did last year,” I’m wondering if we are addressing the inherent inequalities in the healthcare delivery system, or whether we’re just going to be furthering the gap in performance by rewarding the hospitals that are most effective.

JACK NEEDLEMAN, Ph.D.: Good point. I was trying to get at that a little bit in my comments in terms of whether we reward just the top performers, many of them who have benefits to begin with, which almost guarantees that they’re going to do better than other people, as opposed to developing a system where even the people who are at the very, very bottom of performance, if they can demonstrate improvement, we would reward them also. My own personal bias is that we have to do a bit of both. We have to reward the top performers, but I’m leaning a little more myself towards rewarding anybody who has some improvement, as long as they initially are at least at a basic minimum standard. I don’t think we should allow the persistence of people who are
giving inadequate care, which we can all agree that is just not acceptable. It’s interesting; the Premier Hospital Demonstration is 260 hospitals including large hospitals, small hospitals, rural hospitals, urban hospitals, academic medical institutions, and community institutions. I think the takeaway from that demonstration is that there was improvement among all of those types, regardless of where they started. We didn’t talk about Premier Demo as a negative takeaway after the second year to those hospitals that don’t meet some basic performance on that. If they don’t get that, they’ll have negative payments taken away from them under that demo. We’re hopeful, as I think the Premier groups are too, that they’ll all get above that baseline minimum. Be that as it may, there are still certain hospitals, hospitals with large disproportionate hospital-share payment systems, rural hospitals, hospitals in the inner cities, all sorts of hospitals that start off at an extreme disadvantage, and I think we have to keep trying to address that disadvantage they have and bring them up.

ED HOWARD: We have time for one more question I believe, during which time I would ask you to pull out your blue evaluation forms and fill them out. Yes, sir?
TODD KATCH: I’m Todd Katch; I’m with the American Health Quality Association. I think tied into this question is the idea that not all hospitals have the same sort of resources available in them. I think the nurses in the room would probably acknowledge this, especially in a smaller facility you have a nurse who is responsible for admitting patients, triaging, assisting the physicians, and at the end of the day trying to do an extraction and then lead a quality improvement effort? These people are overburdened as it is and it’s hard to find time, as I understand it, to go out and look for the resources. “What are the best ways to improve upon my aspirin rate for heart attack patients? I want to improve it, but I don’t know what some of the best practices out there are for getting me to that next level of performance.” So how do we help those people? I will say that I represent the Medicare Quality Improvement Organizations and certainly that’s something that they’re doing every day, but I would ask the panelists how important is to have that opportunity to have sharing among your peers to learn what the best ways are to do it? Dr. Straube, in particular, whether it’s through the Quality Improvement Organizations or through other mechanisms that CMS is thinking about, how do we further encourage that kind of dissemination of best practices so that we lift all boats?
REGINA BERMAN, R.N.: Can I make a comment? I think there are a couple of points. One is that I know part of the commitment in this Demonstration Project was for the sharing and learning so that everyone benefitted. I think on of the reasons we saw the results of everyone benefitting was because that was built in. I think that’s an important component. I can tell you, and I’m sure Rob will verify this, that as two of the hospitals that are called upon frequently, it does become a yeoman’s task or quite a burden to continue to do that. We probably get 15 or 20 calls a day. We have had requests for site visits. Part of our commitment with Pursuing Perfection was transparency and was to help with constant sharing and learning. So we’ve done that, but it’s at a tremendous expense from a resource standpoint. We keep doing it, but it gets harder and harder and harder because as this has grown, we have hundreds and hundreds of hospitals trying to do that every day. So that’s one piece of it. I think the other component where you spoke about the nurse doing all of her direct patient-care tasks and then trying to do data extraction, I think that may be a workforce model that has to be looked at, because the commitment for the work with Transforming Care at the Bedside is to really keep that special skill set with the patient and to try to take away those other elements that distract or detract from that that. I know in our organization we have
built it into the information management infrastructure; we’ve made a firm commitment not to make the nurses the data folk. But we’ve also made the commitment to keep the data in front of them constantly so they can use it, react to it, and do what needs to be done to improve it. Thanks. [Laughter]

BARRY STRAUBE, M.D.: First of all, Todd’s comment, and I’ve mentioned the QIOs a couple of times, the Quality Improvement Organizations that we have, I think, are a very key part from the federal standpoint of trying to give technical assistance and helping all providers of healthcare to do better. I’ve inherited a program that has been heavily scrutinized in the last year or more, and indeed people are questioning as to the amount of expenditures that go into that program, what comes out of it? I would say in defense of the program first that $1.2 billion every three years for the QIO program, which amounts to about 0.1-percent of Medicare expenditures. Most private companies or payers of healthcare contribute 1 to 2-percent or more of the total dollars that go into premiums et cetera for quality improvement purposes. So in fact, again, for those of you on the Hill, I would remember those figures. Federally we are putting 0.1-percent as opposed to 1 to 2-percent into quality improvement on the federal level. That works out to about $10 per Medicare beneficiary per year for quality

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improvement, which is arguably not a large amount. On the other hand, $1.2 billion is a huge amount of money, whether it’s 0.1-percent or more, and I think we are challenged to demonstrating that the efforts that our QIOs do put into quality improvement do, in fact, lead to a significant improvement. I can assure you that we’re very much focused currently and over the next several years on doing that. But I do believe that QIOs are very important. There are other players here though. I think that the health plans have a responsibility to perform the same kinds of improvements and they have been over the years, some more than others, and we should recognize that and encourage it going forward in the future. The employers are increasingly coming up with more dollars to fund issues like this, and we should encourage that and insist on it. In addition to formal technical assistance, such as the QIOs and the other people I’ve mentioned, I think the way is the formation of large national, regional, and local collaboratives where people can leverage their resources and determine the best and most important tasks to focus on and the best way within that local, regional, or national perspective to deal with it.

The last thing I want to say is something we haven’t talked about this afternoon, this whole business of pay-for-performance. We did talk about it a little bit in terms of patients and how we can get them involved, but one of things
we haven’t talked a lot about has to do with our choice of metrics and reimbursement schemes and whatnot. The question that arises is, is that what patients want? Do they care about some of the quality measurements that we have that we’re paying these large dollars of money to improve upon? Indirectly they do, but most patients want to feel better, get better, and feel like they’re being taken care of. I think they have a somewhat different perspective than we have as policy makers, payers, and healthcare workers. So I think as we’re devising these pay-for-performance methods, we have to keep going back to patients, and we all are potentially patients, and asking them what they want. There have been some national studies and surveys looking at this. In fact and not surprisingly, many patients will answer the question of whether they think their hospital or doctor or whatever should receive extra money for doing a good job, the majority of those surveyed as patients will say, “No, we think they should be doing a better job for the money they’re already getting.” I think that then leads also to what the metrics are that matter to patients and what do they want to know about?

ROB COLONES: There is a business case for quality, even though a pay-for-performance system may or may not be there. There are savings that are real from doing this work

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that free up dollars to do other things, and you don’t need to always have a lot of extra resources. The ventilator-acquired pneumonia initiatives are available on the internet through the IHI website with no cost to us other than meeting time to implement those standards, and that was about $640,000 in savings in two years by having no ventilator-acquired pneumonia, so it doesn’t always take extra computer systems and people to do the work.

**JACK NEEDLEMAN, Ph.D.** I’d just like to share a couple of insights from the Transforming Care at the Bedside initiative that relate to the question that was asked. First of all, one of the things that we heard Regina and Rob talk about was the creation of systems that work. What we’ve seen in many, many hospitals, particularly around the systems that nurses work in are systems that regularly fail and then nurses have to compensate for the system; they are basically work-around cultures that the nurses are living in. One of the big changes we’re talking about here is moving from a system of a work-around culture to a culture of improvement where system failures are fixed rather than lived with day after day. That’s a real shift in front-line staff perspective that can be hard to come by. One of the real challenges in that is answering the question, “I haven’t got time to do my job today; where am I going to find the time to
do this extra work?" So part of it is thinking about how we structure this work to build the system improvement into the data-to-day work of the nurses that are there. The hospitals that are here seem to have built some success there and the Transforming Care at the Bedside hospitals are working on that set of issues. Many of the hospitals have found additional staff resources, whether it’s in their performance improvement process, buying some overtime, or buying some additional shifts to give people some flexibility in the short run to work on the issues of system improvement. In the long run, those may well pay off in terms of not needing the staff down the road because we’re simply not doing as much work around and as much fixing things, but in the short run, those resources may be necessary. The second thing we’ve seen in the Transforming Care initiative is the very powerful role of learning from one another. One of the real benefits that hospitals cite from the work that they’ve been doing in that initiative is the ability not just of the performance improvement people and the leaders to get together with the same people at other hospitals, but also the front-line unit managers and the front-line stuff. We need to find ways to stop having our learning from organization to organization go up the ladder to the top level, across, and then back down. We need to find ways, and I think Transforming Care and some of these other initiatives

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provide some models of finding ways to build the lateral connections between front-line staff and different organizations, the unit managers and truly the front-line staff to build the skills, build the commitment and learn from one another what works.

SUE HASSMILLER, Ph.D., R.N.: I just want to say once again how much I appreciate everyone coming out. As with any very good panel, this has given me a lot to think about as I move forward with our agenda at the Robert Wood Johnson Foundation. I would just say that you have given me many more questions at this moment than I have answers, so thank you for that.

ED HOWARD: Let me add our thanks to the Foundation staff and the Alliance staff who had the yeoman’s duty of putting this briefing together. Thank you for your commitment and your attention during this, the Foundation for the support of and sponsorship of this briefing, and thanks also to our panelists. As Sue said, I think we’ve had a very thoughtful, very useful discussion. I ask you to join me in thanking them. [Applause] Thank you for filling out those blue evaluation forms.

[END RECORDING]