Measuring Up:
A Comprehensive Scorecard for America's Health System
The Alliance for Health Reform and The Commonwealth Fund
October 11, 2006

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ED HOWARD: …to welcome you to this briefing. My name's Ed Howard, I'm with the Alliance for Health Reform. On behalf of Senator Rockefeller and Senator Frist and the rest of our Board of Directors, welcome to a briefing on a new tool. A scorecard from the Commonwealth Fund for measuring the performance of the U.S. health care system. When you look at the grade, and there are a bunch of materials in your kits that allow you to do that, it's clear we have a lot of cramming to do before we take the test again.

Now we all know that, at its best, our health care system delivers very high quality care, what we don't as often recognize though is that the quality varies dramatically from provider to provider and hospital to hospital and health plan to health plan. You're going to hear a lot more about this as we go along, including I think some stunning numbers about lives lost and dollars cost.

Our partner in today's program is The Commonwealth Fund, private philanthropy, whose work stresses the need for a health system that performs at a high level, especially for the most vulnerable segments of our society. We are very happy to have Commonwealth's Executive Vice President for Program, Steve Schoenbaum, with us, along with several key staff involved in the fund's initiative that relates to a

high-performance health care system, to which the scorecard is closely related.

Let me just run through a couple of logistical things, if I can. As I mentioned, you have a lot of materials in your kits that relate both to the scorecard and to the general subject of quality in related topics, like pay for performance. Also more extensive biographical information than we'll have time to give to the speakers and that they deserve. You'll be able to view by tomorrow a web cast of this briefing on kaisernetwork.org and you'll be able to review materials from the kits and some other materials as well on our website allhealth.org and the kaisernetwork.org, as well.

Forewarned is forearmed. We are going to ask you use the question cards that are in your kits, the green cards, as well as use the microphones that you'll find to ask questions in person and to fill out the blue evaluation forms that you'll find on the right-hand side of your kits so that we can make these programs better. One other note that I was reminded of when my left breast pocket made a noise, I would ask you to turn off your cell phones and pagers if you, or put them on vibrate or whatever it is you can do to make sure that everybody else can hear without being distracted.

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We're going to hear from Steve Schoenbaum in just a few minutes. He will be co-moderating today. We also have in addition to Steve, a distinguished lineup of speakers as well so I want to get started to try to maximize the time for discussion.

I'm going to lead off today with Cathy Schoen, who is the Senior Vice President for Research and Evaluation of Commonwealth Fund and the person who's as responsible as anybody, I think, for producing the scorecard. She has a long history of solid health policy analysis in government, in non-profit settings, in academics. We've asked Cathy to lay out the broad outlines of the scorecard so we can get into the substance of the discussion more ore less on the same page. Cathy.

CATHY SCHOEN: Thank you, Ed. Is this on? Working. Okay. Now let's see if this works. Someone has to get my slides up.

As Ed said, we're going to be going through fairly quickly the findings of the scorecard. This was prepared on behalf of the Commission for a High Performance Health Care System, which is a national initiative sponsored by The Commonwealth Fund, whose goals really are to identify areas where we can see that we can do better across quality access and efficiency domains as well as equity. In our packets I

just want to point out that you have a fair amount of material on the scorecard. I'm going to be talking primarily off of these two documents, a short report, there's a longer technical report on the website, and also the health affairs article. I have a fairly limited set of charts today to keep the presentation short, but in the back, if you didn't pick it up, you may be interested in seeing charts on all the indicators that are in the scorecard. There is a chart pack that is also available from the funds website on all the indicators that we'll be discussing today.

This is a national scorecard that's unique in taking a whole system view. It spans five core domains of health system performance, health outcomes, quality, access, efficiency and equity. What we've done as we looked for ways of looking at how we perform compared to where we could be, as we've compared the United States averages to benchmarks, which are primarily drawn from achieved performance rates, either the best ten percent of hospitals, ten percent of health plans, best regions or states in the United States or other providers and we've also drawn in some international comparisons. Most of the indicators draw from variations within the United States. We have about 37 scored indicators in the scorecard, some of which are composites. The way we've scored is quite simple. We compared the benchmark to

the U.S. average and within his domain, the domain is the average of the ratios. You have all the information, both numerator and denominator and all the indicators in the reports that we've issued.

Overall as Ed said, the scorecard finds room for improvement, substantial gaps pull the overall score across all the indicators down to a 66. The ratios could range from zero to 100. The scores are low in all major domains as averages are quite far from the benchmark and also because costs quality is so variable across the United States, but often the average is far from the benchmark because of the distribution. The bottom half is far from quality that it pulls the average down. We see pockets of excellence on most of the indicators and these are benchmarks of achieved performance, so we know we can do better. These are not just statistics and indicators when you think about what it means for people and cost of care. We estimate based on a few select indicators that failure to reach benchmark rates accounts for as many as 50 to 100 billion dollars of wasted money per year and a 100 to 150,000 lives. This doesn't count the cost in terms of sick days and lost productivity. The institute of medicine estimated that we could save as much as $130 billion in lost productivity if we would covered the uninsured. We have benchmarks that provide targets for

improvement throughout the report. I think the central message of the scorecard, particularly if we look at what's happening with cost and coverage is there's an urgency for action that starts taking a whole system view.

As I mentioned, scores are low across all the domains with ratio scores, the benchmark often 50 percent better than the average or the average when we want to reduce the rate, 50 percent worse. Scores were particularly low in efficiency area due to waste, duplication or unnecessary care, access barriers and also high administrative costs, quality and cost variations. I'll be showing you some indicators on each of those domains.

We have just a few indicators that we're featuring in the presentation today in each of our core domains and I will refer to some of the others. Within healthy outcomes we used a global indicator that has started to be used in Europe that compares mortality from causes that are potentially preventable with timely and effective care before the age of 75. As you can see from this chart, the U.S. does quite poorly on this. We rank 15 out of 19 countries. When we created the same indicator, global mortality indicator within the United States, one of the things you see is that some states for the United States achieve the rates of the best countries. It's the wide variation across states that is

pulling our national averages down. We also rank poorly at the beginning of life and at the end of life compared to international rates on both health life expectancies and infant mortality with variations in those across the United States as well. Many of the variations in outcomes can be directly related to issues with quality, access and efficiency. Within the quality domain we looked at several subdimensions of care and I'll talk about each with a few indicators. On getting the right care, care that's appropriate, evidence based guidelines, we created an indicator that looks at U.S. task force recommendations for prevention and screening, basic preventive care that we're supposed to get based on our age and our sex and we find that less than half of all adults get recommended care. As you can see if varies widely by whether you have high income or low income. We have pervasive in equities by income, by insurance. But on many of our indicators, but even the more advantaged, high income and insured do quite poorly and this is one of them. No rate is very high.

On chronic care we have evidence that we can do better on managing diabetes, keeping it under control. Managing hypertension, keeping it under control. From rates reported to the National Committee from Quality Insurance where we, on this indicator, benchmarked to the best ten

percent of plans report to N.C.Q.A. The national average, as you can see, is quite far below the best rates achieved by plans. N.C.Q.A. estimates that on both diabetes and hypertension if the national average could move toward the benchmark it would mean one to two billion dollars in annual savings. Twenty to forty thousand lives. So, again, these are very important, significant indicators.

Within the right care domain we also have indicators of prevention for children, mental health and hospital quality processes. Again each shows wide variation where we're quite far from the benchmarks. We also looked at coordinated care within quality. The extent to which care is coordinated well often means avoiding errors, avoiding duplication, making sure people get recommended care and don't fall between the cracks. On one of our indicators on what happens to people when they are discharged from the hospital we picked one that is being reported now regularly to CMS by hospitals. Discharge planning for people with congestive heart failure, we know is critically important because they leave the hospital vulnerable, still with very high needs. Need to be connected with the next step of care. Needs to know who to call, what they've done. But, yet, only 50 percent receive written instructions when they leave. I think what's remarkable on this indicator is the variation

between the top ten percent of hospitals and the bottom ten percent of hospitals. As you can see, the leaders are achieving near perfection with almost 90 percent of patients getting discharge instructions, meanwhile, we have 9 percent which pulls down the overall average. Ed is saying, yes, he guesses that would pull it down. [Laughter]

We also looked at long-term care and frail. Again, within each of these, I'm just summarizing a few of the indicators. Within nursing homes we know that delivering effective primary care and preventive care can avoid complications that lead to hospital admissions. We know that effective discharge planning to a nursing home can avoid to readmission rates. Discharge to the nursing home and back again to the hospital within 90 days.

On this indicator we've compared across states and you can see a two-fold variation between the lowest rate states and the highest rate states. The way we now pay in Medicaid and Medicare actually has incentives to not worry about these readmissions rates, even though they put patients at high risk for complications and drive-up costs. We could do much better across all our coordination care indicators.

Within safe care the U.S. currently lacks any global indicators across all our system on error rates. We're beginning to have some on adverse drug events in the

community, people taking inappropriate drugs, and the trends we've been able to identify from national data sources, if anything, show some trends ticking up in the worse direction. On this particular indicator we've used hospital mortality ratios, which is a ratio of actual mortality risk adjusted to expected looking across hospitals using Medicare data. This indicator is the indicator that the Institute for Healthcare Improvement, IHI, has used in their 100,000 lives campaign to talk about targeting and benchmarking ways to improve lower infection rates and do better on quality of care. Again, as throughout the scorecard, we see very wide variations between the bottom end of the distribution and the top. On this indicator what we're hoping to see over time is the whole distribution moves toward better performance.

Within patient centered, timely care, another dimension within the quality domain, we know that effective communication with patients having a regular source of care or a medical home who can connect you, getting easy access when we need to see the doctor, not waiting for a doctor office visit two weeks from now, can avoid emergency room care, avoid admissions to the hospital. In this domain we see evidence that the U.S. is not doing very well on those and I'm just featuring one indicator within hospitals that we're starting to do national surveys and this is for a pilot

set of 250 hospitals that Arc shared the data with us. On what is the experience within the hospital, on having your pain managed well, having someone respond when you ring the bell, having your drugs explained to you. This indicator is on others, we can see pockets of excellence. Some of the hospitals achieve 100 percent of patients saying their care really went quite well with big spread between top and bottom performing groups of hospitals. We will, over the course in the future have this type of indicator of patient-centered care for all hospitals in the country.

Turning to access, the national data that I think everyone in this room is aware of shows we're up six million people over the last five years in terms of the number uninsured. All of this increase has been in the adult population. The working age adult population, as we've been able to hold children's coverage thanks to public expansions. I'm starting with a map of the United States and those of you who are epidemiologists would think this is looking like an epidemic as we lose states who have low rates uninsured and we gain states who have very high rates uninsured. The dark blue are states that have 23 percent or more of their under 65 adult population uninsured. This is up from four states five years ago to twelve today. The indicator in the scorecard looks at both uninsured rates and rates

underinsured. People who have insurance, but it's inadequate to protect them against high cost health care bills in comparison to their income. We estimate that a third of all adults are either uninsured or underinsured. This amounts to 61,000,000 adults. They go without care, go without recommended care, they don't follow up on care, so it's both an affordability issue and access and a quality issue.

When we look at the affordability side of access we see increasing rates of adults telling us that they can't afford to pay their medical bills or they're carrying medical debt over time, bills they were unable to pay off. About a third of all adults report this now. What is quite alarming is that it is starting to move up the income ladder. It's starting to show up in middle income as well as low income families.

Turning to efficiency, the one place the U.S. is a clear leader is how much we pay for care. We are born on the most expensive country on a per capita basis or as a percent of national income. We just put a few countries up for comparison. As one of the things you see is there are some countries that are starting to hold the line and really say how can we get more out of how health care system for our resources. We value this, we think we're getting something, but we want high quality, safe, timely accessible care. The

gap is starting to grow between us and other countries. Within the efficiency domain we see evidence of duplication, overuse. We're beginning to collect some statistics on inappropriate care where the care just shouldn't have happened. Access barriers that lead to excessive use of emergency room and also access cost interactions. On this indicator of 30 day readmission rates to the hospitals you see that hospitals in the low end of the distribution have rates of readmission that are 50 percent lower than the highest readmission hospitals. These are Medicare data. On this indicator alone, if we approach the rate of readmission of the best hospitals, the lowest rate hospitals, Medicare would save as much as $2 billion a year. This amounts to real money and puts patients to risk as they come back into the hospital.

On a quality and access, a quality cost of indices that were developed for the scorecard by Dr. Elliott Fisher and colleagues at Dartmouth. They've been tracking what happens to people after a heart attack, after colon cancer, or hip surgery, hip fractures, after that initial hospitalization, out one year. Are they still alive at the end of the year? Survival rates and what was the total cost of the care. What you can see is a very wide distribution where we have regions of the country that do well on both

outcomes, being alive at the end of the year and costs and we have regions of the country that are poor on both quality and costs. For this indicator, if we moved the entire distribution of performance to the highest, best performing regions, meaning low cost and good outcomes, we would save lives and save money and the estimates of those are in your packets.

We also have administrative costs for running our insurance system, particularly compared to other countries. We have complex benefit designs. We have high rates of churning in and out of the insurance system, all of which drive up the overhead cost. Compared to the next most complex countries in terms of the percent of expenditures on administrative costs, Germany and Switzerland, we are well above the rate they spend and three times higher as a percent of national expenditures than the benchmark countries. We could do better to lower this administrative cost.

We are lagging behind as a country on information systems and physician offices in hospitals and we put information systems in with the efficiency domain because they allow doctors to deliver care more effectively, to avoid duplication, that really cuts across all the domains, which is one of the themes of the scorecard, how interrelated these indicators are. As of 2000, 2001, we were well behind the

leading countries. The most recent U.S. data says we're now up to about 24 percent of doctors with an electronic medical record, but what other countries have started doing is moving beyond the electronic medical record to build in decision support and more robust features so we are also lagging beyond on how much multifunctionality these systems afford.

On equity there are pervasive disparities across all the domains captured in the scorecard. The gaps are particularly wide when we compare low income to high income adults, experiences on the indicators that we've discussed, or insured and uninsured. The low income and uninsured rates are about a third worse than the comparison groups. For Blacks and Hispanics there anywhere from 20 to 24 percent worse. I think one of the things that we often forget is that this is not just a quality and an access issue, but it's also an efficiency issue. When you don't get in for timely care or you don't get appropriate care, you end up with complications and much more expensive use of resources. On a set of conditions that are called ambulatory sensitive admissions to hospitals which were potentially preventable conditions, if people received timely primary care they need never have gone to the hospital. We see extraordinary variations by race and ethnicity and very high rates in low income communities. A consistent pattern with much bigger

gaps for the under 65 population than the over 65, who are all insured, although gaps also emerge for the Medicare population.

I want to conclude with what we think are the take homes of the scorecard after this brief review. There are clearly opportunities to improve. We see instances of excellence. We have models of excellence. Most of the benchmarks were drawn from within the United States achieved rates, so we have targets that we can move to. The U.S. ranks quite poorly. Given the amount we are spending, we should expect to do much better, but we rank poorly even when we look within our own country and benchmark to ourselves. Guaranteeing affordable health insurance is a critical step, a foundation for doing better across both quality access and efficiency domains. We currently have situations where, except for the Medicare population, insurance carriers don't even know anything about their patients for very long. They lose them. They can't track a diabetic patient over time. There is very little incentive to invest for long-term gains and for the future. We don't have databases where we can access care and the churning also raises overall costs and leads to gaps in care. Quality and efficiency can be joint goals. We see throughout the United States instances where higher quality is associated with lower costs. We need to

figure out ways of getting to those benchmark regions, providers and understand how to reorganize care to deliver better performance across the board. One of the things that appears throughout the scorecard in different areas is connecting people, connecting care, connecting providers. Both in the need for information systems, the need for better hand offs, transition care, this is the place duplication occurs, errors occurs, we waste patients times, we waste provider time and overall we're not using our resources well. Net gains and efficiency are possible. As we look out into the future we need to make them. As we look toward an aging population we need to put our resources to use better. And last, as I started, I think there's an urgency for coherent policies that address these multiple aspects of performance. With cost in coverage moving in the wrong direction we need to act to secure a healthy nation. Thank you.

ED HOWARD: Thanks very much Cathy. That's an incredible array of material for us to digest and reflect on over the course of the rest of this discussion. Now we're sort of putting this in an order that fits how we think the conversation ought to flow rather than some sort of cookie cutter format template. So we've asked Steve Schoenbaum, who will be helping with the moderation duties as we move through the Q&A session as well to offer some perspective on the

project of the scorecard and the material contained in it. Steve's got a very distinguished career that is sketched out in the biographical information. He is, among other things today as I said, the Executive Vice President of The Commonwealth Fund for programs and the Executive Director of the Commission for a High Performance Health System that was the progenitor of this report. So, Steve, thanks for being with us and we look forward to your comments.

STEVE SCHOENBAUM, M.D., M.P.H.: Thanks Ed. Thanks Cathy for that summary, which was quite terrific. We're very excited about the scorecard. It really marks the first time a report on our nation's health care system has addressed all the key dimensions of performance, quality, access, equity, efficiency and the capacity of the system to approve. It's really the first time that a scorecard has complied a wealth of comparative benchmarks as well as performance data. The benchmarks, as you've heard, are largely things that are being achieved, performance levels that are being achieved, somewhere in states, regions, health plans, et cetera. The collection of such a broad array of data was purposeful. The Commonwealth Fund's Commission on a High Performance Health System, which started meeting in July 2005, was charged with moving the United States towards a higher performing health care system that achieves better access, improved quality and

greater efficiency and focuses particularly on the most vulnerable due to income, minority status, health or age. The Commission, from that first meeting in July 2005, felt strongly that it and the nation needed a scorecard of this kind in order to establish a baseline across all these indicators and dimensions and to provide the tool that we need to target and measure improvements. You might ask well what is the summary score mean and the people have assigned a summary score across all these indicators that Cathy's mentioned that runs it about 66. We think that reasonable people can debate exactly what such a score means. But to us, we think the message is quite clear. We need to do better and we can do much better. The scorecard presents the evidence for both of those statements in that the benchmark data that I just mentioned tell us that in some regions, states or organizations, in this nation or abroad, higher levels of performance are being achieved for each of these indicators. So ask yourself, why not the best for all Americans. As a physician I see the scorecard findings as the diagnosis and the Commission has already begun to map out a treatment plan. In August the Commission released its framework for a high performance health system for the United States, which laid out seven steps that we as deliverers of health care, makers of policy, insurers, employers, or

whatever our role might be, can begin taking right now. I will give them to you very briefly. They include guaranteeing affordable health insurance coverage, implementing major quality and safety improvements, working toward a more organized delivery system that emphasizes patient-centered primary and preventive care, increasing transparency and reporting on quality and costs, expanding the use of interoperable information technology, rewarding performance for quality and efficiency, and encouraging collaboration among stakeholders. Now achieving these improvements will require, what you might think of as a culture of high performance, where all parties share a vision of bringing high quality health care to every American. It is not an unreasonable goal to be trying to be perfect. We may only make it to Six Sigma, but that's several orders of magnitude than our current performance as Cathy demonstrated. Over the next three years the Commission will be providing information and recommendations about how we may move forward on each of the areas that I just mentioned for improving our national health care systems performance. But we also hope that starting today everyone in this room will think about the scorecard and what more you can do in your own work and in your own roles now to begin to move our nations health care system towards higher performance.

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Let me turn it back now to Ed Howard, who will introduce the remaining panelists.

ED HOWARD: Thanks very much Steve. We're going to hear next from Christine Cassel, who is Head of the American Board of Internal Medicine. She has been a medical school dean, she's one of the most renowned geriatrician in the country, she's a member of The Commonwealth Commission on a High Performance Health System, and a veteran of the Alliance programs in the past. We're very happy to have you back Chris.

CHRISTINE CASSEL: It's a privilege and a pleasure to be here. I also want to say a privilege to serve on The Commonwealth Commission on a High Performance Health System. As a physician I particularly appreciate the rigor and the quality of the data that has gone into this scorecard and the work that will come forth. I appreciate Steve Schoenbaum's metaphor of this is the diagnosis, now what is the treatment. So, the Commission is very engaged in addressing that important issue. I also finally appreciate the framing of this as Commission on a High Performance Health System. I think we've heard for a long time about many, many issues in health care in our country, but to think of it as how do we get to high performance I think does a number of things. One is it really drives us to evidence and to models that may

come from outside traditional health care thinking. But, also importantly, it demands that all of us in the health care system do our part. So what I want to share with you in just a few minutes today is what a major part of the medical profession is doing. But first just to point out that if we look at what are potential drivers of quality improvement and of high performance, one way to think of it is that there are sort of three categories. One is market mechanisms and we're seeing a lot of activity in that area these days. Pay for performance, high performance networks and tiering, more demands for public reporting so that informed consumers can make choices that hopefully will drive more improvement. We also see a lot of roles for government, both as a payer and part of this market model, but also, obviously as a regulator. Then the third part, which is the part that I think in policy circles has tended to get less attention and that I really want to focus on today is the professionalism motivation for quality and improvement. Here you have peer standards, licensures, state licensing boards, which is required to practice medicine in every state in this country, and a voluntary peer standard, which is specialty certification. These are how all of these mechanisms are how doctors are getting in the game, if you will, of quality improvement. The goal is to align all of these three

sectors. Wherever possible to integrate approaches if we're going to get to what Cathy Schoen described as an efficient and effective approach to improving performance.

So, just briefly, who are we. I think it's also important for Americans to realize that when you talk about your board certified doctor we all sort of take that for granted, but few people really understand what it means. As I've traveled outside the United States to many of these other countries, they don't have independent certification boards the way that we do. Internal medicine's board was founded in 1936. Most of the 24 recognized specialty boards were founded in the first part of that century. Importantly, they were co-founded by the AMA and the specialty society relevant to that particular specialty because it was felt that there needed to be an independent body that wouldn't be under the political pressure of a membership organization that could set standards for that specialty. So we have this wonderful institution of these independent, not-for-profit specialty boards. For internal medicine it represents, even though we're one of 24 specialties within this broad umbrella, we represent 40 percent of the certificates that are issued. So, we really are by far the largest representing now about 180,000 physicians who are certified in internal medicine, about a third of the practicing

physicians in the United States. For example, a patient's most common encounter is with an internist because, as you'll see in a moment, we represent a number of sub-specialties as well as primary care.

The other thing is that because of this internal medicine doctors tend to be a gateway into the system and, therefore, a potential avenue for strategies to improve efficiency and quality. This is the mission of our board to enhance the quality of health care by certifying internists and sub-specialists who demonstrate the knowledge, skills and attitudes essential to excellent patient care. Now, in addition to knowledge skills and attitudes, we also are including practice assessment as part of the requirement to be a board certified internist. Importantly, certification once was something that you did once in your career and never did again. That's history now. It's now required that all physicians who are board certified in any of the ABMS specialties renew their certification periodically, every six to ten years. In January of this year, we actually began mandating a requirement for performance assessment as part of that maintenance of certification. We've tried, and I'm going to show you a few examples of this, to align this requirement with the other requirements that health plans, N.C.Q.A. accreditation, large medical groups and,

increasingly, consumer groups are demanding. But I think what's important about this is that physicians who certify do so voluntarily. It's not a legal requirement to practice medicine. Increasingly it is an expectation of the public and the payers that physicians be board certified, but when we do surveys of our diplomats and ask them why did you renew your certification, because it is a job to do that, the number one reason they give is not because they get paid more for it. The number one reason they give is because it's part of their professional identity. So I see this as a very important tool, if you will, an oar in the water that we can use to really advance quality through professional motivation.

So here's just a schematic of an internet based tool that ABIM has created for our diplomats and we know actually are making it available to other specialties as well to evaluate quality in their practice through audits of the outcomes for patients with specific conditions. Report the data back to us and then we do an analysis of it and feed back to them how their scores rank, rather like the scorecard you're seeing today, except for an individual physicians office. So, data comes from patient surveys, asking patients who have that condition specific questions about the quality of their care, from chart reviews and from an analysis of the

data within the doctor's practice and some of the systems that are in place, such as electronic medical records. That data is then submitted to us, we do the analysis as I described, send it back to the physician, who then sends an improvement plan and remeasures at a later date and submits that back to us. This is the list of conditions that are currently available for our diplomats to use this kind of practice assessment. I'm not going to go over all of these, but I just wanted to show you sort of the breadth of internal medicine practice and it's 15 different subspecialties and ways in which as we continue to invest in developing these tools, these are now also being given a lot of credibility by numerous national health plans and regional blues plans and others who are incorporating these models in their pay for performance networks.

Finally I want to say a little bit about why practice assessment and pay for performance is not the only tool we need in order to get to a high performing efficient and effective health system. That's because knowledge also matters. If you look at what it takes to get optimal diabetic care, which is sort of the paradigm of how we measure in a physicians office, you don't actually need a doctor anywhere near that practice in order to deliver good, quality diabetic care. If you know the patient has diabetes

you can create a system with a team that will really deliver really good quality care. What you need a doctor for is to make the right diagnosis, to deal with rare conditions that don't allow you to do quality measures if you will, to exercise clinical judgment about do you really need to order every diagnostic test in the book or can you use a reasoned diagnostic approach to a more efficient use of diagnostic technology. Then, finally, because if we're really looking at particularly in Medicare at complex patients with multiple conditions, these single condition measures have real limits in telling us much about the quality of care. We're actually working with Bridges to Excellence on a way that we can evaluate ten different conditions in the office of a general internist, who sees multiple patients with multiple different conditions.

So, just in conclusion, I want to just again emphasize linking professionalism, the core values of medicine, if you will, as exemplified in the physician charter, which is available online at www.abim.org and the issue brief that's in your packet from our leaders forum this summer on Taming Health Care in Efficiency. This was a group of stakeholders and opinion leaders in health care who came together with leading physicians to understand how we, in the professional world, can help to solve the problem of health

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care inefficiency. One important way to do that is to improve quality and to do it through a wise use of resources. So, engaging in both accountability and quality improvement is a way to do that.

So, in summary, the principles that an organization like mine works on and one of the reasons why we're so pleased with the work of the Commission is, first of all, that information must be available. Our information about all of the physicians who are certified and recertified in internal medicine is available free of charge to the public through our website. We feel that physicians must be engaged in that kind of professional identity and that we have to work with the other sectors to make it not impossible and arduous with repetitive and different measures for them to use the same kinds of things. So, using the same measures as everyone else in the national quality forum, for example, is a way to align those activities and make it more meaningful, frankly, clinically meaningful for physicians to engage in quality measures. Thank you.

ED HOWARD: Thanks very much Chris. Last time Tom Miller appeared on an Alliance panel he was a congressional staff member. He was a senior economist at the Joint Economic Committee. Now he's back in the private sector. He's a Resident Fellow at the American Enterprise Institute.

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He's written and testified on a range of health policy topics, many of which are relevant to our discussion today. We're very pleased to have him with us. Tom.

TOM MILLER: I've slipped the leash, Ed. Thank you very much. Appreciate the opportunity to appear again here today to diagnose and treat the U.S. health care system in eight minutes or less. Sort of like an HMO, primary care doc in the old days. Now it's the baseball preseason and you're in for some twisted sports metaphors off the scorecard.

Let's take a look at the opening line up. Will start with the brush back pitch. You got to start somewhere, even if first base is in left field. [Laughter]. All right, nevertheless, some minor props and recognition for the extensive and challenging work by The Commonwealth Fund in attempting to provide better measures of health system performance. It's notable that the focus is on value for money rather than just lamenting resource limits, but there are limits also in terms of the data used and the measures used, the correlation versus causation. We in many cases have a small step toward tentative findings suddenly become a giant leap towards policy conclusions. In particular the link between universal coverage and better value is attenuated at best, and the embrace of systemness overlooks the history limits and embedded culture of U.S. health care.

Now, technically speaking, we've got floating base lines and moving pockets, so the analysis is built on a lot of this. Countries, states, provider groups, regions, you pick and choose depending upon your data source. It leave comparisons, not comparable. Simple ratios are not related to other, switching denominators and nominators, distorts the artificial percentage scores. These scores are an attention attracting marketing device, but not statistically valid. We need to look inside each particular story within the data measure and ignore the score composites per se. We want to know how the better performers actually do something better. That's the key information. Not surprisingly, many of these comparisons find that amazingly enough the mean is just about always less than the top ten percent. I'm just stunned by that. Much of this variation is natural, particularly in pluralistic provider system spread across 50 different states.

Setting an unrealistic bar of reaching the ten percent threshold distracts from the more important goal of providers improving their own respective performance levels. The goals need to be a combination of relative and absolute improvement, the upper ten percent yard sticks will keep moving over time. Now, most of these measures are domestic. There are some international ones. The most noteworthy,

which I decided to take a look at a little closer, was the new mortality possibly amenable to health care. When you peak inside the black box and actually review the study on which its based you find out some interesting things. In the 2003 British Medical Journal article by Nolte and McKee, the authors point out a number of caveats we haven't heard about. Those are that international comparisons mostly rely on an industrial management view of health care, whose apparent simplicity can be misleading and full of technical problems. Amenable mortality measures have their own limitations. Widespread absence of data by diagnosis, the inexact science of partitioning deaths among categories, involving underlying and social and economic factors, lifestyles and preventative and curative health care. Large international differences in mortality are caused primarily by factors outside the health care sector. That's the conclusion of the authors who wrote the study on which some of those findings were based. Summary measures underpinning the rankings are sensitive to underlying definitions and concepts.

All right, we're in the middle innings, let's go to a relief pitcher. A little from the market side now pitching the business of health. Pitching in more ways than one because this is a new AEI book, which will be published later this month by Professors Robert Ausfelt and John Schneider.

Fundamentally they'll tell you that for profits, competition in markets for health care work. They're likely to work better than centralized regulation and single payer financing and you'll hear more about in October 17th forum at AEI. Let's go a little bit further into it. Some summary points of the authors. Why do Americans spend so much more money on health care. Higher incomes are part of it. We have different expectations and demands as consumers. Shorter waiting times and greater choice between similar products actually have value to consumers, even if they're not directly related to better health outcomes. Our higher health care prices also reflect higher input prices, most of all labor costs. But that's also the cost of competing with other sectors in the U.S. economy for well-educated, highly skilled labor throughout the market. Now the relatively poor, this is standard one, we've gone through this definition, the relatively poor U.S. infant mortality numbers. Can't get into all the technical details. It's largely an issue though of inconsistent measurement, definitional issues for cross-national measures of child mortality, very sensitive to the definition of a live birth. If you use perinatal mortality you got a different set of numbers.

Let's take a look at another area, the population health outcomes data. Most commonly, life expectancy at birth reflects a complex combination of population characteristics and behavior, socio, eco, cultural conditions, in addition to health system characteristics. For example, the United States is the fattest developed country in the world. Now Europe is trying to catch up, but they haven't gotten to the table yet. Or, we could also consider that U.S. deaths from injury, accidents, homicides, suicides for adolescents and young adults are abnormally high. So let's torture those statistics would show that a lot of deaths going on before age 60. That kind of factor that's outside the U.S. health care system per se, the differential death rates from injury can reduce estimated life expectancy at birth substantially. That's a table from the book in question, which basically shows cross-national variation in life expectancy at birth and adjusted for variation in injury death rates. Now, after you account for the unusually high fatal injury rates we like to shoot each and crash into things. The estimate of standardized life expectancy it's American. The estimated life expectancy at birth in the U.S. moves from 75.3 under the old measure to 76.9 and we're leading with a bullet so to speak. Now the differences though in population characteristics in cross-

countries also matter. The leader in the club house, by the way up there, it's a little blurry, was Japan. They went from 78.7 to 76.0. That's not the only measure it just tells you that you need to be careful about these kind of broad composite measures which don't drill down into what's actually happening if you want to look at the kind of underlying components. You can slice it and dice it other ways as well.

Okay, third time through the line up, some late inning adjustments. What about the questions not asked in these studies. Some examples, what about variations within other countries as opposed to in the U.S. Now they've got a different size differential in many cases in the entire United States. You're not going to get the same type of variation, but it can occur. Variation of the sectors. What about variation in education? Do we have any measure of that as opposed to variation of health care services? What about other measures of life expectancy at later ages where we pump all our dollars and tell the kids and young working families you're on your own, send the check to Medicare. A life expectancy at age eight in the United States has to do better in that because that's where we invest our dollars. Rankings may differ by sex. Breast cancer is the cause of pre-mature death in varying countries. A large portion of health is

determined by factors outside of health care system performance. Another plug here in getting outside the health services input box, an interesting article by someone I know, me, coming out later this year and measuring distributive injustice on a different scale in the Journal Law and Contemporary Problems. What works here needs to be known as opposed to what's going on elsewhere. We have a bias toward what we do to patients as opposed to what patients bring to the doctor's office and the hospital and what they do when they leave. Most physician practicing groups are five or less. The system is not going to extend not far. We don't have the evidence or the guidelines to give all these recommendations for many areas of health care. There's great variations within a hospital itself. We really need physician identifiable measures more so than hospital measures. Some things work for hospitals, but not everything.

So, finally, different paths to progress putting health care in perspective. Let's remember how we got here. Knowing we have problems and we do have problems, doesn't tell you that identifying problems is the same as treating them correctly. Remember what's failed in the past and be resisted by U.S. culture and history. Reforms need to focus on what we're good at and what we can be good at,

transparency, accountability, portability and expanded time arising for decision making, targeted subsidies, value based competition, patient engagement, shared decision making. We want to build on our strengths, which are innovation, diversity and choice and work with, rather than against, the core values and patterns of U.S. culture and history. Thank you.

ED HOWARD: Wow. Thank you Tom. I'm going to resist any attempt to characterize that as a wild pitch.

TOM MILLER: You're balking? [Laughter]

ED HOWARD: You win. You win. Tom's slides, by the way, will be available on our website, later. As soon as we get back and have time to post them. We've asked two key congressional staff members to help us put the discussion of the scorecard into a legislative context. We're going to hear first from Elizabeth Hall, who directs health policy for the Senate Majority leader and the Alliance Vice Chairman Bill Frist. Senator Frist's interest in improving the health care system of the U.S. is a matter of record. Elizabeth makes sure that that interest is well informed. She had informed us before that she was going to have to leave early so we're pleased that you've made time for us and we hope to get a chance to get you in the discussion.

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Then we're going to hear from Mike Zamore, who's the policy advisor to Representative Patrick Kennedy or Rhode Island. He's had a hand in a slew of health care legislation and has done a great on prior Alliance panels. We're happy to have Michael with us, as well.

Elizabeth, thank you for coming.

ELIZABETH HALL: Thank you having me and thank you all for taking the time out to be here and listen. I especially do though want to thank the Alliance. Senator Frist has been the Vice Chair of the Alliance for the last five years, ten years, a long time. While he is leaving the Senate and he'll be leaving his Vice Chairmanship he has made it very clear that he will not be ending his participation and his work with the Alliance overall. So, you're stuck with him for a long time. I also appreciate the invitation to come and provide some response, both from a policy perspective as well as just on what Commonwealth put together. I had a long list of comments that kind of follow along Tom, wonder why they group us down here on the right side of the table. But, quite frankly, I think I'll stop through those. I think one point though that's important to make is that when we need to use the physician's office or we need health care we don't go to our health care system. We go to our individual provider. While it's important to have

system level information and bring system level information together and greatly appreciate that The Commonwealth has done that, I think what we as policy makers are pushing for and need much more is individual provider level information. Who is the best provider for what condition I have, who has the best outcomes, who can see me most quickly and, who, quite frankly, do I like and get along with, are just pieces of what we look for when it comes to an individual provider. So the point there is that we really do need additional information at a provider level and it's not quite captured in The Commonwealth scorecard.

The second thing that I would point is that quality, efficiency, cost, patient safety, all independently are very important factors and very interesting to look at, but they all combined make up what we consider as value and we are often willing to pay more for things because we put a value on them. I don't know that all of those pieces are reflected in The Commonwealth scorecard.

There's also a few pieces of the study that Tom didn't fully mention that I have some questions about.

TOM MILLER: I only had eight minutes.

ELIZABETH HALL: I only have eight minutes, too. One thing I would point out to start with is the window time that's reviewed. I think the Commonwealth fully admits that

the window and the data, there is a lag in the data and I think that anyone who is dealing with health policy and studying health issues knows that is one of the shortcomings of the data. I think there are several things, though, that have been put in place in the last couple of years, including the Medicare Modernization Act and the Patient Safety Act of 2005 that are not fully reflected in the data and will hopefully bring our score, and I expect will show up in next generations of the scorecard, that really are improvements over what was in place in 2000 and 2002 and, even to a certain extent, 2004.

Second thing and I appreciate that The Commonwealth folks point out insurance administrative costs. I would like to take a second and point out that we have a system unlike any other country in the world where it is employer based, primarily. Whether that's good or bad, we can have a disagreement, but quite frankly we are employer based. You can look at and compare administrative costs for private insurers in the U.S. versus Medicare and Medicaid, but to be quite frank Medicare and Medicaid traditionally have done a worse job of coordinating care and providing preventative care and disease management to patients, whereas private insurers have done a better job. You can question that. I'm sure there are different ways as Tom said to slice and dice,

but the point to make there is that I don't know that there really tells us how much value we're getting, because quite frankly we might be spending more through administrative costs for things that we value.

Last, but not least, is health IT and I think that's something that I think both Michael and I will both hit on. Commonwealth looks at some things and points out that we do not have the uptake of health information technology that would be ideal. It is quite suboptimal. But the fact of the matter is that we are starting to see a foothold with electronic medical records and information technology or technology empowered health information and that we are going to see, I think, that grow, both because of policy that we expect to put in place, but also simply because we are starting to learn how to use it, providers are seeing the possibilities, they are starting to adopt it. And, just today, the Robert Wood Johnson Foundation put out their first report, again kind of establishing a baseline like Commonwealth has to look at uptake of health information technology. Their numbers were a little bit different than The Commonwealth numbers. They show that one in four providers is now using an electronic record, yet one in ten are using an electronic record that they would see as optimal

as opposed to suboptimal, meaning it has decision support, it has a lot of the functions that we hope to see in health IT.

So, that brings me to what does it mean for policy makers and what will be doing here in Congress. I think there are kind of four key things and a couple pieces of legislation that I'll point out to you. One, as I mentioned, we really think that it's important to measure quality, cost, performance, outcome, process, at a very granular level and actually look at individual providers. I know that we need to do this by using consensus based measures and that's the only way that we truly will get value as long as they're consistent across providers, but it is very important. I think that that is the move that we are making is in that direction.

Second, that we don't get value out of that information just be measuring it and collecting it. We have to actually make it available. We can make it available in a number of different forms. As I mentioned Commonwealth is doing so in a system wide level. I think it's important for us as policy makers, at least to Senator Frist, to make that information available to consumers, payers, purchasers, other providers. One of the things that the Society of Thoracic Surgeons has done for years, and Senator Frist is a thoracic surgeon, is that they actually do measure quality. They've

had a database going for the last, I think, 25 years and they don't know what all of their colleagues' individual scores are, but they can actually look and see how they compare to all of their other colleagues as a group. Medians, means, averages, and as Senator Frist will attest, it drives competition and it drives improvement just having that information. So it's important to make that information available.

I would say third that to see the health information technology uptake that we would like we really need standards. We are not promoting health IT for health IT stake. It is not going to do a darn bit of good to get a computer in every doctor's office if we aren't using it in ways that will improve efficiency, that will improve outcomes, that will improve value. That can only happen when we allow for the exchange, secure, private, appropriate exchange of health information. That will rely upon standards. It's very important to get those standards in place. The administration has already done yeomen's work get us part of the way there. We need to get all of them the way there and make sure that that adoption and uptake happens.

I think last that I point out that we really need to do things to eliminate barriers and incentivize providers to actually use health information technology. We can do great

things if we can share information electronically but only if we make them available for physicians. That means looking at ways to bring down cost, looking at ways to provide grants or loans, and potentially looking at some changes to current law that do create a barrier.

This is where I get to my shameless self promotion moment. There are two bills in particular that I'd like to point out that try to do a number of things that I just listed and beyond. One of them is S1418, which is the Wired for Health Care Quality Act. That is a bill that we passed in the Senate. There is a similar House bill that deals with health information technology, I think it's 4157, but I could be wrong on that number, that the House passed. We are in informal preconference negotiations and very much hope that we see a resulting piece of legislation because we think it's important, not only what the administration is doing, but to codify that and keep it going and mandate it. But, quality and standards are two key components of that legislation.

Another bill that I'd point out is legislation that we just introduced that really has taken almost two full years just to write. That is our health disparities bill we've written with Senators Kennedy, Bingaman, Clinton and others. This really is looking at one of things that's pointed out by The Commonwealth study, which is an equity

question. I think we clearly understand from Commonwealth that we all receive suboptimal care, just some worse than others. One of the things that Senator Frist thinks is very important to do is really to eliminate health disparities. One of the key ways that we can do that is by collecting quality data down to the provider level. So I just point out that piece of legislation as well because I think that it goes to addressing a number of things that Commonwealth has identified, including access, including coverage, as well as just the basics of what is the quality of care that was actually provided.

I'll sum up there and give Mike time to talk about his comments and some of the things he may be working on and the House may be working. And apologize that I do have to leave early, but just again, thank you all for having me here.

ED HOWARD: Thank you Liz. Mike.

MIKE ZAMORE: Thank you. Thank you Ed and I want to thank The Commonwealth Fund especially for putting this report together, this scorecard and for just really great work they do in pushing these issues and trying to promote a better health care system. The one comment that Tom made that I agree with, or I should say, one of the comments that he made that I agree with, is that the scores themselves I

think, it's important that we not get too hung up on them. They are, to some extent, just really a measure of how much variation there is in the health care system. The benchmarks are U.S. benchmarks is just comparing our average to the best of us. So, what it shows, the lower that number, it shows you how spread out health care performance is across the system. I think that what's really interesting is to dig down and look at the denominators and numerators of those ratios and the picture still isn't pretty. So, what I think that this report really shows how great a need we have to really transform our health care system and, you know, the silver lining of this report is that in virtually every measure and all these domains there are pockets of excellence Cathy said. It is being done here in the U.S. You know, we're delivering care the right way in various places. But the problem is that delivering excellent health care efficiently in the United States is really swimming against the tide of the system forces. So Liz's boss and my boss and every other politician I have ever heard pretty much like to say that we've got the best health care system in the world. What we actually have is a terrible health care system that delivers some of the best health care in the world. But as the report shows it doesn't vary inconsistently. Ultimately I think that if we want to transfer form care and try to

create a system that's actually promoting care that's going to be safe and efficient and high quality and is moving up the numbers, towards those 90th percentile numbers and as Tom said pushing those 90th percentile numbers higher, we really have to look at how we pay for care. Right now we pay by the piece and when you pay by the piece you get a lot of pieces. So with no surprise we're getting a lot of units of health care produced. When payment is based on how many patients you see and not how your patients do, it's not a surprise that the system isn't really driving quality improvement or efficiency. So we need to be paying for what we want. I think that there is to some degree a fairly broad agreement about we need to do more primary care, we need to do more prevention, we need to coordinate our care better. Certainly, one of my boss' high top priorities is better integrating mental health and to health care, but we also need to coordinate across providers as we have a population that is getting older and more chronic diseases.

So in that vain I see several priorities for the feds. There are several things I'd like to see us really focusing on as levers for changing the way our health care system operates as a system. I think we really need to focus on where the incentives are and how they are pushing our providers and our patients and everybody else.

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So, the first thing is IT. I'll pick up where Liz left off, which is to say that until we get IT we can't unlock the data that's trapped in paper that is the heart of the information that we need to drive value in the health care. We just can't build a system around value without knowing what's being done and what the outcomes are. All that information is trapped in paper record rooms in basements of hospitals or in physicians offices. So we got to get that data out. I think that S1418 is a good start. I actually think the house bill that Liz characterized, I think, generously is similar, is in many respects quite dissimilar and doesn't go nearly far enough. I don't think the Senate bill, frankly, goes as far as we need to go by a long shot either, although it does start pulling on some of the levers. I think when it comes to IT what we really have to be focusing on is why is it that health care is so far behind virtually every other sector of the economy when it comes to investing in information technology. Not an accident, there's real systemic obstacles to investing in IT. So we really need to be focusing our policy on how do we overcome those barriers and change the dynamics. I don't think giving grants to physicians to buy computers or EMR is the way to go because then what happens when they need to upgrade in a few years. You know, you're not changing the

dynamics. It's like the whole teach a man to fish versus giving him a fish thing. We need to be creating a situation going forward where investing IT makes sense for the stakeholders and the health care arena. So I think the Senate bill and the House bill, to some extent, dipped their toes in the water of doing some of those things, but they don't go far enough. In the shameless promotion department, my boss has just introduced a bill before the recess called the Personalized Health Information Act. This is his third health IT bill that he's introduced in the last two or three years. This one is designed to promote the adoption of personal health records because if we can get physicians and patients using them together, web-based, individualized health information records, they can be portals, they can be communication channels, they can get at some of the prevention numbers. We saw in Cathy's slides or maybe it was in the report, 49 percent of patients get their preventive care and screenings that they're supposed to get. People could get reminders electronically saying hey, you're due for your colonoscopy. We can get some of those numbers up a little bit in a pretty low cost way. I'm happy to talk more about that bill if people have questions about it, but it's designed to try to jump start the use of these personalized communications channels to get patients and doctors working

better together and to empower patients to take better control of their own health.

I think we need to be more aggressively be supporting efforts to network health information together, RHIOs the Regional Health Information Organizations I think are important. I think we do need to create incentive structures, not one time deals for physicians, but a way to tap the value that payers, including the Federal government will get by better use of information technology and create a market based incentives for physicians to be getting technology as well as providing support for them to do so. So I think technology, IT, is a critical foundation. I completely agree with Liz that it's not the end, it's the means of what we really want to do, but we can't do it without IT, so that's one priority.

The second one is I think we have to use the Federal government purchasing power to start changing expectations and culture in health care to build the infrastructure for quality. Again, I agree with much of what Liz said and what Tom said about the importance of things like pay for performance, measuring quality, reporting on quality and using that information to help drive consumer decisions. I don't think that that means, from sitting over her on the left side of this panel, I don't think we need to blow up

third party insurance by any stretch, but I do think that better value and value transparency in terms of both quality and pricing is important. It can compliment the third party insurance system where the risk is still spread out, but people are empowered to make better educated decisions about how they're going to find their health care. I think the 646 grant program in Medicare and MMA is a great a great opportunity to be exploring how we do a better job of delivering health care how we transform. I think that we need to be cutting through the tower of Babel in quality reporting. Making sure that we have some consensus based quality measures that accurately reflect the quality of care at the provider level as Liz was saying. I think that was a provision that was in S1418 that was not in the House health IT bill and I think that's one important that be riding along with IT because we need the IT to serve the quality purposes.

Finally, I think that at the Federal government we should be really focusing on doing more to learn what good health care looks like. We spend $28 billion at NIH every year learning about cures and treatments and prevention strategies and how to take care of peoples' health. We spend a tiny, tiny fraction, we spend $70 million at Arc, maybe a billion and a half throughout the government on health services research. Figuring out how do we get those cures

and treatments to patients in the best way in a way that going's to take advantage of that knowledge most efficiency. So we're spending all this money learning what works from a medical point of view and no money figuring how to get it to patients. I just don't think it's a wise use of that massive investment in NIH. We got to be spending more money learning how to deliver good health care. We need to be doing much more with outcomes research, FDA aftermarket research, Arc budget, moving beyond efficacy and just stating whether it's something better than a placebo. We have to be doing much more research into what the comparative effectiveness and the comparative cost effectiveness of various interventions so we know what works and how we can deliver care more efficiently. In doing that it's tricky and we need to make sure it's political installation for that process. There's a distorted history there of the wrong answer being penalized. We do need I think to really be looking carefully at how we can learn what good health care looks like.

Another thing I think we need to be doing is really understanding how we redesign health care and getting at the fundamental question that I started with, which is how do we pay for care in a way that's going to drive the kind of care that we want. That's going to drive up those scores on the scorecard. Ultimately, we need, I think and most might

agree, to move away from the payment models that we have and explore other things, really redesign our primary care around notions of the advance medical home and ways of coordinating care. One of the things that my boss is looking towards doing in the next Congress is introducing legislations to provide some grants or pilot programs to give creative and innovative providers the opportunity to redesign the way their delivering primary care and do so with an eye on improving along with six IOM domains of quality and do so in a way that's going to building a case for better for new payment practices and really be building a research base that can be sold to payers so that we can be expanding models of payment to get beyond paying by the piece and start paying for what we really want, which is better health care. So I think that the Federal government clearly has a big role to play, a lot on its plate and I think that The Commonwealth Fund deserves our thanks for really again taking a step towards this issue front and center, which is where it needs to be. Thank you.

ED HOWARD: Thank you Michael. I'll invite my colleague and co-moderate to co-moderate and invite you to use the green cards for questions and the microphones in the back of the room if you would like to stand and deliver. If you would if you do have to leave before we're finished, or

even if you can stay till your finished, make sure you fill out those evaluation forms so we can get some sense on how to improve these programs. Steve.

STEVE SCHOENBAUM, M.D., M.P.H.: I'd like to make just a couple of comments while you're getting your questions up. I largely agree with Tom, Liz and Mike. Particularly I think we need to build on our own strengths. Tom mentioned innovation, diversity, and choice. I should also mention that our Commission in its framework statement assumes that we will continue to have, but wants a strengthened public and private health system and does not picture it all going in one or another direction. I also agree that it would be great to have better data. We would love to have better data and the lack of better data is a real problem. That's one of the issues that's being address by both Liz and Mike in wanting to have a better IT infrastructure.

I think both individual and system factors are important. I have here an article from this week's Annals of Internal Medicine, which is about missed and delayed diagnoses in the ambulatory setting. It's a study of closed malpractice claims. I suspect some of you are interested in malpractice issues and the conclusions are the diagnostic errors that harm patients are typically the result of multiple breakdowns and individual and system factors. So,

it's not that it's all one or all the other, it's really both.

I also want to agree and give an example with Tom, that it is important to ultimately drill down. That's critical if one's going to solve our problems. I don't know how many of you looked at the N.C.Q.A. report on the state of quality in the United States. There is a fascinating figure in there that just came out in the last couple of weeks. It's available on their website. The figure I'm referring to shows a very isolated drilled down entity, if you will, which is giving beta blockers to patients who've had acute myocardial infractions. There are now ten years worth of data on that subject. If you look at what the results were in 1996 they looked very much like what Cathy showed in this scorecard. The top 10 percentile of performance was somewhere was around 90, 90-something. The country of health, that is the health plans average of reporting in 1996, was some somewhere in the sixties. So the score would have been somewhere around 66 percent. If you look at what's happened over the last ten years the top deciles is now performing at the 100 percent level, but the average across all health plans is now somewhere up around 96 or 7 percent. So ask what's the score now, yeah the top deciles is still higher than the average, but the score is up to 97 percent.

That's an enormous improvement and what we think is that can occur with any number of the parameters that Cathy showed you today. I really would like to focus on the fact that there's a hopeful picture here and I think that's one good example of it.

ED HOWARD: Okay. Let me just start with a couple of questions that have come forward here. I guess we can start with you Cathy, to respond to this if you'd like. The report says we could save up to $50 billion a year and up to a 150,000 lives per year. How do the estimates of cost savings and lives saved take into account the fact that 100 percent of these people will die eventually, but from some other cause, probably frailty, dementia, and organ failure and old age, if they live long enough.

CATHY SCHOEN: I think that's a great question. I think whenever we're looking at safety and mortality, we're looking at what can be done for that patient. When you save that patient, I was actually asked could these people die more than once in a year. One of the doctors in the room said, some of the people with multiple conditions have been in the hospital multiple times and we could do well by their heart attacks. So it's something that has driven all of medical care to look at what we can do to improve quality of life and drive down these numbers. The doctors in this room

can talk about pretty dramatic improvements over time. We've seen them and that's part of the goal that we're looking for. So, yes, when you save a life this year, that may be the person is now dying two or three years from now, but for the family and for the person, or ten years from now, we're talking about preventing early mortality, not giving us all immortality. So I think these kinds of numbers, what we would have loved to have had, by the way, is some quality of life measures. What it means to be walking around pain free with her hernias repaired and when you talk bout where those are they're extraordinarily difficult to find so we're back to clinical process measures.

TOM MILLER: Ed, if I just might for a moment. It is true that all health care systems fail and no one gets out alive. However, the more important metric as we're seeing some improvement in this regard is not to be so petrified at the thought of longer lives. What we want to have is longer healthier lives. It's your time until death, which is the real metric in terms of the high cost measure, so if you can postpone to further out at a later age, that time in which you are going to go into spiral before death, which is where all the costs collect, in terms of the annual carrying costs you are coming out way ahead.

ED HOWARD: Good point. The suggestion is, according to this questioner, that the fundamental problem we have is providers are paid to do things to us, not to keep us healthy. Are there not some capitated, integrated systems in the U.S. and do they perform better. Kaiser Permanente they suggest or perhaps the V.A.

Any body, Chris.

CHRISTINE CASSEL: I'd be happy to address that. I think that was what Michael was referring to that we need to look for different financial incentives. It really is true that most of the fee for service system is a driver of two things. One is potentially over utilization, but more importantly, lack of coordination. Because if you're able now through e-mail and other interventions to keep patients out of the hospital or even keep them from unnecessarily having to take time off of work and come to your office you don't get paid for that. So, it's not rocket science to figure out ways to pay people where you have different kinds of incentives. Indeed, the prepaid models that have been successful in this country have used that incentive and have been big enough in the markets that they've succeeded. Kaiser is the biggest one, but others in Minnesota, the Henry Ford system in Michigan, and others, where you have a big enough panel of physicians that consumers don't feel like

their choices are limited by having to be part of that system. I think that's one of the key models. There has to be enough scope to what these models are. The other problem is that if it's not big enough then the physicians are too great risk. I think that's what we saw with some of the unfortunate failures of that model at recent times that we've tried it. So, there are other ways you can do this. You mentioned, Michael, the advanced medical home which is something that is trying to capitalize on primary care, both internal medicine and family medicine being able to be responsible for coordinating care which reduces unnecessary specialty visits, reduces unnecessary diagnostic procedures and reduces, frankly, unnecessary visits either to the visit or to the hospital, then somehow gets rewarded for that. There are concierge models of care that do this, there are bundled ways of developing payments. So I suspect that's going to be a big discussion ahead of us next year, because the private sector payers, the Blue Cross Blue Shield Association, all of the big national health plans are coming to us, that is to say, the physician community, and saying how can we reinvigorate and recapitalize primary care because young physicians aren't going into this specialty any more and these are the people who really have the skills to be able to do that care coordination.

ED HOWARD: I think another piece to this question had to do with the sort or organized systems of cares and gave as examples the V.A. or Kaiser. What those examples show if you have a managed care system, which is not the same as manage care mind you, you can in fact achieve better results. It's not a given, but the system can be managed to do so. Those, however, are very unusual examples. They're systems in which for the most part the physicians are employed and that's not the dominate form within the United States. So I think the challenge for us is how do make this same set of results occur in the more individual practices we have. I suspect that's why Liz and Mike tend to agree on needs for things like information systems because those are things that can be used to help integrate what are otherwise very individual physicians or other clinicians. So that's I think one thing that's worth thinking about. The second is that it's very interesting to see some of the things Chris was talking about, the importance of board certification, and there's some evidence that people who have board certification do better in practice than people who don't. I can tell you in the days I was at a Kaiser like organization many years ago, it was called Harvard Community Health Plan and we used to pay physicians more who had taken boards. Now

I see in a recent pamphlet that Chris has sent me that there are other insurers in this country who are giving what look like mostly non-monetary awards but mentioning that people are board certified and trying to distinguish them within their networks. So that's another way in which the kinds of things you've been hearing can link together to try to improve performance.

CHRISTINE CASSEL: Then we should also mention the malpractice discount. I think in terms of recognizing the value of what doctors know and t heir willingness to demonstrate their performance that the Doctor's Company, which is one of the larger malpractice insurers, is actually offering a discount to physicians who engage in maintenance of certification. So I think we're seeing more and more of that kind of activity.

STEVE SCHOENBAUM, M.D., M.P.H.: I just have to say, though, I've been on so many panels and so many conferences where everybody pledges allegiance to the idea of integrated care and how great Kaiser is. You have to step up to the challenge of answering the question, why don't doctors want to practice this way? Why don't patients want to go to these places? The Kaiser cargo colt of health care did not transfer from the West coast to the East coast. I mean, there are competitive forces, there are cultural forces,

historical forces, psychological forces, but you need to confront those because you can point to these really great performers, but it doesn't get out there in a broader marketplace.

MIKE ZAMORE: I think that's right. I think that's why Steve was critical, which is to say how do we take some of the upside of an integrated practice like that and figure out how to use technology and use other means to gain some of those advantages in a more heterogeneous practice environment because clearly not all docs and not all patients, or maybe not most docs and most patients want to be in that setting, but I think most do, and certainly from the patient side, most want the advantages.

ED HOWARD: Yes, sir. You want to identify yourself?

JOSH SIDEMAN: Josh Sideman from the Center for Information Therapy. My comment and question actually follows on that last point and it goes to the legislation that you brought up that Congressman Kennedy just introduced. Because I think it's the first piece of legislation that focuses on two things. One what consumers really want and need from advanced information technology and two enhancing the physician patient relationship and looking for mechanisms that we can do that, that go through other forms of delivery systems other than Kaiser and group health and so forth. I

think what's also important about it is that it builds on a tremendous body of research led by Ed Wagner and others around the chronic care model and things of that nature that really support the value of those two things. So the question for you is, I know that in the bill there's a brief section on interoperability, but one piece that is not addressed is the fact that most of the work on IT interoperability isn't doing much to help to translate the information that's going to be out there in various information systems into language and utility that will be useful for consumers as they try to make use of the information that's flowing into the personal health record. I wonder if there's anything you'd like to say about that.

MIKE ZAMORE: Sure. First of all, I'm Michael Zamore and I approved that message, by the way, about the bill. You know the interoperability question I think I see as a little bit separate from the question about how do you ensure that the information is usable and understandable by patients. One of the things that we hope this bill would accomplish is to really kick start some competition around delivering user friendly, high value personal health records to consumers. A critical feature of this bill is that information, in order to qualify for the incentives that are built into the bill, the personal health records have to be fully patient

controlled and the patient has to be completely transportable. In other words, the data doesn't stay with the personal health record, the data stays with the patient. If the patient wants to shut down their personal health record and wants to go to some other personal health record vendor or supplier, that's their right to do so. Ultimately, what I would hope would happen is that the market will evolve to making these things as user friendly and high value to consumers as possible. So that if WebPHR, Inc. has the answer, in a way to present the information that patients get and it allows them to do things that are really useful to them, they'll gain market share because ultimately what we're trying to do is breath some demand into this marketplace for PHRs where right now there's a lot of offerings by various folks, but very few consumers actually taking them up. I'm loathe to say that there's got to be a right way to present the information to the consumers, but I do think needs to be insured is that the information can pass from PHR to PHR, from PHR to EHR, or other computer based technologies in a way that's going to translate. I think that making it user friendly for the patient is something we shouldn't be dictating by standard.

ED HOWARD: Question I guess may be directed at Tom Miller, the problem with dealing at the individual physician

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level as both Tom and Elizabeth Hall stressed, is that the operate in a vacuum as Elliott Fisher's work at Dartmouth shows geography is destiny, most docs practice based on what they learned in med school and what others are doing in their practice or region, not what's considered the best care based on the evidence. Larger systems, CMS, health plans, large physician groups can help drive more the use of evidence based care and reduce the disparities and differences that The Commonwealth study illustrates. That's not a question, but it's an opportunity for a comment.

TOM MILLER: Of course, physicians are imperfect and they can do a better job of performing. Now the question is where are those incentives and signals going to come from. One way is by that physicians performance. They don't count for everything in health care. There's some decisions way outside of their reach they have nothing to do with it. Where they can be accountable and be measured then they should know about it and the people who deal with them should know about it and then they can kind of move forward. Their patients need to put some pressures on the physicians. We always think about stuffing it from the top down as opposed to thinking about some signals from the bottom up. So we want to get everybody pulling together, looking for better health care and they're measures that matter and measures

that don't matter and some things are going to be blind and ignorant about, but where we can improve, we should improve. It doesn't mean that everything is done at the aggregate level. It does matter what one person does in one minute, on one decision that transcends upstream into the rest of the system.

ED HOWARD: Yes.

MICHELLE DENNING: If I may go back to the issue of the electronic medical record.

ED HOWARD: You want to identify yourself please.

MICHELLE DENNING: Sorry. Michelle Denning, Georgetown University, an intern at Academy Health. My question is more as a person who sees patients, oftentimes homebound patients, not only do I want that patient to have their medical information, I want to know that with that limited time that I have to see the patient that information is available to immediately before I even go into see them, so that the little bit of time I have, I can make sure that I'm not missing the critical information, that I'm not making errors. So I not only want that patient to have the medical record, I want that patient to have it portable immediately throughout the system, but how do we do that now and we have no legislation to protect someone with preexisting conditions. So, I if I don't have an employer and have to

get individual information, we have a national health care record, how do I make sure that I can still get covered for cancer, if I, say, lose my job and have to get private insurance. It's a legislation or what are we doing about that, or would anyone like to comment?

ED HOWARD: Good question.

MIKE ZAMORE: It's an excellent question. I think my boss thinks that, the questions around medical privacy are critical to consumer adoption and acceptance of information technology in health care. These are discussions that we ought to be having right now before we start building up the technology. We need to know what the capabilities are that we needed to have with respect to privacy. I don't think we need to reopen the HIPPA question entirely, which sends everyone kind of quivering. Everyone who lived through the initial HIPPA privacy wars kind of turns into jelly when they think about doing it again. But, we do need to, I think, adapt our medical privacy kind of model for new technology and a new environment. There are some things that are very similar. If you're charting a patient on paper versus in an electronic medical record, there's not a whole big change in terms of what you're doing there. But, if you're talking about accessing a persons complete aggregate medical information from disparate sources at once that's something

new, it never existed before. We need rules of the road governing how that can be used. I think that privacy question that you're raising is essential and one that should be engaged right now. The fact that we have not gotten into that, one of my bosses big disappointments with HR4157 the health IT bill that passed the house and one of the reasons he opposed it despite a long record of being one of the most outspoken members of Congress in support of health IT, doing health IT without privacy, I think, is really a mistake and you could set back the whole effort. The other thing that I would add is that the approach that we're talking about this new bill of personal health records, one of the advantages of a personal health record is that it is patient controlled. As long as you require it be patient controlled the patient decides who sees it, it's a way to address some of those concerns about access to the records. Finally, the last thing I would mentioned is that we need a pathogenesis non-discrimination act. Medicine is getting more and more personalized. The information in our health records is going big more and more predictive of our future health care costs in a way that could devastate our opportunities for life insurance, for employment, for health care, health insurance and it's been bottled up in the House for years, passed the Senate unanimously. It's just got to happen. We need to

make sure those protections are there in the event the privacy is breached.

ED HOWARD: We're getting down to the end here. Did I see somebody standing at a microphone. You may have the last question. Right there.

MALE SPEAKER: Good, I want to end up in a positive note.

ED HOWARD: And you are, sir?

ADOLPHO [Inaudible]: I'm Adolpho from the U.S. Center for Health Disparities Research and Education. First of all I think having this scorecard is a major achievement and I want to congratulate The Commonwealth Fund and Cathy for this effort.

We are forgetting that some of us and I have retired from practice in '99 and been involved in health policies since then, have been piecemealing or trying to put together pieces of this information from so many different sources that has become available at different times in our history to put this together and to draft some kind of plan of action to address some of these issues. Here we have it. It would have been impossible to achieve this without falling through the cracks that have been pointed out. All the criticisms are valid. We're not negating that, but it's important to keep in mind that these scorecard doesn't address the issue

of how to correct and doesn't mandate how to address it. It just indicate in these broad field of inquiry from which data is available from so many sources at some levels of resolution, this is a package that we offer you the world to those who are concerned, whatever your discipline is to pick and choose. If the issue that you are interested in addressing comes from the perspective of business practices and to improve delivery of the quality of care to your constituencies of your stakeholders, plug out which are the indicators that you feel are relevant, find which are not to the standard according to your definitions and interest and correct them. That is the proper use in my mind of the obligation of this tool. Now…

ED HOWARD: I know there is a question in here somewhere.

ADOLPHO [Inaudible]: Yes. The question is having this as very broad and the temptation will be, if we're going to subject to so many criticisms to just put it aside, it becomes controversial. What I want is to highlight the potential value of this maybe not in its entirety, but in pieces of it to different stakeholders. What is the plan of The Commonwealth Fund to promote a utilization or reflection of the different elements of this scorecard in the process of

business development and policy development in the promotion of health care research? Let's put it that way.

STEVE SCHOENBAUM, M.D., M.P.H.: It's a wonderful question. As I mentioned to you, our Commission was formed really to start addressing those issues. It first needed to see what the panoply of issues was and what the current state of the health system was. That's what's led to the scorecard, and it's now moving on to trying to develop what I call the treatment plan, and I listed about seven different pieces of that before. I don't think we have enough time for me to relist them, but what I'm expecting is that we will be trying to move the Commission and Commissioners like Dr. Cassel will be trying to think about how do we best put in front of those parties, both public and private, a set of recommendations and an agenda so that in fact we can move from whatever point we're on and whichever indicator you want to look to something better. I think we can also use those indicators or we can use as other people generate new policy ideas and are doing different things to try to say well what would the effect of those ideas be on the scorecard. Are they likely to be positive, neutral or negative. That also will help, I think, in trying to say which are the most positive things that can be supported or promoted.

ED HOWARD: A pretty good last word, Steve, thank you. I think we do have to wrap it up despite some very interesting questions that we had on cards. That will teach you to go to the microphones next time. I want to thank The Commonwealth Funds, Karen Davis and Steve and Cathy and Ann Coffey was here and Alana and the folks at the Fund who have really done an incredible amount of work and who have made the basis, I think, of a very interesting program. I want to thank you for staying with some very difficult material as we went through it. I will thank you for filling out those blue evaluation forms before you go as well.

Liz Hall mentioned that Senator Frist will be leaving the Alliance Board as Vice Chairman at the end of this year and I guess we had not announced before this the fact that at our board meeting just a couple of weeks ago Senator Susan Collins of Maine was elected to take over as Co-Chair when Senator Frist leaves the board. So we're very much looking forward to working with her and her staff to try and get programs that can be of value to you.

I wonder if you can join me in thanking the panel, including Elizabeth Hall, for, I think, an excellent, excellent presentation of very difficult material.

[Applause]

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