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**Reforming the Health Care Delivery System: A Team Approach
Alliance for Health Reform, Kaiser Permanente and the AFL-
CIO
March 27, 2009**

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ED HOWARD, J.D.: I don't get a chance to say this very much in our briefings, but good morning. My name is Ed Howard. I am with the Alliance for Health Reform. On behalf of Senator Rockefeller, Senator Collins, and our Board of Directors, I want to welcome you to this program, which is centered around how we can improve healthcare quality by using multi-disciplinary teams combined with the thoughtful use of healthcare technology.

Health reform is right at the top of the legislative to-do list these days, and extending coverage of course to more Americans is incredibly important. But there is an emerging consensus that we are going to have to make reform also find ways to improve quality and value in the system. How do we do that? Well, one of the prime targets for reform is the way care gets delivered.

Some healthcare organizations have combined appropriate technology and better use of personnel to improve preventive care and treatment of chronic disease to obtain better outcomes and to offer better satisfaction on the job to their workforce.

MALE SPEAKER: We can't hear you in the back.

ED HOWARD, J.D.: So these microphones are always on but not very much. I apologize. Thank you. I will try to swallow this now. And it is timely that you can hear this part. The rest you are going to get as the substance to the hearing.

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How about this? But I want to make sure that everybody in the room knows how pleased we are to have as partners and co-sponsors in this briefing Kaiser Permanente, the largest non-profit healthcare plan and provider in America, and the AFL-CIO, a federation of more than 50 national and international unions.

Yesterday's New England Journal of Medicine carried an article some of you may have seen that found that less than two-percent of America's hospitals have moved their clinical activity fully into the electronic age. The figure for physician practices is pretty abysmal as well. We know that the stimulus package that was recently enacted is going to help a lot of providers, a lot of hospitals get the health information technology they need. But if we are really going to make progress, that is not going to be enough. The technology has to be applied effectively and it has to be used by people who understand and appreciate the potential that that technology presents for improving quality.

Fortunately there are some places where that combination is already in place and the results—in terms of better outcomes, better value for the dollar spent—are starting to emerge. The main point of our briefing today is to look at some places where that progress is being made, and to focus on what needs to be done to have that progress occur across the country.

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Now, at this point, I am very pleased and proud to be able to introduce the co-moderator of today's session, John Sweeney. John is both the President of the AFL-CIO, a position that he's held since 1995. He is also a long time board member of the Alliance for Health Reform. The AFL's member unions include thousands of healthcare workers. And I should note that John and his staff, especially Jerry Shay, have done a great deal of work in pulling today's briefing together, and I want to thank them for that. And I want to really thank John Sweeney for being with us today at this briefing. John?

JOHN SWEENEY: Thank you very much, Ed Howard. I am very happy to be here and happy to see all of you here. It is always an informative and stimulating experience to participate in forums sponsored by the Alliance. And our thanks to you, Ed, and the Alliance for helping us stay on the road to healthcare reform.

That road is coming to a critical intersection where need and history cross. And that makes today's discussion particularly timely. All the players in this debate are realizing that attitudes and public positions must change in order for us to end the national shame of tens of millions of uninsured and to remove the yoke of healthcare cost from our economy.

Private insurers and health plans are coming to understand that they will have to accept a strong role for

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government, as well as a significant new public health insurance option. Drug companies are having to accept negotiations with the federal government for products sold to the elderly and other participants in public insurance.

Employers are beginning to understand that they will all have to pay their fair share for health benefits if this thing's is going to work. Consumers, health plans, hospitals, and physicians are realizing they will have to accept major changes in healthcare services, including payment reform. And all of us know we are going to have to look seriously at how to control cost and increase quality because without both, no new system will work.

We are pleased to have presentations today on successful quality improvement efforts from the Kaiser health plan and from Montefiore Medical Center. Nobody understands all of these realities more deeply than George Halvorson, who has been pioneering in healthcare management for more than 30 years, first holding several positions with Blue Cross and Blue Shield of Minnesota, and then as President and CEO of Health Partners.

In March 2002, he was named Chairman and Chief Executive Officer of Kaiser Foundation Health Plan and Kaiser Foundation Hospitals, where he oversees the nations target non-profit health plan and hospital systems, serving more than 8.5 billion members. I know him best as an incredible partner with

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the labor movement in the Kaiser Permanente Labor Management Partnerships, which is now one of the older and most successful such partnerships in history.

I don't want to steal any of the attention from what George and his team will be sharing with us today, but I think you will be amazed at what Kaiser Permanente clinicians, managers, and frontline workers have been doing together to develop a healthcare delivery system that can serve as a model for national healthcare reform. George Halvorson?

GEORGE HALVORSON: Thank you John. It is a great pleasure and honor for me to share a microphone with John Sweeney, one of the giants of healthcare reform in America. We need healthcare reform in America. We are the only industrialized country that does not have universal coverage for its citizens. Universal coverage is way overdue. We need to cover everyone in America. We also need to reform care delivery in America. We need to get care better. We need to make care significantly better and we need to make care more affordable.

One of my favorite studies was done by the Commonwealth Fund. And they took 5 million people and studied all of the claims for those 5 million people for two years. And they looked at all of the expenses that came from care that should not have happened. They looked at care that happened from infections, and they looked at complications from chronic conditions that should have been managed. And they figured out

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how many dollars we could have saved if we could have just gotten care right. And the answer was half-a-trillion dollars. That was against a \$2 trillion spend at the time they did the study, so half-a-trillion dollars by getting care right.

The people from Mittleman and Robertson [misspelled?] took the best practices of the best run care systems in America and did a study and said if we took those best practices and extended them to every care-giver in America, how much would we save? And the answer was half-a-trillion dollars. They came up with the same 25 to 30-percent total spend. So, best practices were the same amount.

And then John Wynberg [misspelled?] took a look at the variations that exist all over this country now and said what if we got care right and did it as well as we do it in the parts of the country where we do it really well now relative to cost of quality and came up with the same 25 to 30-percent savings.

And so what we have in front of us is an opportunity to save a huge amount of money in American healthcare by getting care right. This isn't by rationing. This isn't by denying care. This isn't by shifting cost. It is just from getting care right. We need to make our agenda getting care right. We need to figure out what the right care is and then we need to deliver that right care to the population of this country.

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So if we are going to do that, we need to understand a few things about care delivery. If we are actually going to get care right, we need to figure out who is spending dollars in healthcare right now. And if you look at who is spending dollars in healthcare right now, it is people with chronic conditions, not cancer. Cancer gets a lot of publicity and we need to do best care for cancer patients, but the healthcare dollars aren't going to broken bones and broken legs. It's not going to cancer. It's not going to infectious disease. It's going to chronic conditions.

Seventy-five-percent of the costs of care goes to people with chronic conditions. And 80-percent of that care is spent with people with co-morbidities, multiple conditions. So, 80-percent of the cost is on people who have multiple health conditions, multiple physicians. And in today's healthcare world, multiple filing systems, multiple databases, multiple caregivers who don't link or coordinate care very well with each other, so the cost of care for that population is uncontrolled and growing. And the quality of that care is not good.

The RAND study that took a look at the quality of care in America concluded that we were getting care right barely half the time for the people in that population. And when you take diabetes, the number one chronic condition for cost,

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diabetics consume 32-percent of the costs of Medicare, and we get care right for diabetics about eight-percent of the time.

So, there's massive opportunity in healthcare that come from delivering care appropriately. Let me show you another very important couple of slides that we need to understand. The cost distribution of care is not even. We have a very small number of people that incur most of the healthcare cost. So, one-percent of the population is 30-percent of the cost of care. And if we could bring that cost of care for that population down to the average cost of care, we'd get the same savings that I talked about earlier and healthcare costs in America would be about the same as healthcare costs in Canada.

We have a small number of people who are incurring a lot of expense, and if we could intervene, if we could get involved in the care of these folks before they get to that point, we could make a huge difference in the quality of their care. And when you look at where the intervention opportunities are, it is in the 10-percent of the people who are incurring 80-percent of the cost. We have got a small portion of our population incurring most of the cost of care.

We are not delivering care very well for that population. We need better data, better outcomes, better care tracking, better care coordination, and there are great opportunities to do a much better job of taking care of these patients. And we could cut the number of kidney failures in

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half. We could cut the number of heart deaths in half. We could cut the number of asthma attacks that result in hospital infections in half if we delivered the right care to those populations. There is a massive opportunity about care delivery. It's about improving care and making care better.

So how can we do that? Well, if we want to go down that path, we need to do a couple of things and do them very clearly and collectively. The first thing we need to do is focus. Instead of trying to fix 2,000 conditions, we need to focus in on the half-dozen conditions that drive 60 to 70-percent of the healthcare cost in America. And we need to say we are going to make care better for these folks. We need to make care better for the people who have diabetes. We need to make care better for the people who have congestive heart failure.

And we should set goals. We should say we are going to reduce the number of people who have a congestive heart failure attack so severely that they have to be hospitalized by half. We are going to reduce the number of kids who have asthma attacks that are so severe that they have to go to the hospital by half.

If we set goals, then the beauty is you can work backwards from the goal to figure out a solution. If we don't have any goals, all we have is a lot of random, unconnected, idiosyncratic, one-off, non-transferable little care

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improvement events that don't actually move the needle very much at all on the quality or the content of the care delivery.

If we focus and say we're actually going to cut the number of asthma attacks in half, then we can step back and say "what tools do we need to do that" because the second part of the agenda is tools. Once we figure out what the goals are, then we figure out what we need to do to actually make that goal happen.

And that is where the toolkit comes in. That is where you take the electronic medical record and have the electronic medical record transform care. Now, if you take an electronic medical record and just put people's data on the record and do nothing else with it, that is just paving the cow path. What you basically then have is a record with some information on it. It doesn't cure cancer. It doesn't make asthma care better.

But if you say we have kids with asthma and we want to improve their care. What tool can we have in our hands that can actually do that? That is when you have electronic data about each kid. You know who has asthma. You follow up on their asthma care. You track to see if they are filling their prescriptions. You track to see if they have been admitted to the hospital emergency room. If they have gone to the emergency room, you do an intervention to figure out why they went to the emergency room and what can be done to end up with a better care outcome in the future.

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And if you systematically follow up on those kids, you can cut the number of those asthma admissions by anywhere from 50 to 90-percent. Right now in America, asthma is the fastest growing condition for kids. It is the number one cause of death in kids. In the African-American community, the kids are 1.4 more likely to have asthma, half as likely to be treated for it, and four times as likely to die from that condition. It's because we don't have coverage for those kids, but also because we don't have any kind of a follow up system to track the care and monitor the care and intervene in the care.

So we need to focus in some key areas. We need to collectively focus, not on 100. Five or six are enough. Then we need to set some goals in those areas. Then we need to work backwards from the goals to figure out what is the toolkit that we need to achieve the goals.

And the third agenda that we need is health. We really need to have a national culture of health in this country. We need to improve health. We could have half as many people become diabetic. If you walk half-an-hour a day, four days a week, your chance of becoming diabetic goes down to 40-percent. And if you lose 15 pounds on top of that, your chance of becoming diabetic goes down by 60-percent.

This is not rocket science. We do not have to have really complex programs. We need to get rid of trans fat. We need to label all saturated fat and train people not to do it.

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We need to get the right food into the diet so people have good food available to them. But those are all things we can do as a culture and as a society and as a program.

So if we say we are going to have healthy eating be a major agenda, activity be a major agenda, it doesn't have to be running marathons. It is literally walking half-an-hour a day, four days a week. It cuts the likelihood of becoming diabetic by 40-percent.

So we can be transformational on the health of the population. We could save Medicare just by having half as many diabetics going into Medicare. We could save Medicare by having the diabetics who are in Medicare have half as many complications.

This is not rocket science. And if we just do a whole bunch of uncoordinated, unlinked, unconnected quality improvement programs around the country and hope that they will somehow come out at a good outcome, that is magical thinking. That is wishful thinking. That is not going to be real.

What we have to do is be very focused and focus on tools and health. Healthcare will not reform itself. We need to have a national agenda to push us for healthcare reform. Healthcare is making \$2.5 trillion right now in this country. It is doing very well with cash flow and is not likely to do things to impair that cash flow. We need to intervene and

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create some goals and objectives and move us towards the end points that we want.

Remember the 25 to 30-percent I talked about at the beginning? All of those studies came up with that same number. And every one of them got there by improving care—cutting the number of people whose kidneys failed. Nobody got there by rationing. I keep hear all the time and it drives me crazy that we are going to have to get to the point and make tough decisions and say who gets care and who doesn't get care; we need a rationing model. No, we don't need a rationing model. We need better care. Better care is possible. Better care has great outcomes. Better care will get us to where we need to get.

You are going to hear some programs today that are focused on better care, systematic care improvement using the computer and using the toolkit, focusing on individual patients, and making sure individual patients have their needs met so the care outcomes are better. It is possible to do that, but as a country, we need to have enough enlightenment to do it collectively. So I will end with that and turn the microphone over. Thank you very much.

ED HOWARD, J.D.: Thank you George. George Halvorson's going to have to leave in just a few minutes, and so I would like to sort of change the regular order and give you a chance to ask a question or two before he has to leave. There are

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microphones at the center of the room both at the front and sort of the center-rear that you can use to sort of ask that question.

If I can take the prerogative of the chair, I wonder, George, if you would consider payment practice as being one of the tools in the toolkit that you are talking about.

GEORGE HALVORSON: I think we need to use the entire toolkit, including the benefit set. I think there was some magical thinking going on a while ago saying that if we gave people big deductibles they would somehow become intelligent purchasers of healthcare. And I think that was a very bad set of benefit design approaches because what it did was cause people who had chronic conditions not to get the preventive care that they needed for chronic conditions. It caused the mother of the child with asthma not to be able to afford the inhaler that it needed to prevent the asthma attack.

So, I think benefit design needs to be focused on making sure that people have the right care for their condition. And I think we need incentives in the benefit package to get people to connected caregivers. I think we need to identify the best caregivers, track the performance of the best caregivers, and then use the benefit package to incentivize people to use the best caregivers.

And I think we need to be using prepayment for teams of caregivers where we can do that. I'll give you a quick example.

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In southern California, for Kaiser Permanente, we have a program called Healthy Bones that we rolling out. The Healthy Bones program uses the electronic medical record to figure out who is at high-risk for breaking bones.

Then those people go into data registry, and every time they come in to visit with their doctor, there is a follow-up intervention done relative to the Healthy Bones. There's coaching and counseling. And we've reduced the number of broken bones by 37-percent in two years.

Twenty-five-percent of the seniors who break a bone die within a year, so it also has an impact on the mortality rate. But we've reduced it by 37-percent in two years. If we were a fee-for-service model, that would be crazy because that would be 37-percent of the hospital admissions that we would make a huge amount of money for.

So those are very profitable hospital admissions, but because we're a vertically integrated system and own the hospitals, own the care system, and have total accountability, it's very much in our best interest to prevent the broken bone. The rest of American healthcare benefits by having those bones break.

And it is even a joke within our shop that the orthopods may lose their professional standing with the rest of the society from being its own world of prevention. But it is very real and it works. It's the kind of program that we need.

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We need the reimbursement program for healthcare for all of the care providers to be set up so that the reward system is for preventing the broken bone, not just waiting until it happens and coming in. So, yes, I think we need improvements and modifications in the payment approach.

ED HOWARD, J.D.: This is the last chance for your immediate questions for Mr. Halvorson. Yes, go ahead. I will ask you to identify yourself and be as brief as you can with your question.

BOB GRISS: I'm Bob Griss with the Institute of Social Medicine and Community Health. Since most people are not integrated healthcare delivery systems like Kaiser, how would you apply the tools that worked in the integrated setting to most people in the highly fragmented healthcare delivery system?

Your personal history involved dealing with other parts of the healthcare delivery system, so I think it's a question that you probably have ideas about. But I'm looking for strategies for getting beyond the fragmentation in the healthcare delivery system so that all of the elements that you say are critical to improving health status really do come into play.

GEORGE HALVORSON: That is a very good question. Chronic care done well is a team sport. You have to have a team of people working together. When you have got all of the

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fragmented pieces of the system not functioning normally as a team, you have got to create something to connect them. You need a connector. The connectors that work best and have been done outside of Kaiser-kinds of systems have been computer systems that look like care registries.

Some of the community clinics, for example, that put care registries in New Orleans and Denver—there's a number of communities where the care registries have been put in place, and the patients with particular conditions have their data in that computer and every doctor who treats them needs to be required to interact with that tool. You have to connect with something and if you can connect with vertical integration, that's a really good model. But if you can't connect with vertical integration, then you need to connect and virtual integration can work as well.

So virtual integration tools can work and the benefit package should reward patients for going to connected physicians. And also, the payment should penalize providers for not connecting. And if you penalize providers for not connecting, facilitated connections will happen.

But right now, the doctors that want to connect can't connect. They have no way of connecting. They have no way of getting together and interacting with each other, other than picking up the phone and hoping somebody's available. And that's a really bad model. So we need to facilitate the

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connection, but those connector tools do exist. They do work. Every payer should be required to have them and you shouldn't buy health coverage from a health plan that will not make connectors available as part of the package.

ED HOWARD, J.D.: Alright, George, I think you are going to escape unscathed. They never lay the glove on you. Thanks very much for your participation and for making sure that we have people on our new panel. [applause].

Thanks to George Halvorson and to John Sweeney who have graced the program and gotten us off to a very good start. I also want to thank you, by the way. I neglected to for not only getting here reasonably on time and by coming to a completely different place. We haven't been here in about eight years. But you remembered and I'm very glad for it.

Let me just deal with a couple of logistical items that you can infer actually from the way we started. Obviously, you are going to find a lot of background information including a lot of biographical information on our speakers in your packets. And there are hard copies of the PowerPoint presentations that we had available for copying.

On Monday, you are going to be able to watch our webcast of this briefing on www.kaisernetwork.org. We are very grateful to Kaiser Network for that. If you are looking for the background materials that were distributed here, they will be on the Kaiser website at www.kaisernetwork.org and on the

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Alliance website of www.allhealth.org where you will also, a few days after that, be able to find a transcript and a podcast of the briefing as well.

Fill out the green question cards for the appropriate time when we get to the rest of the Q&A period. And as you have seen, we have microphones that you can use. And we would appreciate you filling out the blue evaluation forms at the appropriate time to help us improve these briefings for you.

The rest of our line-up of speakers is also a little unusual. It is just as high-quality, maybe even a little higher quality than our normal run of speakers. But in keeping with the idea that teamwork enhances quality, we have two teams of speakers. Leading of this part of the program, the first is from Kaiser Permanente Colorado. The second is representing Montefiore Medical Center in New York City. And we are going to turn first to John Rasmussen and Susan Kuca, two professionals from Kaiser Permanente Colorado.

John is the Chief of Clinical Pharmacy Cardiovascular Services for Kaiser Permanente. And he is on the faculty of the University of Colorado, School of Pharmacy. Susan is a Kaiser Permanente Cardiac Coordinator nationally known for her work to improve the quality of care for cardiac patients. And they have quite a story to tell about cardiac care in Colorado for Kaiser. John, do you want to start? Susan, would you like to start?

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SUSAN KUCA, R.N.: Thank you Ed. I would also like to thank the Alliance for Healthcare Reform for inviting us here to share our story. I am thrilled and honored to tell you about our work and to be a small part of improving healthcare for all.

My name is Susan Kuca, and I have been a Registered Nurse for 17 years. I currently work as the Care Coordinator in the Cardiovascular Cardiac Rehabilitation Program at Kaiser Permanente. My title is Care Coordinator, but in reality, I am a coach, an educator, a sounding board, and an advisor.

In our cardiac rehab program, a team of health professionals collaborate to coordinate care for patients with heart disease. My teammates and I work with about 1,300 patients annually. Because of our sophisticated health information technology, we are able to connect with patients soon after hospital discharge or a new diagnosis of heart disease.

Our goal is to make the initial outreach call within 24 hours. During this call, we review medications, educate and screen for symptoms, coach on lifestyle changes, and help patients identify what is normal and what is concerning. We also provide hope when many are discouraged or afraid.

The best way, though, to understand how our program works, is to look at it through the eyes of a patient. So I would like to introduce you to Paul. Paul is typical of our

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patients. He is a middle-aged male who had angioplasty and stents. My colleague made the initial outreach call where she insured that he had all the medications that were prescribed, he knew what they were for, and how to take them.

She reviewed symptoms and risk factors. Paul happened to smoke, but the hospitalization had scared him and he was quite confident he could quit without difficulty or assistance. A few weeks later, when he came to see his cardiologist, Paul's fear had faded, and so did his confidence in quitting smoking, and that's where I came in. The cardiologist contacted me and I started working with him to stop smoking and to make other lifestyle changes.

I coached Paul over the phone for about three or four months keeping his cardiologist apprised of his progress by using the electronic medical records. At the end of our work, Paul had quit smoking, lost weight, changed his eating habits, and lowered his cholesterol. One person cannot do this in isolation. It takes a team of healthcare providers working together to produce great results.

The efficiency of our EMR allows me to coordinate care, not just for Paul, but for hundreds of Pauls. And the technology systems have allowed me to spend my time focused on what is most important: the patient. As the results of our EMR, I can do discharge documentation in real-time, along with the

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medications that have been ordered. I can identify if those medications have been purchased, and if not, find out why.

Because I have access to all the doctors' documentation, translate the data, providing it in a manner that patients can easily understand. I can communicate my care plan to multiple providers and initiate referrals at the touch of a button. The technology enables our work, but it doesn't do the work. It is our people. It's the cardiologist, the nurse, our techs, dieticians, exercise physiologies, and the pharmacists, and the primary care provider working together in partnership with the patient to help that patient live a longer, fuller life.

The type of work that I have described usually lasts around three months with an individual patient. But their needs do not end at that time. We have team of skilled and knowledgeable clinical pharmacists who help patients manage their conditions over the long-term. I am going to turn the podium over to John Rasmussen, Chief of Kaiser Permanente's Clinical Pharmacy Cardiovascular Services, who will illustrate how another team is transforming healthcare with the power of technology.

JOHN RASMUSSEN: Thank you Susan. I also want to echo Susan's sentiments about being honored to present before this group today about the outcomes that we have been able to achieve for our patients.

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My role is Chief of Clinical Pharmacy Cardiovascular Services. I lead a group of clinical pharmacy specialists who help to manage and monitor the heart medications of more than 12,000 patients at Kaiser Permanente who have heart disease. Our program has been in effect for over a decade. And in that time, we've monitored and managed over 19,000 patients with heart disease. Each of the specialists that just described is trained to be an expert in medication management.

To continue Paul's story, he is followed by our team of clinical pharmacist specialists. Susan, or a member of her team, will tell Paul to expect a call from a clinical pharmacist after he completes any necessary lab work. Once that lab work has been completed, I will see that information and all of Paul's labs and medication and office visits in our electronic medical records. I will then call him on the telephone to discuss his current heart medication and make any changes to those medications deemed necessary to improve his heart health.

Using a collaborative drug therapy management agreement with Paul's physicians, I am able to make medication changes using specific guidelines. After documenting any medication changes in Paul's medical records, I will send an electronic copy of that note to Paul's cardiologist or primary care physician through our electronic medical records. And that is

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done very simply by literally pushing a button and sending that message to their physicians.

Because we know that long-term follow-up is critical for improving Paul's health and preventing another heart attack, I will continue to monitor Paul's heart medication as long as he is a member of Kaiser Permanente. We know that it's that long-term follow-up that will continue to keep Paul healthy.

While the process that Susan and I have described seems linear from cardiologist to primary care physicians, to nurse, to pharmacists, that in fact is not the case. It is always a collaborative process, working together as a healthcare team to improve the lives of patients with heart disease.

If you will look at the first slide, an important part of improving the health of our patients with heart disease is ensuring their cholesterol is well controlled. It is one part of the constellation of medical issues that we need to address in these patients.

As you can see, we have significantly improved the percentage of patients who had their cholesterol checked and controlled after a cardiac event. Much of this work is done by pharmacy technicians, quite honestly. With the push of a button using our health information technology, they are able to generate a list of patients who are due for lab work and send that list out. That's taking our cholesterol screening rate

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from 55-percent before the implementation of this program to 97-percent. And it has been at 97-percent for over 10 years now.

Now that you have a sense of how our collaborative cardiac care service works, I want to demonstrate our success in keeping patients healthy. We know that patients who have heart disease are at very high-risk of dying in the 10 years after their event. We have significantly improved the odds for our members.

This is a graph that demonstrates survival, up to 10 years in patients who have heart disease. The line you see at the top in green are the result of patients who enrolled in within our cardiac care service within 90 days of their event. The red line at the bottom demonstrates those patients who were not. If a patient is enrolled in our service within 90 days of their heart attack, their risk of dying is reduced by 89-percent.

Even if that patient had a heart attack outside of Kaiser before they became a Kaiser Permanente member, perhaps five years before they become a member, we will still enroll them in our service. That member, even though they've had a heart attack in the past, decreases their risk of dying by 76-percent once they are enrolled in our service.

Using estimates provided by the National Committee for Quality Assurance, we know that as a result of our coordinating

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care, we prevent more than 135 deaths and over 260 hospitalizations every year.

Lastly, you'll see here that because of the powerful combination of technology and teams, we really set ourselves apart when it comes to quality. According to the National Committee for Quality Assurance, we're consistently ranked near the top of the nation for heart disease care and prevention.

I hope it's clear from the presentation today that in the hands of a well-trained, coordinated healthcare team, electronic medical records, and other health information technology leads to a full spectrum of individualized care. Maximizing information for the clinician means optimizing care for the patient.

The collaborative cardiac care service has achieved impressive results by aligning people and technology in an efficient, seamless care delivery system. It is not newer or more expensive treatments, but an integrated approach to delivering the right care at the right time that has led to the results presented today. Thank you.

ED HOWARD, J.D.: Thanks very much [applause] Susan and John. Next we're going to hear from Maria Castaneda and Rohit Bhalla who are here to tell us about the activity at Montefiore Medical Center in New York. Maria is the Secretary-Treasurer of 1199SEIU where she oversees \$130+ million budget. She has been

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in the lead in a whole range of initiatives to improve patient care quality and worker job satisfaction there.

Dr. Bhalla is in charge of Montefiore's performance and quality improvement efforts. That means leadership in areas like pay for performance and heart disease care for minority populations and patient safety. So the next team is up. And Maria, you're going to start?

MARIA CASTANEDA: Yes, thank you Ed. Thank you for inviting us to share our story. 1199 represents 6,300 members at Montefiore Medical Center. We represent Registered Nurses of the Montefiore North Division and all the technical and professional service clerical members in Montefiore network.

Partnership has been the model of labor management relations at Montefiore since 1998. And our partnership focuses on three areas. One area is training and workforce development. In training and workforce development, we see a lot of our members being retrained in moving skills enhancement because we are always seeing new technology and new systems in our workplace. And without the training to adapt to the new technology, the new processes, the work processes around the technology, the technology will not do an efficient job. So we see our members always in retraining and skills enhancement.

Another area of training that we do is training our members on job classifications that are hard to field because of the market shortage. And it serves the starving needs of the

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hospital and it also serves the goal of our members for career development. Another area of our partnership is on promoting positive labor management relations to promote a greater employee satisfaction with the job and also a greater voice in the work place.

The third area is on labor management initiatives that improve quality patient care, patient safety, and patient satisfaction. And we use this by training our frontline workers or frontline members to be quality cautious and to support word processes that would improve or enhance patient satisfaction.

I'd like to turn over the mike to Dr. Bhalla who will share the outcomes of all these initiatives. Thank you.

ROHIT BHALLA, M.D., M.P.H.: Thank you Maria. My name is Rohit Bhalla. I'm Chief Quality Officer at Montefiore, and I want to thank you for the opportunity to speak here. I want to thank the Alliance and Kaiser and AFL-CIO for sponsoring. As quality improvement professionals, we're thrilled to make it out of the office to work with the care team, much less come to Capitol Hill to speak to you about our QI initiatives.

So I'm going to briefly talk a little bit about where we focus and what we've accomplished. Maria has talked briefly about our labor management partnership and I just wanted to provide the backdrop. You have some information on Montefiore in your packet. But Montefiore is a delivery system that's in the Bronx. We're a network of hospitals, ambulatory sites, and

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home health agencies in addition to community services. The Bronx is one of the boroughs of New York. It has 1.4 million people, some 30-percent of whom live below federal poverty level in a very diverse community. And that's really the backdrop against we conduct our QI initiatives.

So this paradigm, really, our colleagues from Kaiser talked about initiatives in cardiac care or clinical effectiveness. And Dr. Halvorson talked about the need for broad based initiative in quality improvements. We will talk about some efforts, to round out the discussion, that we have put in place to improve patient safety, namely our efforts around Ebola and infection prevention, as well as some efforts in patient satisfaction, and some initial in-roads we feel we've made in the area of healthcare equity.

So I'm going to show you a series of snapshots on some of the results from our initiatives and perhaps discuss the implementation in more detail during the question and answer. But here depicted is some of the results from our fall prevention initiative. Falls, as you know, are very prevalent in acute care or hospital settings. And here, what we've done is to work very actively with our labor partners and to really, if you will, broaden the safety surveillance net that we have in our facilities.

Normally we think of physicians and nurses as direct care givers as being responsible for the outcomes that we see.

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What we've done is to broaden that in this program to effectively include nurses' aides, patient care, associates, and others are labor partners so that we actually have a rounding program where people take turns on an hourly basis surveying the unit for customer services, patient safety, and other issues.

And you can see here that we implemented that program in 2004. We had a fall rate that was in the neighborhood of 5.5 falls per thousand patient days. We have now dropped that to about four. That's about a 30-percent reduction in our fall rates. It's a little bit difficult to appreciate with these relative numbers, but that actually translates to about 300 or 400 fewer falls per year at the medical center, which is that many fewer fractures and potential deaths that occur at the medical center.

Here, in terms of infection prevention, is a similar type of philosophy in that we've tried to broaden the net, if you will, of surveillance for infection control. We have actually, in addition to our physicians and nurses, also trained other members of the team and broadened the team in infection prevention practices. So these are things like hand hygiene. In addition to that is how to properly maintain an optimally clean environment and how to engage our labor partners in actual monitoring, allowing labor partners to

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actually stop a physician if they feel they are not actually doing hand hygiene properly.

In those intensive care units where we have actually done this, we've seen a lower line infection rate. As you know, line infections can result in life-threatening infections and extend hospital stays and increase cost significantly. We've seen in those units where we have actually trained the coaches. In addition to physicians and nurses, we've also seen a reduction in those rates. So those are measures of how we think we've done.

In terms of our patient's satisfaction score, if you look at an item like cleanliness of the hospital and how patients actually view those because there's sometimes a disconnect by results that we feel we've achieved. Do patients actually feel that improvement? We fare better in that regard than other New York facilities and as a result, I think our quality and safety initiatives have also received higher ratings around recommending our facility and overall appraisal of our facility by our patients and families.

I also want to talk very briefly about healthcare equity. We were one of the ten facilities in the Robert Wood Johnson Foundation Expecting Success: Excellence in Cardiac Care program, which is a program that's centered on improving cardiovascular care for minority populations—African-American, Black, Hispanic, and Latino populations.

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And one of the key ingredients in that project, which was catalyzed by funding from the foundation, was to reengineer how we actually collect race, ethnicity, and preferred language information. And so while that sounds like somewhat of a trivial task, Montefiore, as large as it is, has a registration community that's now up to 1,600 people, in and of itself, who can actually perform registration.

So we standardized those processes a couple of years ago by a large scale training process where we moved from direct observation to actually asking the question and actually changed our IT systems to do that and worked very proactively with our labor partners. Most of the registration staff that we have are unionized personnel.

What we have been able to accomplish is to actually reduce the proportion of our patients where we don't know what their demographics are. One of the challenges that organizations face is in terms of actually proactively addressing disparities to be able to actually evaluate themselves and how they're doing at their own institutions.

And so, as you can see here, we've reduced the proportion of our inpatients where the demographics are unknown. And what that allowed us to do during the lifecycle of the project was to effectively evaluate cardiovascular care, not so much for all of our patients, but to look at cardiovascular care for each of our demographic subgroups that

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we see. And that has allowed us to now start the building blocks to be able to develop more patient-centered services in the future.

And then finally, I would just close with this. I talked briefly about making changes from our perspective that we feel improve patient care and how patients perceive that benefit and, to close, with how our employees perceive the benefit. These are the results from our associate opinion surveys which are conducted every couple of years. We have over 10,000 employees who are surveyed. The response rate is in the neighborhood of 50 to 75-percent, depending on the year of the survey.

And you can see the pertinent items that pertain to these types of initiatives—the job making good use of skills and abilities, getting the training to do a good job, the workplace, and their immediate work area providing high quality care and service. The score is going up. This scale is from one to five, one being strong disagreement, five being strong agreement, and also the perceptions of the organization as a whole and its commitment to quality and safety improving the ability to provide high quality care and services, as well as, the level the pride to be working in at Montefiore. So, I will close there and thank you for you time.

ED HOWARD, J.D.: That's great. Thank you. Thanks very much, Robit and Maria. Our final speaker — I'm sorry.

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Our final speaker is Dr. Carolyn Clancy. She is not a team but she is a great team leader as Director of the Agency for Healthcare Quality and Research, a position she has held since 2003. She is responsible for HRQ's annual reports on quality and disparities that a lot of us look to every year. She is overseeing the only federally funded comparative effectiveness research for the last couple of years. A project that's about to get a lot bigger I guess.

Carolyn is an internist and, I'm happy to say, a veteran of a number of Alliance for Health Reform panels. You've heard some excellent examples of how individual institutions and groups can improve quality and Carolyn can help us to apply those principles more broadly and get some system wide improvements. Carolyn?

CAROLYN CLANCY, M.D.: Thank you, Ed, and good afternoon everyone. I'm really excited about to be here. Many talks I give about improving quality and safety start with the idea that it's a team sport and I think you've heard two fabulous examples. So, the idea that serious sustainable health reform has to include focusing on improving how we deliver care is not new, but I think what you're hearing here today is tangible excitement about the possibilities.

This is from an article in *The New York Times* a couple of years ago and had you seen the article, you would have read about the fact that although we've become increasingly

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excellent and proficient in the acute side of cardiac care, when you get to the people who take the medicines that they need to make sure that they are not going to be back for another procedure or, frankly, don't die from the disease, not so much. We don't, we do a pretty terrible job. So the work that you hear from Kaiser in Colorado is incredibly important

So, I just want to talk a little bit about making reform of how we deliver care apart of healthcare reform, share some success stories with you. So, our mission at AHRQ is to improve the quality, safety, efficiency, and effectiveness of healthcare for all Americans. In general, our high-level priorities are patient safety and quality, health IT, and effectiveness in comparative effectiveness of services.

We also support a lot of data and analysis needs for policy makers. And I should have pointed out at the outset, although I'm giving a solo presentation, I'm very pleased to see at least three members of the team I am privileged to work with who are here.

Our key challenge I think in actually getting to sustainable health reform, to get to that 25 or 30-percent you heard about from George Halvorson is we're not going to get there unless we both do the right thing, as well as, do things right.

Now, comparative effectiveness research, which has been the subject of a great deal of excitement and my new middle

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name is error for all the resources that we're getting from the Recovery Act, is very much focused on do the right thing and we will return a good value on that investment and we are incredibly excitement about it. But that is not going to solve all of our problems in healthcare delivery. We also have to have an equal focus on doing things right and that's really what we're talking about today.

So, I wanted to share with a success story. One of our early patient studies, patient safety studies was done in the state of Michigan. Now to be quite honest, AHRQ was actually one of the minority funders here because Blue Cross Blue Shield Foundation in Michigan did a fair amount of the funding, but it involved 108 hospitals in the state of Michigan. Now we're talking very tiny rural hospitals and we are talking the University of Michigan and about everything in between.

And what they focused on was reducing serious bloodstream infections from central lines. Here in an ICU, it's very common to need a central line between we have to treat you with all kind of stuff that we can't put in a peripheral vein. They are very, very helpful, therapeutically very important; however they provide an excellent nestis for bacteria to get introduced into the bloodstream. It is a very efficient way to kill people, which was not the idea to begin with.

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So, it turned out the CDC had been collecting data on how common these are. They actually had good practices but they simply were not being implemented. So Peter Pronovost and his team at Hopkins worked very closely with the Michigan Hospital Association. The intervention is pretty straightforward. All team members in the ICU agree on the Kopman approach based on CDC recommended practices. They collect data to see how they are doing. They get that reports back quarterly, so that they can see the connection between what they are doing every day and the progress that they're making. And the results were dramatically reduced infection rates across the state that have been sustained. Not rocket science, actually harder than rocket science to get people to all play as part of a team but dramatic results. That's the kind of scalable success that we need that George Halvorson was alluding to, not just hearing about one improvement problem - program in one particular institution.

So, we are very pleased that a few months ago we began work with the AHA's research arm to expand this project to ten more states and as a result of our own item appropriation will be adding another 20 states so, coming soon to a hospital near you or your relatives or people that you care about.

The most remarkable thing about this for me was hearing a leader in ICU medicine say "of course, we knew about infections but we thought they were inevitable, part of the

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ticket price for getting care in an ICU because we thought we were working really hard to get rid of them and that just didn't happen." This actually challenged everyone's assumptions about what's possible and, of course, then the teams want to go on to tackle new problems. It is very energizing, as well as, incredibly good for patient care.

Now several speakers have mentioned health IT and we've had the opportunity to fund between \$200 and \$300 million worth of projects and initiatives since 2004. This has to be a team sport, as well. Otherwise, if you simply digitize what we're doing now, you can actually speed up how fast we make mistakes and that has been reported in the literature, as well. I won't delve on that.

I do just want to share an example for one project that I think gets to a member of the team that we sometimes forget about which is the individual patient. This is a project in Virginia through Virginia Commonwealth University, which is highlighting something called My Preventive Healthcare designed to increase the delivery of healthcare services. And this is being done in a primary care practice based network.

Now, one of the projects that we have worked on with the Department of Defense, which has become a very important partner for us, is something called Team Steps; team strategies and tools to enhance performance in patient safety. It

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improves communication and teamwork skills among healthcare professionals and has been adapted broadly across the U.S.

In fact, I got an email the other day that for early registration it would only cost \$995 to go to a conference to become a trainer in this program. The teams that are being supported here that do all the training are almost overwhelmed with enthusiasm and excitement. This is really great stuff for hospitals. I'm going to skip over the next few slides but you will have the details in terms of how it was developed. It's very; based on vigorous science and some of the communication information looked very simple to some of my other colleagues at AHRQ.

So let me just say that if you think about it, there is more communication checks that goes on at Starbucks than there is in most of healthcare. Right? You order a coffee, they read it back, they tell their colleague, they read it back, they write it on the cup. We simply don't build that kind of error proofing into healthcare. It's possible and it pays off big.

So, these are just these slides that illustrate that it has been very widely disseminated in peer review literature based on very good science. There are a number of national implementation teams and they are completely exhausted. We recognize that all members of the team need the best possible tools so I'm showing you here a free evidence based nursing

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book that was written with a number of experts in the nursing field. I would commend it for your attention. We did this in collaboration with Robert Wood Johnson. Having reviewed it a couple of the chapters, I can tell you I was astonishingly impressed.

One of the projects that we also supported, which was published very recently, is something called Project Red for the reengineered hospital discharge. Those of you who have never been in a hospital or picked up a family member will know what is going on at hospital discharge. The patient can't wait to get out of there. It's very noisy, chaotic; please take me home to my own bed. The family no matter what, how much they've planned has been held up because they were told to come at 10 and it is now 12:30. They can't wait to get out there either. So the very moment when seamless and effective communication is required is when everything stacked against it happening.

So, in this project, what they did was to work with nurses and pharmacists and it sounds a lot like what you heard in Kaiser for cardiac care. And they were able to reduce subsequent utilization of the next 30 days by 30-percent. We're talking return visits, preventable readmissions to the hospital or return visits to emergency department. We're having a webinar on this next week. As of two days ago, over

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1400 hospitals have signed up to be part of this. They're anxious. They want to go. They need the tools and so forth.

So, my bottom line here is that this is a team sport, a common understanding and common strategy or focus, as George Halvorson said, an easy way to collect data so you know how you're doing. A lot of what's happening in quality right now we see report cards and we've made a whole lot of progress on that front, but if people don't get the feedback of that information in something close to real time, what they think is it's the quality department's problem. When I can see the connection between my day job and that report card, then it has a great deal of meaning to me. And, of course, these tools have to be adapted based on the specific circumstances involved.

The last comment I would make is Team Steps and some of these other programs have worked incredibly well in hospitals and that's something to celebrate and to continue it to expand and spread. Where I think we're going to need some help and some serious thought about the right infrastructure is in primary care. There is a lot of interest now in medical homes but when we try to think about creating a Team Steps for primary care settings, there is not a 'their' there to connect to.

So that gets to your point, Bob Griss. Health IT, I think can be an important backbone of creating virtual systems

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but there has got to be something to connect to and its not just about moving electrons. So with that, let me thank you for your attention and look forward to your questions.

ED HOWARD, J.D.: Hold it up and the staff will bring forward or you can as the lady at the microphone in the back of the room is about to do, come to the microphone and actually ask your question. Please identify yourself.

CLAUDIA BUTLER: My name is Claudia Butler. I direct policy and advocacy for the Americans Society of Consultant Pharmacists, who represents pharmacists who are not working, well some of our members do work [inaudible], but most of our members do not. Some of them focus and we are focused on the appropriate and effective [inaudible] of the elderly.

I'm really thrilled that Dr. Rasmussen was here talking about the role of pharmacists at Kaiser. I want to make a statement and then ask a question to Dr. Clancy. I had the pleasure of interviewing, Dr. Chester, Dr. Chester who heads at entire public pharmacy program at Kaiser in Colorado just a few weeks ago to get an understanding of the scope of the involvement of pharmacists in a private program.

In fact, Kaiser employs I think over 175 clinical pharmacists, in addition to the [inaudible] in cardiac care there several other specialty care clinics focused on anticoagulation as far as pharmacy call center that deals with

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just the issue that Dr. Clancy talked about the transitions of care.

And we're getting results for example, when you see a risk of capital in 60 days of nursing following discharge by 78-percent, a very, very, very striking improvements in quality. In addition, every single new addition to Kaiser Colorado sees it own performances and every single [inaudible] clinic has specialty pharmacists working in that clinic.

Knowing that medications are so important in our healthcare system, but also create lots of problems it's a \$200 billion problem, what is the goal of pharmacists right now our healthcare system, you take pharmacists only for dispensing drugs, the product. We don't really pay them, outside of Kaiser, the VA, and a few other places, they're really not a value in pharmacists for their [inaudible] services, and yet we see that when we use integrate pharmacists into primary care, there really is a huge benefit.

So my question to Dr. Clancy is how can we fix this in our healthcare systems, particularly Medicare where the cost of the [inaudible] and the potential saving and quality of care can produce effect.

CAROLYN CLANCY, M.D.: Well thanks for your question, Claudia. I appreciate it. When I was on the faculty at the Medical College of Virginia, we had the privilege of working with pharmacists closely in the medical clinic and I use to

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think that our medical residence would be completely unprepared for private practice because that same team would not be there. They were amazing.

I know that some Medicaid programs have tested some demonstrations to make pharmacists a viable member of the primary care team. I don't think the reimbursement rate was sufficiently attractive to attract a lot of participation. I think it comes down to the point that George Halvorson made earlier about changing payments. And I think particularly for folks, I'm thinking of my dad right now, who is on multiple medications where the opportunity for challenges is enormous. And the opportunity for adverse interactions and so forth is ever present, that we're going to have to be rethinking some models about payment that would include pharmacists as part of the team.

My guess is it's not going to say you have to give pharmacists X amount. It's going to be much more of a prepaid or prepaid like arrangement. And I'll leave it at that.

VALERIE TATE: Hi, I'm Valerie Tate. I'm the quality care program's coordinator for the Nurse Alliance of SCIU Healthcare. I'm a registered nurse. My question goes to the costs and benefits of the labor management partnership or involving front line workers in the assessment, diagnosis, design, implementation, evaluation, of quality improvement initiatives to delivery systems.

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You know, for instance, have you been able to measure or anecdotally can you tell me anything about recruitment, retention, how it affects patient outcomes, financial outcomes for the hospital this tapping into the incredible resource of our front line workers in making these quality improvements. Thank you.

ROHIT BHALLA, M.D., M.P.H.: Yes, I think I can start with that. Certainly in terms of some of the information that I showed, I think that there certainly is a business case in terms of if you look at the cost of care associated with hospital acquired infections, as well as falls and so forth. If you look at the amount that is paid for a hip surgery versus a hip surgery with a fall, there is a tremendous difference. I think in terms of the business case following on that also from the organization's prospective, the improvements in quality and service we hope translate into increased volume at the medical center overall.

Some of the, obviously some of our services are elective and some are emergent of course, and our reputation with respect to quality and service certainly drives a lot of our elective volume. Further I think in terms of retention, I think Maria can talk more about the partnership in the workforce. We've certainly seen gains with respect to those improved trends in satisfaction among our associates as we've gone through these efforts.

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MARIA CASTANEDA: Well, the slides that talked about the improvement on our employee satisfaction shows you that despite of all of the work that we're doing, our worker satisfaction keep increasing to go up every time we survey our members. And I know at Montefiore, maybe the nurse – our nurse manager, Eva, can show, tell us something about the rounding that they do at Montefiore that really increase patient satisfaction. At the same time, it gives joy to the workers who are doing it for their patients because they get a lot of thank you notes from their patients as they get home and they get discharged.

ED HOWARD, J.D.: Okay, yes, go ahead.

FEMALE SPEAKER: [Inaudible] at Research America [inaudible], how are you?

CAROLYN CLANCY, M.D.: Great, thank you.

FEMALE SPEAKER: This question is really for you. I wanted to point out what confidence level you have that research can improve health which is happening all along and all through the healthcare system. It's going to be part of our thought process when we are reforming healthcare. It is very complicated process when you think about teams, certainly the research, the teams of everyday better ways to treat people and ultimately prevent. How can we design a system that is going to adopt that complete, absorb it quickly, and works it quickly and efficiently?

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CAROLYN CLANCY, M.D.: Well, I think those are incredibly important questions. I think the first part of that is actually getting to some very clear priorities for what we want to accomplish in healthcare by way of improving health. There is a National Priorities Partnership which has begun some very important work that front and I think has got about the high level of priorities. Transitioning from there, from where we are now to there is going to be an interesting kind of journey but I think at the end of the day, everyone believes that we are going to have changed how we pay for care with more of a focus on results.

Now that can't be the whole basis of payment, but I think that we're also going to have to provide incentives for strategies that we know are highly effective. I mean on some level what you're hearing up here is voluntary and it is exciting and you know what for health professionals who train to do the very best they could for patients, it is highly rewarding. But you've also heard President Obama say on the campaign that he's expecting families to save over time about \$2500 a year.

There is a huge opportunities in terms of improving quality and efficiency, so I think it will get a big focus and frankly I hope today's dialogue and subsequent meetings is a big part of linking this to the investments in the Recovery Act to the ongoing discussions about reform and so forth.

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When I talk to folks on the Hill about performance improvement and the science there. They get it. So stay tuned but we're going to need everyone's help to be part of this. That will definitely be a team sport.

ED HOWARD, J.D.: Carolyn, just following up on that a little bit, how closely do you think that model ought to go forward by applying some of these lessons directly where the Government has a little more say in the way things are run such as the Medicare program?

CAROLYN CLANCY, M.D.: I can tell you that my colleagues in HHS would probably want to exploit every opportunity to encourage and incentivize the best possible care. At the same time, there is a question about how far you can go if there is not the capacity to do that. So I think a strategy that said everyone has to do exactly like what Montefiore and Kaiser are doing would probably not go too far. I mean we could mandate it but it probably wouldn't be happen.

So, I think that there is going to be a trick in terms of trying to figure out what are the core elements that you need to be, that need to be incentivize and encouraged or potentially even required, but that are general enough that could be adapted to any local circumstances whether you're in Montana, Idaho, or a rural corner Nebraska. I was looking over Ed's shoulders and he had written that as a note to himself.

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And at the same time are specific enough to get us the results that we want. But that I think is going to be the challenge we have.

KATHY NASHIM: My name is Kathy Nashim [misspelled?] I'm the executive Director of the Maryland Healthcare Association. So I think my curiosity is that people could actually do a part two on the team approach in terms of talking about home care, because home care is currently using like monitoring and case management and all the elements of what we've talked about here today but they're doing it in home setting where there is no room and board and less chance of some of the other things that happen in the hospital.

Given the fact that hospitals are up against the insurance pressures to get people out of the hospital, I'm curious as to how these team approaches are currently using home care or how they envision they would use home care in terms of our goal to continue to provide care in the most appropriate setting.

CAROLYN CLANCY, M.D.: I'll just mention two things briefly because I think it is an important question. One is that theirs is a group of folks that emerged over the past six or eight months that's looking at improving quality in "long-term care." And I'm saying putting that in quotes because what they're doing is looking at all of the settings from home to short stays in nursing homes, skilled nursing facilities and so

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forth where a patient might be and trying to figure out do we develop measures and approaches to focus on the patient's journey rather and that it is patient centered rather than setting specific.

So I'm very excited very excited about that. I never thought a meeting here in Washington in late August when the Congress was out would attract an energetic group of over a 100 people but sure enough. So they're busy at working. Brookings is having a lot of to do. They Engleberg Center for Health Reform working with many, many other partners. So, that and a number of grants we're focusing on and I think give me cause fro optimism.

The VA's program, My Healthy Vet, actually does take an electronic approach to the care of homebound veterans. And effectively what they have is a portal that helps the multiple caregivers including those who live with the individual patients, social services, different healthcare workers, all of whom are coming and going at different times, different days of the week. It provides a very clear organizing framework and plan and a team rulebook if you will. They've had very dramatic results when they have begun to evaluate that in terms of avoidable hospitalizations and avoidable bad outcomes.

So, I think you're exactly right and again the trick I think is going to be to figure out do we bring all these pieces together.

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MALE SPEAKER: [Inaudible] of America and I really I enjoyed hearing about some of the work that Kaiser is doing on [inaudible] for prevention [inaudible]. And I guess one of the things that I wanted to ask about obviously chronic disease, is an over paid visit, really a large cost to our health system but blood work at Kaiser or any of the other panelists doing to prevent some of these onsets of chronic disease and especially interested in what kind of outreach or collaboration is being done with kids, for example. I appreciate it.

GEORGE HALVORSON: So, let me address your question about what is Kaiser Permanente doing to prevent some of the things that we talked today. The Kaiser model is set up primarily for prevention. We have specific departments who deal explicitly with preventing some of the diseases that we talked about today.

What Susan and I have talked, we act as sort of the SWAT team, if you will. Despite all of our best prevention efforts, bad outcomes do occur and so we've focused our efforts on that specific population of patients but that's a small slice of the membership in Colorado, so even more efforts are focused on preventing some of the events that we talked about today.

ROHIT BHALLA, M.D., M.P.H.: I can also add from our organizational prospective that in terms of preventive efforts, we've done a lot of work there. I think one of the issues in

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the Bronx is obesity and diabetes. The prevalence of diabetes in the Bronx is about 50-percent higher than New York City. Obesity and overweight also about 50-percent, certainly pertinent to the pediatric population as well.

So, there I think its, in addition to what the organization can do and what it can measure, how it can effectively partner with other stakeholders in the healthcare systems. So in the area of diabetes, as you may know, the New York City Department of Health and Mental Hygiene is now required labs in the city to report glycosylated hemoglobin values, which are basically the test that tell how well a diabetic sugar is controlled.

So we're actually working with them to start to develop our capability to create registries. So we actually know who our diabetics are in our population. Normally an organization will look at the group that it sees who happens to come through its doors but by partnering with agencies such as the City Department of Hygiene and Mental Health we're able to actually start to develop the capacity to actually identify a cohort or a group of people who have a given condition.

We're doing the same thing with respect to pediatric populations with obesity. Its one thing to note down the height and weight on a piece of paper when a person comes in the door. It's another thing to make sure that's entered into an electronic system and then have a cohort that can then be

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used for outreach efforts. So from an organizational end, in addition to what we're doing on our own, those are areas where we look to more effectively partner with other stakeholders in the community.

ED HOWARD, J.D.: Let me just follow up on that. There's a question here that talks in terms of prevention in general and how you can get CBO to score prevention as something other than a big cost item. But it does raise the question or whether or not the kinds of things that all of our presenters both from Colorado and New York were talking about; whether they, in addition to improving quality as they demonstrably do, save you any money. And if George Halvorson is right that all of this money is right there to be plucked out of the system, CBO ought to be recognizing it. So there does seem to be some dispute in the literature about how much money you can save by doing prevention. What's your experience, or do you have experience?

JON RASMUSSEN: So, our experience at Kaiser, certainly when we created some of the programs that we have, we want to improve the health of our members and wanted to see quality outcomes. But we're also very pragmatic in realizing if that costs a tremendous amount of money, long-term success isn't assured. So while we've talked a lot about quality today, certainly we're focused on providing the most cost-effective care.

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And having done with the cardiac program what we've done for over ten years, we have evidence now that shows that we saved a tremendous amount of money, generally around hospitalizations. I can't give exactly numbers today; we'll be publishing that data hopefully later this year, but we have seen those outcomes. So when we talk about policy being developed and how do we invest money now, hoping that we'll see cost-effective care down the road, we've done it. We've invested that money, invested that time in people ten years ago, and now we're reaping the benefits of that quality work in reduced hospitalizations and reduced deaths.

ED HOWARD, J.D.: So that's the trick, look beyond the ten-year window that CBO usually uses. Anything that you'd like to add to that?

ROHIT BHALLA, M.D., M.P.H.: No, I think — yes, I'd agree with that.

ED HOWARD: In the back please.

FEMALE SPEAKER: [Inaudible] quality and innovation, innovated work [inaudible] you can identify similar innovation. But I wanted to get past the technology issue. We've also done a two-year really drilldown to [inaudible] hospitals look at the impact of technology and the patient's safety quality eases tension on all professionals that [inaudible] pharmacists and [inaudible] and others.

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And you did [inaudible] Jon and Maria, are you seeing that you're engaged in the purchasing the design of deployment [inaudible] equipment and the more technology or systems are purchased, which is something that was identified in all of the 25 sites as a real serious issue. That decision [inaudible] but that they ought to be allowed the staff [inaudible] rather than having to [inaudible]. So I'd like to – are you engaged and Kaiser also is part of another [inaudible] study, case study on find the notion about the amount of time wasted by health professionals hunting and gathering trying to fix the equipment.

So our effort, the next part of our effort is clearly is the hospital association and others to really involve people before decisions like that are made. So I'm wondering if you all [inaudible].

SUSAN KUCA, R.N.: I can tell you that at the case coordinator, so I am a staff nurse, and we weren't involved at that level in my day-to-day work whether we weren't a – they didn't come to us and say which system should we choose, which quite frankly I'm grateful for, because my knowledge of the systems that are out there isn't enough to be able to speak to that.

I can tell you that once the system was in place and we had some training, we have been allowed to use it as long as we're meeting certain metrics and gathering certain data, we

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can adapt that system to our particular unit's needs. And because we've been able to adapt the system to our needs, we used to employ a full-time nurse in the hospital six days a week, reading through paper charts looking for our patients. And now because of the use of technology and skill sets, our cardiac techs are able to electronically gather data regarding laboratory values and procedures, do the screening as part of their routine day, and then send that to us electronically.

So it's saved us a tremendous amount in efficiency. I don't have the dollars that we saved, but I can tell you that the efficiency of the work and putting the right person doing that piece of has helped. So it's more the adaptability of the system which Kaiser has allowed us to do.

MALE SPEAKER: Yes, we – Deborah, do you want to – microphone?

ED HOWARD, J.D.: And you'll want to identify yourself.

DEBORAH KING: Hi, my name is Debbie King. I'm the Executive Director or 1199SEIU's labor management project and training project in New York, and we're doing similar work that you've heard about from Dr. Rohit and Maria in about 50 different institutions. And one of the things we find in terms of the electronic medical record that it is very important to have employees have a choice of the use of a record.

For example, we – I just did a project in 20 nursing homes. Susan, they didn't have to be experts on the

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technology, but the company gave the nurse's aides different models. It could be a handheld PDA, it could be a computer screen, and they were able to say what was most useful to them. And also in terms of how to use it, were there different innovations in the way it could be programmed, and then found that when they got the equipment, it was really customized to what they wanted to use it for.

But also I think a very important thing is that we don't want people just to learn how to use technology, we want them to understand what the technology is about in terms of how it can improve care. And that was part of the project that we did to help people really understand that. And we have to make sure, I think, when we're going to do a major national effort on this that this – that that frontline healthcare workers and our technical professional workers really have ownership of this new system.

ROHIT BALLA, M.D., M.P.H.: Is it all right if I comment? Yes, I would say that we put together interdisciplinary groups to evaluate proposed technology first and have a user group too effectively – so we do certainly engage our staff in that process.

As an example, we implemented computerized physician order entry about a decade ago. That's basically the electronic ordering of medications as opposed to scribbling them out on paper. And that implementation was done in – it

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started in the early 90s. The commitment actually was in the mid-90s, which is about four or five years before the Institute of Medicine report *To Err is Human*. It actually talked about the magnitude of medication error and medical error in healthcare. So we had an advanced commitment to it, but whenever we do an implementation, we do have an interdisciplinary group that comes together that is actually responsible for making the final selection of the group that we go with.

And I would just say that one of the things in the discussion about IT that I think is often lost is that even though it's electronic, it's not an on and off switch. There is a tremendous amount of training and work that has to be done once a system is implemented because healthcare is such a complex service that the moment you introduce a system for the simplest aspect of care, a lot of work has to be done to assimilate that.

So if you look at something like computerized physician order entry, which just deals with initially the narrow slice of physician prescribing, we actually didn't roll that out in a month. We took somewhere on the order of four years to roll that out. It was start low and go slow, but we feel that that has resulted in uptake of the system where the physicians were onboard guiding the evolution of the system.

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And I would also just point out one other distinction, which is that when we talk about IT, we often talk about its implementation as kind of a dichotomous thing. Is it done, yes or no? Once the system is implemented, there are a whole array of possibilities in terms of making better or worse use of that.

Some of you may look at the medical literature periodically and have seen that there are some good papers now that show that, for example, alerts on drug interactions are frequently ignored. And when I say frequently, some papers say as much as 90-percent of the time. So just implementing the system is not good enough, it's - you need to get people's input, you have to have multiple stakeholders involved in the system's implementation and then also utilize their insights to make the system better to work for them over time.

ED HOWARD, J.D.: If I can, there's a question asked on a card that is very much related to the earlier answers to this question. Since the - obviously, 1199 has been so involved in many of the instances of introducing technology, and there's a unionized workforce as well in Kaiser Permanente.

Both of the examples this person points out that we've heard today are of unionized workforces. Some might expect that unions would be a barrier to the introduction of efficiency and technology, and I wonder if you could elaborate

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on the possibility of your work and success to be replicated in union or non-union kinds of atmospheres.

MARIA CASTANEDA: Well, I want to address that first of all, I think unions have evolved the – our vision, union vision has evolved. I'm speaking for SEIU; we're not just a union that address bread and butter issues of our members, but we are also a patient advocate. So anything to do that I will improve quality patient care, we are for it. I think we're also getting sophisticated in understanding the environment we're in, how healthcare's industry is undergoing a challenge, so much challenges – funding cuts, you know. So we have to work together not to fight to who gets the bigger share of the pie, but to work together to create a bigger pie.

Second, this model is not unique to Montefiore. In fact, in New York, all the hospitals that we represent, they always tell me we want to be like Montefiore in the Manhattan area. So this model has been replicated in New York in nursing homes.

And second, because we are SEIU nationwide, we are always visited by our labor management teams in different parts of the country, Florida, Pennsylvania, California, Seattle, to learn what we're doing so that they can start something in their own areas. And even non-union hospitals who are involved in trying to work with us, they are looking – the reason why they're not resisting unionization because they feel that our –

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the model that we're doing, we adding value to their mission and vision of their hospital.

ED HOWARD, J.D.: Anyone else? Susan?

SUSAN KUCA, R.N.: I'd like to address that comment, as well. I am a Local 7 member, which is the union that organizes the health professionals at Kaiser Permanente in Colorado, and we have in place which is called the Labor Management Partnership Agreement. So it's a combination of managers, it's a combination of labor people coming together to make decisions on how we're going to implement and roll out things. So we work together, it's not an adversarial relationship that we have.

Whether that these can be rolled out to non-labor, non-unionized shops, two of our contract hospitals, Kaiser in Colorado is a little bit different. We don't own the hospital systems that we use; we have contracts with a couple of different hospital systems. They are going to different kinds of health technology, health information technology, and as far as I know, they – neither of them are unionized. So it can work in either an unionized or a non-unionized shop.

ED HOWARD, J.D.: Okay, we have just a couple more minutes if you – there was someone standing at the other mike, but I think they've been discouraged. As we finish up, let me ask you once again to take a moment to fill out the blue evaluation form. And let me take this opportunity to ask one

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of the questions exactly submitted in advance, and it is directed to both of our teams here. What kind of resistance has there been in the transition to team delivery models like the ones you've been describing? And for those who might try to transition to the model, what can be done to facilitate? Go ahead.

ROHIT BHALLA, M.D., M.P.H.: I think - yes, I think that at the end of the day, this is doing quality improvement has changed. It's generic change, and so I kind of view it as resistance to change in general. There's always going to be resistance to changing the status quo.

I think each constituency responds differently to different levels of [inaudible]. I can speak for the physicians, and that's why I showed a lot of data as if the physicians respond to data. I myself, before we started the rounding program for falls said, so let me get this straight, we already walk around three times every day to go see our patients. We're now going to walk around every hour to do this?

And so we piloted it, which is a basic premise of quality improvement, is start small, see if it actually works. And the pilot had great results, and so we fanned it out and now I'm here speaking to you about its merits because the data actually shows that it works. And so depending on the constituency, different things are important. I can say data,

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certainly for our professional staff, is extremely important. That feedback is very important.

Same things goes with line infections; if you look at central line associated bloodstream infections, what's happened is nothing less than revolutionary. It's gone from being a forever event to being a never event. We have intensive care units at Montefiore now that have not seen a line infection for eight months. And so – and that is strictly by rigorous adherence to all of these quality improvement practices, enlisting all of the members of team in the process, and lo and behold, you come back and you post on the intensive care unit, a chart that says January, zero, February, zero, March, zero. That has a very powerful impact on the staff. So when you get to July and people are not feeling as motivated, they look back at all the other zeros and they keep going and they keep doing the right thing. So I can certainly speak for the value of data in that process.

ED HOWARD, J.D.: Jon?

JON RASMUSSEN: I'm going to mix medical metaphors a little bit here and say that what we've done at Kaiser isn't brain surgery. What we've done is taken evidence-based therapies and put them – used a team-based approach in a structured fashion. And the health information technology we have available to us has sort of been that special sauce that's been the catalyst to allow us to see the results that we have.

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And we've been very fortunate in that all of the different members of the teams, from the physicians to nurses to pharmacists, have bought into the fact that roles, traditional roles, had to change in order to see the outcomes that we've changed. Certainly they call it the art of medicine for a reason, because there's always going to be negotiation about what's best for an individual patient. And what we've been fortunate to have is, in that team-based approach, that back and forth between physicians, nurses, pharmacists, all the members of the healthcare team can be them very effectively electronically across a very wide geographical area.

So when we think about transferring some of the things that the panel has talked about today, tools that we have make that possible to do it in Montana or a rural corner of Nebraska.

ROHIT BHALLA, M.D., M.P.H.: And I don't know if there's time, but I mean we have several members of our team here and not to call them out, but Eva could talk about the different roles and responsibilities of different people in some of our initiatives and how she's promoted engagement with them. Carol could certainly, if time permits, talk about how we build consensus among the registration community to make some of these changes that we made in our registration system if you want. It's up to you in terms of time constraints.

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ED HOWARD, J.D.: We have a moment if you would like to try.

ROHIT BHALLA, M.D., M.P.H.: Do you want to step up and just describe?

EVA WILLIAMSON: My name is Eva Williamson, director of nursing at Montefiore Medical Center in Bronx. I'm pleased to say that Lemanine [misspelled?] have partnered with us leadership team in getting the nursing associates, the nursing attendants, the service associates onboard to help us with rounding and improving patient satisfaction, also decreasing the amount of complaints we get from patients on a daily basis.

I must say rounding every hour by the nursing staff both worked for the patients and the staff. It decreased the amount of time the patients have to call for some additional things. When the attendants go in the room, they anticipate the patient's needs. So it'll address position, pain, personal need, and if patient may need to go to the bathroom. So instead of the attendants leaving the patient's room, they always check and see is there anything else I could do for you, I have the time. Once they do that, that also help the patient trust the employee, also that they know that somebody will always be there for them.

Also it, as Rohit mentioned, it also decreased the number of falls that we've had over the years since we began this process in 2004 and the amount of money that we had to

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spend on taking care of falls with fractures. The nursing staff also, now, they began to utilize our daily huddles. Nursing attendants speak about things that they find on rounding and how together, the entire team can make a difference in the patients' lives. I think from — I was a former nurse manager in a nursing unit, and to see that the staff have evolved and looking at it as a partnership with Lemantine [misspelled?] is not just they're our adversaries, we're in it together with one goal, patient care.

ED HOWARD, J.D.: Good. That sounds to me like a very appropriate last word in this conversation. We've heard a lot of great examples of ways to improve quality and value. Now, the trick is going to be to convert those anecdotes into analysis and then into policy. And we're going to be open to those kinds of suggestions, and we'll be happy to work with the folks who are in the policy-making business to try to make that happen.

I want to thank Kaiser Permanente and the AFL for working so hard to put this program together with us, and I ask you to join me in thanking our panelists for some really enlightening observations about the way things really work in the healthcare field. Thank you.

[END RECORDING]

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