

One-day Conference: Delivery Systems Matter! Improving Quality and Efficiency in Health Care March 17, 2004

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MALE VOICE: Kaisernetwork.org.

MALE VOICE: What we want to do this afternoon is think about some of the themes that were developed this morning and how they can migrate to less organized settings as a way to create more organizations and integration. And we have an excellent panel to do that. And chairing is Dr. Christine Cassel. Christine is the President and Chief Executive Officer of The American Board of Internal Medicine as well as the ABIM Foundation in Philadelphia. She's had a rich career before that in New York and in Oregon. And I'm delighted that she's joining us for this session. One of the things that she did which is directly relevant to our consideration today was she was an active participant in the deliberations around the quality council report which is the framework for our discussion. So Christine, welcome and thank you.

CHRISTINE CASSEL: Thank you Bob. This is a real pleasure and to my mind a very important conference today. Those of us who are involved in the Institute of Medicine quality work have been—in talking with the so called outside world about it—often find people's reaction—particularly to reading—crossing the quality Chasm—to be well that's a very nice idea but it's just hopelessly idealistic and what does it have to do with all of the struggles that we all face in the real world. I think the challenge that we're discovering here

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today is one about, as much as anything, what we face is a challenge of perception and as I guess the PR people would put it, messaging really. I now live in a world where I spend a lot of time with medical organizations, physician organizations, or what is sometime loosely referred to as organized medicine. Which may be sort of like organized health systems. But within organized medical organizations, if you talk about integrated delivery systems as an answer to the multiple challenges and barriers for why we, "can't achieve the vision of the Quality Chasm." People will say, just as you heard from Jay Crosson this morning, "well that's all fine and good, but that's Kaiser and they're in California." And they don't know about this map of various kinds of integrated systems and deliver systems around the country. I would venture to say that even in these meetings of medical organizations, they don't know that the guy sitting next to them is actually in an integrated group practice of some sort. And that has to do with the mindset. And that perhaps has to do with what we heard earlier this morning about culture change. But I think it also has to do with the health policy world. That the mindset in the health policy world has been similarly limited and I think in some ways, not well informed about the many varieties of attempts of integrating this non-integrated system. Because everybody, I think, recognizes the logic of it. Let me just give you two quick anecdotes before I

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introduce our speakers. I was present last fall at a summit meeting of The American College of Physicians, which represents all of the specialties of internal medicine looking at what are the challenges facing internists. And from the same podium, you hear people in practice, practitioners, talking about how impossible it was to be in practice. How miserable their lives were. How they would never tell their kids go into medicine because there were all these hassles and they had not time to spend with the patients. And there was someone next to them talking about how they were in a 30 person group practice somewhere where they had figured out, internally, systems to solve a lot these problems and to relieve some of that sense of frustration and anxiety. And I think, as Greg Polson mentioned, the ABIM Foundation and NCQA are doing a project now to look for these examples around the country of practices that have begun—without any huge \$2 billion dollar investment in IT and other kinds of things—but just to kind of figure it out themselves and it turns out there are quite a lot of those out there and so we'll be really excited to be able to put that project out there for people to look at. And we're getting close to being at the stage we can do that. So this afternoon we're here to hear from five people with different approaches to how do you take disorganization if you will, and turn it into organization without the super structure of a pre-existing, large, all ready in place organization? My role is

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just to introduce these wonderful speakers and my biggest challenge is going to be to keep them on time, of course. And then to make sure that there's enough time for you at the end to engage in some dialog and some questions. So let me just, very quick, I'm not going to into a lot of detail about each of the speakers. You have their bios in your packet and I urge to read about them because they really bring wonderful breath of expertise to our conference today. The first speaker will be Ed Wagner, whose director of the MacColl Institute for Healthcare Innovation center for health studies at Group Health Cooperative in Seattle. And, as I'm sure all of you know Ed is internationally recognize leader in improving healthcare for chronic conditions. He's both a general internists and epidemiologist. Paul Tang will speak next. And Paul is also an internist and the Chief Medical Information Officer at the Palo Alto Medical Foundation. And has been responsible for implementing clinical information systems and an enterprise wide electronic medical records system and e-system connecting doctors and patients together. And Paul has been a real leader in the IOM's efforts around electronic medical information systems and behind those two recent publications that Harvey mentioned earlier. Our third speaker is David Brailer who is recently completed 10 years as Chairman and CEO of Care Science which was a national registry of medical errors and physician and hospital performance. He's both a physician and an

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economist. And currently is Senior Fellow for Information Technology and Quality of Care at The Health Technology Center in San Francisco. And our last speaker is a practicing physician, otolaryngologist, and plastic surgeon who is also, John Cochran, who is also President and Executive Medical Director of the Colorado Permanente Medical Group. And John comes to this discussion not as a lifer within the Kaiser Permanente System, but as someone who is in the private practice world in Denver until 1990 when he joined Permanente and will have a chance to tell about the vision and experience that that has given him. So without further ado, let's turn this over to Ed. People are going to speak from these seats here. [Laughter] And just in case there are any questions that remain unanswered after these speakers have spoken there will be research opportunities for all of us and those research opportunities are well represented and we all keep hoping we'll be even better funded by The Agency for Healthcare, Research, and Quality which is ably directed by Carolyn Clancy who's a general internist and health service researcher who has been with the agency for I think almost 15 years now. Isn't that right Carolyn? And risen through the ranks and leadership there and provides really, and important, both health policy voice but also an analytical voice that keeps looking beyond the horizon, where we need to go next. So, my apologies, we'll now start with Ed.

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ED WAGNER: Thank you Chris. It's nice to be here at what I hope will be the renaissance of pre-paid group practice. What I'd like to talk about is, obviously, chronic illness and the magnitude of the problem, it's implications for human and financial costs have been stated. What we've been working is the system changes called for in the chasm report. That evidence shows, lead to better chronic illness care. We've tried to put them in a graphic form that people would find useful in guiding their quality improvement activities. And that's the chronic care model that some of you may be familiar with. We've been, for the last several years, testing the question of can one use modern approaches to quality improvement to change the system in accord with the chronic care model, A, and B, will that change outcomes? We have now worked with over a thousand healthcare organizations ranging from the Mayo Clinic to one and two doctor offices and small community and migrant health centers. And what I think we can say at this point is that about 70% of participating teams in those breakthrough series collaboratives achieve improvements in their patient care. What have we learned in the process of doing this work? We've learned one, that the national breakthrough series, the model many of you are familiar with, promoted by The Institute for Healthcare Improvement, is not the best and most efficient way of disseminating ideas like this. Two, we then began working at regional and local levels

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to see whether or not we could do collaboratives among organizations that may even be competitors in the same market place. The other thing that was very clear is that large organizes systems, especially multi-specialty groups, were much more readily able to implement changes in their micro-systems than were isolated, independent practices. What also became clear is that system was really applied at multiple levels. And that where our focus was on the micro-system, where patients and practice teams come together to do the business of healthcare, what went on—this is not in any kind of theological sense—[Laughter] what goes on in the larger organization in the larger system had a great deal to do with the success of what went on at the micro-system. Our experience in these national collaboratives has been more rigorously evaluated using research rather than quality improvement data by the Rand Corporation, by Stephen Shortell, and his colleagues at Berkley. I urge you all to go to the Academy Health meeting in a couple of months to find out the results. Needless to say, I wouldn't be promoting it if I didn't think they were going to be positive. [Laughter] But what we did learn is that, began to get some glimmers of what aspects of the larger system were primitive of better care and transformation at the micro-system, at the practice level. And coincidentally, we were visited, as was Kaiser and some other in health partners and some other healthcare organizations in the United States by the

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Kings Fund, from the U.K. which engaged in the study of organizations that were the highest performing hedist performers. There were also large managed care organizations. They studied five, three of which I just mentioned. What they found was just published in the British Medical Journal and this may of be of interest to American audiences. They found that the organizational factors that encouraged good management were one, strategic values in leadership that support long-term investment in managing chronic illness. Two, well aligned goals between physicians and corporate managers, a critical element of integrated group practice. Integration of primary and specialty care a hallmark of multi-specialty group practice, Investment in IT and attention to the quality and accuracy of clinical data, use and performance measures and linked financial incentive to shape clinical behavior. And use of an explicit improvement model, most often the chronic care model. So the question for us in working, now outside of the integrated group practice system, is can we develop those supportive elements of system ness in our disorganized world and assist small, independent practices? And so what we have tried to do is come up with an idea for system ness as a community property. This was really underlined, I think, the community summit that IOM held. Leadership has to be by a coalition of purchasers, health plans, and providers. There has to be a measurement system. There has to be models of

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change. There has to be support for learning, like collaboratives. There has to be an IT platform. This is beginning to happen in local communities. I want to close by talking briefly about what's going on in Indiana where the Health Commissioner and the Medicaid Director want to improve the care of 80,000 Medicaid recipients. What they've done is a series, a breakthrough series collaboratives all over the state supported by the distribution of web based registries to all Medicaid providers. The development in nurse case management system in every community to support providers that are caring for Medicaid recipients. So I think this is the beginning of a community approach to system ness that I think bears some attention in the future. Thank you.

CHRISTINE CASSEL: Thank you Ed.

PAUL TANG: I'm going to talk about another component of the integration and a very different part of the multi-special group practice. As we know, all doctors are special, or at least all doctors think they're special so that's the multi-special group practice. But that's really to incorporate [Laughter] the most special person of all in this whole equation and inspiration, and that's the patient. So I'm going to focus on discussing the tools that we can put in the hands of patients according to the chronic care model. One of my favorite principles from the IOM Chasm Report is that of the continuous healing relationship. And it says really that we

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need not, we shouldn't be giving patients only access to us on some pre-determined schedule, or try to get scheduled visits, but really be more continuous and we need to apply all the means possible to deliver on that promise, including the internet. So let me walk through sort of a demonstration scenario of using an eHealth system that use a Palo Alto Medical Foundation that Kaiser will also have as another example. So the patient logs in after an authentication process we put them through and has a set of things they can do. If you scroll down a little bit, one of the things they can do is ask for an appointment, electronically, 24 hours a day, instead of only when they can get through our telephone system. So in this case, Stacy's asking because she's having trouble with her back again, and wants to see if she can come in. She'll sort of come on in, we have open access now, so we'll say, "Yes, if you can come in, in fifteen minutes."

[Laughter] Now I'm going to show a little side of the EMR side, just to show the integration. So we won't go into any details, but this is the doctor's note after talking to Stacy and examining her. But important part of the doctor's note is what you might call information therapy. So typically we talk at patients during the encounter and we know from studies that patients remember about 50% of five minutes, because it's the wrong time and the wrong way to communicate information. But instead what we'll do is we'll enumerate that in something that

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we'll hand out to the patient at the end of the encounter and we can add URLs, the modern way of getting information. Okay, Stacy is really excited. She goes home, [Laughter] and she clicks on recent visits where she can get details and low and behold, in addition to the piece of paper she was handed at the end of the visit, she gets that in a way that's persistent and can be shared anywhere Stacy is, 24 hours a day. Including going on to that URL, and popping up another very simple—okay, back pain is, in a sense it's a chronic disease, or at least it's a chronic susceptibility and we know it's a big factor in morbidity and days lost from work and we know that the treatment is not magic, the treatment is words, education, and I just told you they forget half in five minutes. So why don't we give them something more persistent and probably a whole lot more effective than words. So this is truly information therapy. Simple, but that's the only way they're going to be prevented from having that morbidity in the future. Okay, well the other thing I told her, could you let me know how you are doing in a few days? Or she has a question. She says, "You know my back is doing better," so it's started now, the teachable moment. Cause most of the time, I think I'll just call my doctor and ask, na, I'm not going to do that. So what they can do though, 24 hours a day, query and pose that question. And the important part here is that this sort of in-basket for the doctor, it's the same place I get my lab test

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results, I get the messages from my nurse, it's totally integrated from a workflow point of view, the most important thing to the patient and physician. So here's her message and if I want to reply just click this button and put out my reply saying, "just start slowly." What happens when I hit this send button is going to a very secure web server and a bland you've got mail message to notify her that I've sent her something. And she'll login the same way she did before and she'll go straight to that in-box message and see what I've said. But this whole encounter, unlike the telephone and unlike other ways of communication, is automatically documented and it's in the record that I and others can get at and also Stacy. What else can she see? Well she gets to peer into our medical record, not something she's sort of made up or something she's managed to escape with from our office. So she'll see the same problems that we'll have in the record. The medications, the allergies, the immunizations, the health reminders that are designed for her, for her risk, because we've tagged each patient with their own modifier, because not all patients are the same. And in fact, because immunizations can be gotten from other places, she can click and tell us what other immunizations she's had and we'll update our shared record. The most popular feature is getting lab test results. Probably as a combination of what we don't do now. So she gets it very quickly and can get the value. The values are just a set of

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numbers. What we'd rather do is have her be able to graph those and show what she's done because she took the little white pill in the morning. So what we find anecdotally, and I'd like to study this, is patients don't react to the number, the number of the blood pressure, the number of the LDL cholesterol, they react to a change from something they do behaviorally and I think these are patient character that it talks about. Other things she can do simply, so she has a list of chronic medications, she can say, I'd like to renew these. And again, I want to show just a glimpse on the EMR side for the physician, this is what it takes to complete that action. And that's the power of this interconnected, shared record system. So just a couple of things, we started this general lease in 2002. We now have 20,000 patients that are enrolled in this. They [Inaudible] pretty much our demographics. One of the exciting things is, 23% are over 60, 9% are over 70 years old. Our oldest living patient who uses the system is 102. So the age barrier is certainly crumbling. The other question is, and this has been shown by commercial sites, as well, isn't this for the worried well, isn't that who signs up? And probably that's true, but when you link it to a group practice, their physician and their electronic medical record, when I compared the folks that are not using PMF Online, the health system, compared to the people who are, they are actually the sicker, the people who see us more and the people

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who take more medications. That's the good news I think and that's the powerful opportunity. What do they like about it? As I told you, the things we get the most kudos about is test result, getting those online quickly. We do have a subscription model for messaging their physicians, and essentially substituting for a visit, people who subscribe to that liked that the best. And physicians, which are an important part of this integration, do they like it? And fortunately the answer is very much, yes. And the reason is because it integrates and the workflow is efficient and they get positive feedback from their patients. I want to share a few comments. We just released our annual survey and we have over 2000 text comments, and we haven't completed yet, but I wanted to share some of the things that we learned from them. One is they're saying that it's changing the dynamic of healthcare. It's making them a partner; it's making them an integrated part of the team. The other and I really like this, this is a nurse who's in her 80s, and the connection is important to her because she's a bit physically handicapped, but not mentally, and this gives her the connection without doing that exercise of getting to us. Future healthcare deliver and perhaps my favorite, it's not just a website, it's a good deed. And that's how patients feel about this. This something that we should have always given them access to but we were challenged before the 21st century. So I think,

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clearly, this is one of the ways that we can deliver that continuous healing relationship. There are a number of benefits to patients, but it integrates care with the most special person on the team. So maybe "the" patient safety question that I'd like to pose to all of us as providers is, "have we got an electronic health record system and do we give it to patients?" [Applause]

DAVID BRAILER: Let me tell you about the first two research projects I ever did when I started at the Wharton School. The first was from the Hartford Foundation to develop and economic model for community health information networks. Six months later they came and asked me to do a post-mortem on why community health information networks died. [Laughter] I wasn't done with the first project. One of the things that we found in the post-mortem was obviously there was a substantial cost of technology for community efforts coming together. A second barrier was a substantial lack of technology infrastructure not only a cost issue; there were non-feasible components of computing at that time. The third was very interesting; I think it's intriguing given this conversation, which is that there was hopefulness in the community that other forms of integration would supplant the need for community models. And of course now we're on the back side of failed asset integration and most places except for probably participants in this conference, and clearly other forms of

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financial integration that we helped through capitation. And it's very interesting then for me to be here talking about community models of integration. I had the privilege of being asked to be the principal investigator of a project that is now called the Santa Barbara project, which was originally called the Community Health Data Exchange Project funded by the California Healthcare Foundation starting in 1996. And this model of communities coming together really take the challenges that we have here in enterprise integration and apply the Pal Doctrine, and for those of you that don't know the Pal Doctrine of International Diplomacy, it is if you can't solve a complex problem and make it larger. And obviously [Laughter] by going to level of the community we make the problem quite a lot larger. It turns out though that Santa Barbara was not invariance. Many other regions were discussing and contemplating this, and while it may be true that Santa Barbara and Indianapolis, for reasons that I think are similar to why, Ed mentioned them, were developing full scale health information exchange platforms, many other regions were doing this. In fact the Crossing the Chasm follow-up meeting that's been referred to today, that occurred in January, was comprised of 15 regions that are doing community efforts, obviously. But on a disease basis and I was struck by the extensive similarity between the issues, challenges, and value propositions that they presented and those with the 100 to 150 health information

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exchange projects that are buzzing around the United States over the past two years. Just a word on Santa Barbara, Santa Barbara is an effort of providers and a few plans to come together to be able to provide a full scale information utility available to doctors and to patients. About 80% of electronic information about patient care is online and available in a secure manner, the technology is not really relevant in this discussion, but it's been a model that is one of several ways of thinking about an information level integration of care. Or I think, as Bob Margolis, virtual group ness. I'm not sure if this achieves that state but this is clearly a step towards allowing behavioral models to be applied without the organizational or asset boundaries. By the way, it was mentioned in the Institute of Medicine, fostering advances report as well as a GAO report that, I think the officer here of that GAO report, you can put your hands up. Oh, there you are. So it's a wonderful report, if anybody wants to get access to that, it was recently completed. So what is the value of these community collaborations around information technology? First, they develop longitudinal perspective on the patient. All of know that most care is local. Patients tend to be migratory over long periods of time. That at any cross-section, patients stay in one region. On the other hand, with the exception again of perhaps the leadership in this room, patients tend not to stay in the same organization. In

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Santa Barbara, in Indianapolis, that if you get care at one facility, I mean if you're a healthcare consumer, you have a 70% chance of having care delivered by another facility within one year. If you're cared for by one doctor in Santa Barbara and Indianapolis, you have a 50% chance of being cared for by a doctor in a different group within one year. If you're cared for by having laboratory data in one lab, you have a 40% chance of having data existing in another lab, within one year.

There's substantial fragmentation that we know, and maybe these two communities have variances, but we've documented this, in at least 20 regions that I've been involved with, and I think it's consistent with what we see across the nation. So we've developed this longitudinal perspective. Secondly, we develop patient centeredness. One of the hallmarks of health information exchange projects is the recognition, perhaps painfully derived hopefully not, that the data does belong to the patient and while the patient can't deny use of the data for important care, or can't change the data or edit it, or do things that would transform the data, they can tell who does get to see it and use it. And that means that that sets up other boundaries in the utility about how it's used for proprietary purposes. Not that I would accuse any system of using their data to maintain stickiness of their patients, but it's very difficult in these settings and that allows the patients to determine who sees their data and when. Pat can

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tell you more about that. Team collaboration in Santa Barbara, and I think in other projects, the merger between IT and the efforts of disease management have come together. We've now started three disease management collaborative that are using the longitudinal comprehensive set of data about a patient to be able to do interventions and high utilizer and Medicaid, Medical in this case or CHF or other conditions. Finally there's a shared infrastructure which allows each organization to access a broad network of data and computing but actually lowers their fixed cost, particularly for small physicians and small groups. Some of the barriers, and I'll just list each very quickly, and I won't delve into detail, there are real governance issues. Obviously there's a relationship between the proprietary interests of the systems and the need to have common governance and common standards and application of rules and there's a real groping the industry right now of where the boundaries are. About how much control gets delegated upwards in these models. Legally, there was a question earlier, there are substantial, stark, anti-kickback, anti-trust, and malpractice issues and in fact there's a lot of discussion about ways to address those. It turns out though that the perception and fear of arbitrary prosecution under stark and anti-kickback in particular, far exceeds what the actual statues say. And so I think this is an issued that's been taken up by variety of people in the administration on The Hill

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and hopefully we'll get some clarity there. Financially, there are winners and losers. Obviously in a fee for service system, where Santa Barbara and Indianapolis are and many of the other markets that aren't here, when we start doing things that create clinical efficiency; we largely harm entities that rely upon incidental high value care, like hospitals. And we benefit other entities. So a lot of the financing schemes are leveling the playing field to keep everyone sitting at the table. And we don't have time to go into that but I think there are models that have been talked about by Mackenzie, with our project, by some projects that are going on in eHealth initiative and other places and I think soon, some coming out of AHRQ, which I hope [inaudible] Carol so she can talk about those. And then finally, there are information infrastructure issues, and I'll just mention two. One is security. Obviously the most secure way to do this is to make sure that no one gets access to data at any point in time, that's not feasible. In Santa Barbara we've developed a model called Presume Consent, which is, unless it's denied, the data is available to any caregiver that is seeing that patient and has a legitimate basis for care. The other one is identity management. As we cross enterprise boundaries, give that it's very difficult to create a unique identifier that truly identifies a patient longitudinally, there are substantial issues in creating identity tools that allows us to know who we're talking about

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and so far our industry has enough access to methods like SAML or Liberty Alliance Standards for federated identity, and so this is an issue that it's one of a long list of technology issues. So I am hopeful that this is a mechanism and I'd be happy to talk more about it.

CHRISTINE CASSEL: Thank you David. [Applause]

JOHN COCHRAN: I'd like to thank Dr. Margolis for joining me in my concern over there being not dot in Colorado. In Jay Crosson's map, I want you to know Jay that I did call home at noon and we still have a 750 physician group there so [Laughter] you have to get yourself a new dot. [Laughter] I think this morning I think we heard some compelling evidence on the impact of delivery systems. This afternoon we've heard some terrific information and some insights into the methods of chronic care, the power of IT. But Dr. Shortell, this morning, mentioned the study that said that physician organizations use less than half of recommended care management processes and Dr. Fineberg identified issues such as culture, values, leadership, and management skills as either facilitators or barriers to change. So I'm from KP at Colorado and we've actually had a mixed record. We've got some excellent care, excellent regions doing well, but we also divested a few regions in the 1990s and so we haven't exactly solved the enduring challenges and I think part of it is execution, so all great ideas still need to be executed well in order to be successful. In Colorado we

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started a turnaround in 1999 in really all areas, physician, employee morale, service, finances, membership, and we have done a lot of great things there and I'm only telling you that little brief story because I think it's based in large part on a lot of things we've done around developing leaders in the region. And I know we've got a lot of superb position leaders in this room, in many ways we're talking to the choir, but my daily effort is to challenge physicians, challenge physicians in my group to be leaders in health care, not only on behalf of the individual patient, which is what we're accustomed to, but also on behalf of this larger, sicker patient, called the American Health Care System and how the physicians play a role as leaders in that area. We have devised physician leadership, a development in a very plan full and disciplined way in Colorado. It's one of the reasons we're able to influence the community beyond our walls. We also do physician performance management with great discipline because we believe the physician leaders, by definition, must only protect patients. We don't protect physicians, so physician performance management is a discipline of ours that we consider to our changes. When I talk to our physicians, I say there three rules they need to play. They need to be healer, which is not only a great clinician, but a great communicator, a great advocate and a very empathetic caregiver. They need to leaders in health care. We have too many physicians in this country

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that have adopted the role of victim and their voiceless, they're completely voiceless, and we need to stop being victims and become leaders in all areas and really opting in to help solve the problems in health care. And the last role we need to play is partners, which is part of this patient safety culture, of being terrific colleagues for nurses, and pharmacists, and other members of our teams. And integration in our system is real, it's not virtual. But it's really optimized when it's also aligned. In other words, it can look integrated but it's not fully aligned. When we're really aligned with health care financing, I think we can get some new outcomes. So I have a little graph in there that looks like stair steps that I gave you which I challenge our physicians to make the transition from the victim role, which is resisting all change in health care, transitioning to the reactive role, which is new insurance products and incremental changes. And ultimately getting to the place of the top rung which is the creation of new innovation in healthcare enabled by IT systems, enabled by better care systems, and really also being key in transferring those from region to region, from group to group. I came from the fee for service practice and I found I was voiceless and as you might guess, that bothered me, that I was voiceless. And so I joined Kaiser Permanente. I'm a pediatric plastic surgeon actually, so I had to use insurance coverage for my kids. And it was remarkable, that an organization was

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that aligned and that ethical, and it's been a great, terrific career move for me. But while I was voiceless as a solo practitioner, as small group, I had a voice, my specialty society, had a voice, but it was constituency driven and so selfish in its orientation, that I don't think it was a voice that had a lot of audience. And I think once physicians can step and be patient advocates, and use their voice to create systems that are good for patients, then I think we have a voice that ought to be listened to and we'll never get that in a smaller groups. So I've illustrated four examples, tangible examples, of our influence beyond our organization. One of the Colorado Springs network model and the Colorado Springs network. We have only a CPMG medical director, but all of their physicians are linked to our specialty departments. Our department chiefs, they come in small groups to our monthly quality committee. We go to their hospital to do safety talks, quality talks, they are linking with our anticoagulation clinic, so we have a fairly strong bond, we scholarship some of them to the IHI every year, so we have a bond there. Secondly, is that our primary hospital example, St. Joseph Hospital, we have an intensive care unit coverage with our leadership, we have the OR leadership, we hospital's teams, and we are using our protocols and using our physician leaders to create a lot of the good outcomes. The third one is what we call our preferred clinical partner program which started two years ago

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when CPMG said that we had a responsibility and an opportunity to solve the nursing shortage. We started off by donating money and raising money to create an opportunity, with matching funds, etcetera, we have over a million three-hundred and fifty thousand dollars right now. We've started three new nursing programs in the city Denver, two for KP employees and one for the community in general. We have double the number of scholarships and we also have physicians serving as mentors and faculty. So it's another example where a physician group can decide to step up, step into a problem in healthcare that is at least partially ours in the doing, and create an opportunity around solving them. And the final thing is we actually are actively involved within our city, within our company, within our regions, of going around and teaching physician leadership development, of teaching performance management for a physician groups. Because unlike some of you, all of our doctors are not from Lake Woebegone, their not all above average, and we have to deal with physician performance issues if we're really going to be the ultimate fiduciaries for patients.

CHRISTINE CASSEL: Thank you John. [Applause]

CAROLYN CLANCEY: Good afternoon, and happy St. Patrick's Day. Growing up outside Boston, this was always a day off for school for me and [Laughter] of course a reprieve from Lenten abstinence for adults anyway, so it's a very special holiday in my family. [Laughter] We've been very

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conscious at AHRQ about the importance of the deliver system, both inspired by The Institute of Medicine reports as well as, frankly, seeing what's happening in health care. So Irene Frazier and her center have led an effort to actually try some new types of research with our integrated delivery system research network which Kaiser is a part, so that's one way that we get a little bit close to some of the issues related to deliver systems. Now this past year or so, there's been a great deal of excitement in the nation's capital about the potential for advances in information technology to solve all of our quality and safety problems. In fact, it sort of goes like, if health IT is the answer then what is the question? And the question is how we fix it with everything that's wrong, with the health care system. On one level, AHRQ has been the beneficiary of some of this excitement and on another level; I sometimes worry a little bit about expectations. But what I want to tell you about is what we're going to be investing in this year for those of you who have missed the grant announcements, they are still open till April 21st, so it may not be too late, and also to talk about some opportunities in the recent Medicare bill that was passed, because I think that may also be of interest. Building really on Secretary Thompson's passion for this topic and being very, very convinced, he's not mired in technical details, which actually makes him the perfect visionary leader to just tell everyone to

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get this done rapidly. This year we will be investing \$50 million dollars in the use and application and evaluation of health information technology to service the coordinating function if you will, and to help improve quality and safety in health care. Now the grant investments we're making has three components. We are directed by our budget to focus particularly on those communities serving rural populations and under served communities. Which I think is a good thing, so \$7 million dollars is advocated to help those institutions apply for planning grants. These are people who haven't heard about Santa Barbara and Indianapolis, and really have not begun to needs assessments about what it is that their communities need. So those would be one year planning grants. Another \$10 million dollars is allocated to focusing very much, on what might be called the proposition for health information technology. Now I have to say that one of the more relaxing things I do these days is actually to go periodically to speak to members of Congress about information technology and it's great because I could actually take nap. They're so excited and they do all the talking and just nod and occasionally say, no, no, no, it's that one and then they keep talking some more. [Laughter] But having said that, that excitement at 20,000 feet, we need whole lot more information than we have right now about what are the upfront costs, what are the transition costs, if there were, is a case to be made for public

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investments. And there's certainly a lot of excitement about that right now, some bills that are being introduced on the Hill and will be forthcoming as well as the Secretary's interests. The question is really what are we buying? Most vendors and people who are knowledgeable about this area, will say that software and hardware is somewhere between 20 and 30% of the problem, by the way that's a guess of course, not empirical estimate. And the rest all relates to the very messy business of culture, sharing information, trying to figure out how you make this technology work in your practice. Because after all, if all you do is digitize our current chaos, Irene Frazier, sometimes reminds me that we may actually speed up this function but that wouldn't [Laughter] get us to where we want to go. On the back end, I think that we need to learn a whole lot more about benefits. And one of the big benefits questions that we're struggling with is, how can you actually model the economic gains from improvements in health care quality? We know a lot from the work of David Bates and others, that use of a fabulous system like they have at Brigham and Wynn's can substantially reduce medication errors and so forth, but what effectively have is sort of a lovely photo album of snapshots of studies. We know very little about how generalizable these findings are to other settings that have not had a long tradition as they have had in Indianapolis Inter-Mountain Health Care and so forth. And the question is,

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how replicable and reliable and how much of that value do you lose when you transport this same technology elsewhere. We need to learn about culture, about how physicians and those they work with, actually learn how to use this technology. So there's a great deal to learn and I don't think that we're going to be able to develop sensible policy until we understand a whole lot more than we do right now about both the benefits and the cost of making these investments. And by these investments I mean, both at the individual health care organization or component, but also in they types of community data exchanges that David Brailer was describing. So there will be some investments on the community exchanges made this year and more next year from the department. Finally there's a big RFA that focuses on, literally, demonstrations of implementing components of health information technology. Let me just also close by making two observations. One is that 60% of doctors in this country practice in groups of 6 docs or less. These are the people that Steve Shortell has to exclude from his fabulous work because it's almost not fair to assess what sort of infrastructure that they have and yet that is a huge proportion of the American population and a huge proportion of Medicare beneficiaries who get their care there. I think an under-appreciated aspect of the Medicare Modernization Act is that there are a lot of opportunities and demonstrations that will be forth coming, focused very squarely

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on improving chronic illness care, and we're working very closely with our colleagues on CMS. Some of those are going to be aimed at small physician practices as well as evaluating very specific disease management programs and so forth. So there's a lot of exciting news and thank you for your attention. [Applause]

CHRISTINE CASSEL: Okay, now we get a change to hear from you and welcome, I think I'll try to take a page from the Jamie Robinson Doctrine, we took the Powell Doctrine earlier, which is the questions and answers should be short, but I welcome hearing some. But while you're getting ready to do that, I've got a couple of my own and this really goes to kind of the visionary part of the, of crossing the quality chasm and of this issue of creating systems out of chaos. I guess it's a question for Carolyn or maybe Paul or David, which is that we've been thinking about the integrated systems of being some aggregation of providers, but in communities, in particularly in the rural areas, people do move from one provider to another, from one system to another, what is the real promise of IT in helping a community become a system? This is what The Institute of Medicine Summit, last month, was dealing with, was people who were looking at broad communities had had multiple provider system. Is there a way that information systems can realistically help connect all that?

CAROLYN CLANCY: Let me just make the transition to

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David Brailer who I think can address this from having much more direct experience, but I think one of the vision right now is that one way that we get to a kind of information infrastructure that The Institute of Medicine essentially said we can't have safe health care without, is that we actually support the development or enable the development of these community information infrastructures similar to what David and his team established in Santa Barbara. Now of course after all of their labors, it's really easy for us to imagine that now it can much more rapidly and I think one of the open questions is, and I think David's thoughts here would be very helpful as well, is how much investment in electronic technology do you need before that strategy. It's kind of a chicken and an egg sort of questions, but that's very much part of the vision. And I think where we struggle a lot with this vision is it a community collaboration around information technology and data exchange, or is it a community collaboration around improving care for which information technology is a vital component. I don't think that they are mutual exclusive, but I do think in terms of the organizing focus and the reason that people would come to the table and work through all of the governance issues that David mentioned, they're very, very important. David you want to address?

DAVID BRAILER: Sure, just a couple of comments.

First, I see a convergence happening in efforts that are

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primarily community health information exchange being merged into or with community efforts that are disease improvement based. They're codependent. While there's a few visionaries that have a sense of a very broad infrastructure within a community that essentially creates a medical internet for data to flow, that doesn't have a lot of resonance with most people. They want to solve very real and tangible problems and so these are very much coming together. That was what impressed me about the last Crossing of the Chasm meeting. In terms of the role that the IT investments play, I think we should bear in mind that, largely speaking, the information exchange process does nothing that a paper process cannot do. It simply does it remarkably cheaper, faster, in a more controllable manner, and in a way that allows new things to happen. Now clearly, we can't perform a drug interaction check on a paper prescription. But that's an attribute of the automation of the office itself and health information exchange's mechanism is to be able to convey that directly to pharmacy or to a patient. But I think to come to the core question that both Chris and Carolyn addressed, this is a step-child to the real issue which is, is the health care system going to be patient centered, truly or not? And one of the things that impressed me was, and I won't talk about Kaiser, because I think they're an unusual example, but many of the pre-paid group practices that we have dealt with in these project. For example, in Santa Barbara, there

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are sizable ones, 180 physicians. But also the other pre-paid group practices called The Veteran's Health Administration, and the DoDs Tricare, they significant patient leakage. Where patients are sub-contracted out for special procedures or other treatments, out into the fee for service environment, and you know, some are sizable, 20% of patient care, and because they're expensive procedures, potentially even more dollars. And so if you really want this to be longitudinal, it can never really be an enterprise based solution, I think, almost ever.

CHRISTINE CASSEL: Yes, Paul?

PAUL TANG: If I could just add a comment about the chicken and egg, and put in a plug for hormones, and I'll restrict my comments to the natural ones, and that maybe data standards, which Carolyn didn't give herself credit for sponsoring that as well. Cause that's the integration glue that would put these systems of care together I think.

CHRISTINE CASSEL: Good point, good point, they have to be talking the same language. Yes.

MALE SPEAKER: Actually just a comment on the-up in Vermont right now, there's a little project going on around some diabetes and asthma improvement, that's frankly I think, spent not more than \$50,000 to date, over the last few months, that has 3 or 4 payers. The state is a payer, Dartmouth Hedgecock, Fletcher Alan of The Integrated Networks, all sitting around a partnership for chronic disease improvement.

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And I'm using as an illustration, in sort of a simple system to connect some of the elements together. But if the governance and the will to fix health care that comes before any of the IT part. All those people were sitting at the table and wanted to fix this, all the laboratory information was available so there was a big spicket and it was really pretty simple to just put the last piece in to kind of connect some of this stuff together on the web, and if the governance isn't there, and that is the question, can you do it if you don't have that governance? And I think the answer is no, but just as a discussion.

CHRISTINE CASSEL: And that's really what Harvey Fineberg this morning I guess, called culture, and Carolyn addressed that. Anybody want to address, Ed?

ED WAGNER 2: Leadership and a vision focused on quality improvement is a central aspect of what I was trying to describe a system as, which is why I think there may be success in Indiana and maybe Vermont John. But I'm skeptical in other places where it is simply to provide easier access for the professionals, to data.

CHRISTINE CASSEL: Anybody else want to address Ed's question? I think that's another aspect of the hormone issue, Paul, I think what it takes to bring it all together. Yes sir.

MALE SPEAKER 2: Hello. My name is Dack Gorlov and I'm very glad to be here and applaud the work that everyone is

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doing to bring this together and if you would, with me, for a moment, think back to the early 90s when our health care system came across the pandemic that they finally admitted to and we asked ourselves where were the angels who were going to help us because we knew not where else to ask. Our research wasn't helping; our physicians looked at what needed to be done. And then we got to the mid-90s and Hollywood decided that this is as good as it gets and Helen Hunt came together with Jack Nicholson and they said, okay you guys, the doctors and the patients you self victimize, well you should. Well here we are and I'm very encourage to be here, and I'm very encouraged to be here because I think that now we can say, not only is not as good as it gets, it's going to get better and we have an idea how to do it and again, thank you for everyone who's put careers and work and everything here. I think that we now have a message for what can be better. Thank you.

CHRISTINE CASSEL: I wanted to pass a question along to maybe to Ed Wagner to start with or Carolyn you mentioned the new Medicare law and while a lot of the aspect of the drug coverage basis of it has gotten a lot of attention, there's a lot of other things in that law that perhaps reflect some of the excitement from Congress about things like IT and other kinds of systems that we need to think about taking advantage of. And I wonder if, particularly in terms of this issue of quasi or virtual integration, is there a real opportunity there

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and Ed I know you've studied that pretty carefully? You want to comment on that?

CAROLYN CLANCY: Let me just say that there's a certain irony for me in seeing Bob Barrington here in the office because there are actually opportunities in this field he was alert to and trying to push that—I don't know 4 or 5 years ago—when he was with what was then called The Health Care Financing Administration. There are a number of demonstration opportunities. Several of them focus on improving chronic illness care. ON some level it would be hard to necessarily tell these apart from something ARHQ might support. For a variety of reasons, we're going to be closely involved with their development, but I think they reflect a very strong interest among members of the Congress in trying to figure out how do we make this better in recognizing that paying for a drug benefit obviously was going to soak up a lot of energy in terms of trying to figure out how to finance it, but that there were much bigger problems facing the health care of older beneficiaries. So one of the ones that we're very excited about, and we'll be working very closely with CMS and also sort of intersecting a bit with some private sector efforts, is something called Dr.'s Office Quality IT or Docket, cause you can never have a demonstration without a clever acronym, and this a demonstration in which physicians will be encouraged and actually enabled to use information technology in their offices

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and using very similar incentives created by the Bridges to Excellence program, will get, you know, a certain per patient, per year with selected conditions based on their using these systems and then they will get a good more than that for each patient if they meet target performance goals. I don't know if this is going to work. So I think that these are interesting steps in the right direction. It's just kind of impressive that although the Medicare bill and various aspects of it are getting a lot of press, sort of all the time, this particular part of it hasn't.

MALE SPEAKER 3: Well I think we should all take a hard look at then chronic care demos that are part of the bill. Because I think we're approaching a Yogi Berra moment, where we're approaching a fork in the road and we're going to have to take it. And the fork in the road which is buried in the legislative ease of the bill is, is are these demonstrations going to support private vendors that are essentially going to bypass basic system change in medial practice for what are hoped to be short-term cost savings and health improvements. Or are they going to be used to build that system ness and support the improvement of practice systems such as I described? And it's not clear, we'll have to see what the RFPs look like, but I think it's an opportunity if practice support is in fact the road that most of us go on. It is an opportunity to finally get some money behind practice

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improvement for chronically ill people.

CHRISTINE CASSEL: Yes, I'm looking forward to that.

Bob.

ROBERT MARGOLIS: I just wondered if I could ask the sort of question the following way. Will information systems kill more people than they will save? Why? They're likely to be implemented on an enterprise basis and we've already heard that people go to different places. The doctor now is going to be faced with having a convenient system of drugs that he gets from electronic record and a patient that's gotten a lot of drugs from somebody else they went to that's not in the record because they're not coordinated, and I understand the patient could access it by web and stick it in, but there may be reasons the patient doesn't do it. The doctor may not ask the questions, and are going to; I mean we're between sort of a rock and a hard place now. My sense is we're going to reinvest billions, hundreds of billions of dollars that we're going to spend in medical records at the enterprise level to redo it at the community level, because we can't get our act together now, that it needs to be done at the community level. And I wonder whether you think that whether it takes 10 or twenty years to get from this point to then next point. Somebody like David Bates will come along and demonstrate that more drug interactions that haven't been picked up and more people being killed than less because you now have dual systems in place.

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First a very imperfect system, now you have dual systems in place that are not coordinated and we double or triple the work. One other piece to this, the other piece is the disease management stuff. We have not made the disease management, in general, the disease managers that we assist around the country to do your chronic disease model, they don't have available all the information, and they have very poor contact with the doctor, and we're developing a whole system of integration that basically from Phoenix or maybe India, they will basically help people get better, which they seem to do, save money, without having any of the information in the doctor's office, only the information they get from the patient. So we're building all these halfway systems with sort of the halfway technology and I wonder how you guys think about this now? Kaiser again, and the VA, and the DOD are the best examples of, not having to face as much of that problem, but all the rest of us have to face that problem. And how in the heck are we going to handle this without a policy at the national level to really do something about it?

PAUL TANG: I think that's an excellent questions and I think it goes along with what Ed was saying, here's the challenge of the Medicare bill, but there's many ways to skin that cat and for example electronic prescribing with all of its benefits, could be a downfall along the lines that you mentioned. If there is no central blueprint—the blueprint in

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hormones—there has to be a blueprint for an electronic prescreening module to fit into, otherwise it will be yet another standalone silo of patient information that's not integrated. And the hormone pieces again, to go back to the data standards, is if the machines can't communicate with each other, then pity the poor human that has to then put it together. But I think your point is well taken and that we do actually need a national blueprint, a national framework for the systems to plug into each other and the criteria for how they would plug in and then the hormones in-between.

FEMALE SPEAKER: Well let me just say Bob, there's almost a metaphysical aspect to your question, which is that of course if we had better data, we would know with precision, how many people were being harmed, we could know right now, so I'm not sure one could ever address the question as to whether IT would make things worse or not. I think you do raise a number of serious concerns, and there are a number of dimensions of the Medicare bill as well as other policy initiatives being developed now to focus a lot on interoperability through standards as well as support, a little bit this year and more next year for community information exchanges. I think that we need to learn, and there will also be a blueprint of sorts, and standards to enable electronic prescribing, that's very much part of the bill. One of the questions that I think that you're implicitly raising is what's the right trajectory in

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terms of investments made by practices or organizations providing care if there is not this unifying locust or community wide structure in place and I think that that is very much an open question. When I read Tom Bodenhymer and Kevin Grumbags paper in Genoa, I guess it was last summer, talking asking whether information technology could save primary care, they then get to the point, well what are the steps to get there? At which point he made some very informed, totally data free judgments about what might be the logical place to start. And I'm hoping that some of the research we're supporting will help to inform us in that way.

MALE SPEAKER: Let me just follow-up. I just wonder whether we all believe, I mean I know how hard all this is and I know how hard everyone who spoke this morning is working to make this better, but without any of the governmental structures that every other country has, whether it's a cost effective analysis, a technology assessment analysis, a group that produces quality indicators, guidelines, that produces anything without any structure at all and any coherent policy at all, and this is not a Democrat or Republican issue, neither one has done it, can you really do it? And can you really make this happen by driving this from the bottom and the concept of the market without anything at all? Even the most famous people in markets believe that there was a role for government to do something and I'm just flabbergasted that you guys are

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working, and we're all working as hard as we are on this without any help from above. And I don't necessarily mean God. [Laughter].

MALE SPEAKER: I'd like to make two comments about that. First, I find it somewhat disappointing that the medical errors issue, when it became so prominent and got so much attention, was immediately translated into CPOE. Now I'm a very strong supporter of CPOE, having the privilege of using it in residency and then not being able to use it as an attending physician bothered me a lot. But we all know that there are more system properties and system engineering issues than simply decisions that point of care will address. And I think we're setting up failed expectations in the future about this, but nevertheless, I think we're on that course. I think it's an irrevocable aspect of the reasoning in Capitol Hill and throughout the whole decision making process, so we have to ride it out. But I think in the end there's a question that I'll pose that I think we have to decide how we feel about, and it's the following question? Why is it that one form of information technology is advanced and pushed and reimbursed and supported and evaluated as intrinsic feature of our reimbursement system? And I'm talking about the MRI. In my view, it's an information tool with a big magnet attached, that supplements physician decision making, reasoning, and precision of treatment. Which is exactly what an electronic health

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record does, except it doesn't have a magnet attached, and I think that's the big deficit. [Laughter] If you read the New York times Saturday, thank you, you would see that now there's concern that physician's offices are putting in MRIs and in fact the business case is such that for many, there's a payback within 2 years. Yet Carolyn and I and many of us sitting here an people in this room have spent night and day in meetings trying to figure out how to get a doctor's group to adopt an electronic health record. And I don't know if we can all the way and address the system from the top down. You now the problem with fragmentation in the industry is that half of fragmentation is like half of infinity, it's still infinity. But we can certainly address why we're paying on a volume basis for care when the direct result of using these tools is that it makes care more efficient and why it is that we don't pay for the technology but we pay for many others that are equally IT and equally clinical?

MALE SPEAKER: I think this explains why it is helpful, Bob, to believe in God. [Laughter]

CHRISTINE CASSEL: Yes.

MALE SPEAKER: The, I guess your cost around incentives. If you look at what David was just describing, nobody told the docs to put the MRIs into the office. If you look at the Balanced Budget Act, nobody told Home Health Care to change what it did but the whole home health care industry

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blew up within about a year. Look at sub-acute rehab after the balanced budget, same idea. The rules changed around the reimbursement, and even in the Medicare Modernization Act, there was an article in the paper the other day about health plans falling all over themselves and counties in Florida trying to recruit patients again. And it's not because the patients have changed, it's not because the docs have changed, but all of a sudden the reimbursement changed, which risk adjustment. And so, so you guys have a view into lots of other parts of the world, is there a so docket may be one example of pay for performance in Medicare but is there sort of a cohesive financial incentive that's kind of winding its way through the legislature at this point? It would start to really then allow a zillion experiments to occur because they'd be paid for as part of the reimbursement.

CHRISTINE CASSEL: Can I maybe just add to that question? I think, and building on Bob's point about financial incentives, since, like it or not, we are still trying to fix these things with market incentives, and earlier this morning someone mentioned the pay for performance kind of train that's left the station. And I particularly want to ask Jack Cochran to address this, but other as well that we've talked a lot about system ness and about IT in this panel, we haven't talked a whole lot about quality improvement per say and how that's built in. I know Ed that's built into your model but I think

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it's kind of, we sort of take it for granted as begin party of why we're doing these things. But I'm just curious what any of you think about whether financial incentives, whether to hospitals or to physicians, can in fact drive quality improvement?

MALE SPEAKER: Well I'd say first of all, that part of our journey has been a quality journey and in the 2003 hedist measures, [Inaudible] Colorado region of Kaiser was named the top 10 in the nation, or the top 10 organizations for clinical quality. [Applause] [Laughter] We don't have a incentive of any significance around that. We do have a couple of things; we have an automated medial record that we've had for several years. It's an IBM based OS2 system which is like driving an easel in need of an oil change. [Laughter] It's extremely slow, it's laborious, but we have a computer literate, computer [Inaudible] physician work force who are very excited to have it and they would actually lay in front of the exam room door to get you to take it out of their office, although they are was initiating with data breath to get the epic system in, so I'd say we have a compute enable workforce and we also have a biased for performance management and I think that's very significant, because we deal with low performance issues, both in terms of clinical outcomes and in terms of physician performance. But not by paying

CHRISTINE CASSEL: But not a financial incentive?

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MALE SPEAKER: No.

MALE SPEAKER 1: We did a little study for AHRQ not long ago of nominated best ambulatory care systems in the country. Studied about thirty different, most were fee for service. Almost all of them were using financial incentives relatively small, never more than about 10% of any body's salary and all of them were basing it on unblended performance data was of in emphasis and out comes. Now the question that we can answer is whether the incentives of the stimulated the quality improvement activities that led them to be nominated or followed. My personal sense that they followed that they were put in place by quality driven work organizations to spread and sustain gains but not to, not as the driver for quality improvement. But that's a guess.

CHRISTINE CASSEL: I was just going to say just to paraphrase your question, what do you see out there in terms of the idea of the differential of different macro forces like payment, can move us more quality system, should we looking to that to sort stimulate. If people understand that in order to achieve some of the tags, if you pick the sweet spot of a certain measure that really would required people to become integrated systems in order to get measures, which is associated payment.

MALE SPEAKER: I strongly endorse what was said this

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morning which is that you pay for outcomes, not for specific services because that, the evidence is pretty good, that can be gained.

BRUCE HAMREY: I'm Bruce Amery, from Gesiginter I guess another question that might be asked, and I think several people have mentioned it, Dr. Cochran in particular, physicians choose to join a group practice, the make that conscious decision. At the point of those of us in group practices use that to set certain expectations which electronic medical records facilitate in terms of measurement and feedback, and pay per performance and other things. To me an essential question in this issues in trying to form community networks, and drive performance in the community. Others that work in a free living community, where physicians have made other pleases and may not be as amenable to measurement and feedback. And I'd just be very interested in the comments from Santa Barbara, and Indiana where those experience are under way.

MALE SPEAKER: I think that I'm going to answer a slightly different question because I'm not talking about Santa Barbara Indianan, but, [Laughter] I think the one thing very much like. Very much like, people say well you know why don't all payers want your insurance or why don't all physicians want to join this? Well I think it's up to us to make this the career of choice. Physicians don't leave from our medial group for more pay, as a matter of fact, we have very low turnover.

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It's a place where they can feel proud about the work that they turn out. They can feel valued, they can feel enabled by systems, like our IT systems, etcetera, so I think one of the things we have to do is we have to make it the most attractive career spot for physicians. Now you will never get the people who feel like if they just do more incremental work, they can make more money. That's just never going to be somebody that's going to join a group like ours certainly, but it doesn't mean you can't get terrific people. We had tons of vacancies, 5 years, in our specialties. We've got a couple. I think one GI Doc and one cardiologist we've got a waiting list in most specialties. So I think one part of it is making career physicians very important. A lot of the sense of protecting doctors because we still have to performance management but mainly a place that they would be proud to be associated with.

CHRISTINE CASSEL: Any observations about Santa Barbara, of any of them?

MALE SPEAKER: Obviously Santa Barbara is a regional model, it doesn't have selection process although the physicians do self select and therefore we've looked in great detail at what are the characteristics of physicians that participate versus those that don't, and I'll tell you I think we don't have the answer. Because I think Santa Barbara's a highly self selected market to start with. I will tell you, going back to my earlier life, doing quality improvement for

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large integrated systems, That physicians that participated in those projects and were highly involved tended to be of a certain archetype and we could find them by specialty, by age, by practice history. And I think many of those physicians have become leaders of this moment and they're still very broadly involved. So I think they're clearly, I think every ones identified there's leadership and education issue for almost every physician who's faced this problem.

CHARISTING CASSEL: Paul

PAUL TANG: There may be a little bit of a natural experiment in terms of the selection in the group versus the non-group. We're moving up the peninsula in the San Francisco, Bay Area, and we've actually had an independent group single specialty group, want to contract for IT services to that group. And I wonder since that's skimming the cream off the multi-specialty group practice that who knows maybe that's the enter.

CHRISTINE CASSEL It's the retro girl model.

[Laughter].

MALE SPEAKER: Chris, just to just add to the equation you raised just minutes ago about can financial incentives drive quality improvement? And can financial incentives actually drive IT adoption in [Inaudible]. And just some information on California's pay per performance. I think we have some evidence that the former is probably yes, and a

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little bit less about the later. But on pay per performance in California, the first year there's going to 1% of the money earned is actually on adoption of electronic health record with specific components and two domains. That's being increased to 20% during the second year to send a clear signal more money in the pocket in the group to invest in this infrastructure. The thought is that in ongoing years, then if that investment takes hold, You won't have to put the payment on the proves. So the infrastructure will be reflected in the process and outcome measures. You know, have more diabetes in control, being able to reward on that if infect, that platforms in there, but until that's in there and until God or the government or whatever, [Laughter] I think you know, you're going to put it right in there. The only demonstration that I know of, I could be corrected on this. This actual wording specifically at the medical group level for the adoption of the electronic record.

CHRISTINE CASSEL: Okay so that's, but that' still very much in the sort of structure part of the structure process outcome. Michael.

MICHAEL: Can I just make on comment. I wonder Steve if they should 50% on IT early then go to 40/20/30/10.

CHRISTINE CASSEL: You went the other way around.

MALE SPEAKERS: [Inaudible]

BIRD SIDEMAN: You've been talking about changes that have to be made in order to improve the quality of care and I

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understand that, but at no time that I heard, and I wear hearing aids and maybe I didn't hear it, but has there been any discussion of the changing age distribution? And what impact that will have on the quality of care of the ageing population which will be so dominant in a very short time?

MALE SPEAKER: I don't have to tell the people in this room that those are the people who will need chronic care. They will need integration of the various specialties and so on, more than the younger people, than they did when they were younger. They are least able at that age, and I can tell you that from personal experience, to coordinate their own care, to understand to what their own care should consist of. So I wonder how all this fits into the changing age distribution.

CHRISTINE CASSEL: Well you know that's a really good question. If I could be so bold as to suggest and answer for that. Paul sort of mentioned that a lot of the older patients actually were quite comfortable and faithful with using these electronic records and my sense is where as a decade ago we had to make that case. And as a geriatrician, I've been very involved in making that case. It's now just sort of like the air we breathe. We start talking about chronic illness management because we all accept the reality of demographic changes but that said, there probably are some important issues. I know there are still important issues about quality of care outcomes that fall outside of our traditional idea of a

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group a practice, or a hospital or even a health care system that relate to health outcomes in older populations, so that's an important reminder. Does anybody else on the panel want to comment on that and then we'll take one more comment and then I'm getting the red flashing light. So.

CAROLYN CLANCY: Well I guess um I would offer both an optimistic observation and one that's a little less so. The optimistic observation is that as people talk more and more about a patient centered care approach and the opportunity for patients to be co-managers, if you will, of their own health care, I think that the baby boomers aging into Medicare, many of them are going to begin a much better position to do that. They use you know all kinds of technology and they're used to doing this in their own lives, and I can see your skepticism when you're ill it's hard to do that on your own, but I think they're going to be a very prime group to market. Coordination, service, and so forth, I imagine some of my contemporaries actually have their own agents who coordinate for them [Laughter] bit of smart artificial intelligence stuff that helps them. At the same time that very sort high individualistic, skeptical attitude may actually undermine sort of community wide, or integration efforts so it's going to be fascinating to see.

MALE SPEAKER: You know I think that when they did the stair step, the top line, which is creating the future

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differently. And innovation is pretty consistent with the IOM systems and having good IT and disease support. I think we have to have a health care culture that allows us to try new and different things because we're not going to be able to do it to the tyranny appointment. And that was very clear in the IOM report. It's asking a very different question, which is how many different patients problems can you solve not how many patients appointments can you see? And I don't think we can even necessarily imagine all of those solutions but a lot of them are going to come from IT, they're also going to come from, as George Elverson says, the new miracles that are going to come out in health care.

CHRISTINE CASSEL: Okay, Michael, excellent. Steve, I'm sorry.

STEVE HURSTY: I'm with Kaiser Permanente and I work with national purchasers and I wanted to revisit this concept of more universal standards in light of some economic reports. We haven't taken a lot about what purchasers, what part they play in this equation. And I don't know if I can call it a trend yet, but I've seen on a couple of occasions, large purchasers who want to solve problems for all their employees that span individual physician practice groups, are putting in to place solutions based on things like WebMD, where they come to us and essentially ask us to un-bundle the integration that we've done to re-integrate it through another platform like

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WebMD and so we can talk academically about what's going to happen but ultimately it may be market forces that drive us to come up with a solution because they are some substantial major purchasers that are heading in that direction. I was just curious what sort of reactions or comments you might have on that.

CHRISTINE CASSEL Anybody want to bite on that one?

[Laughter]

MALE SPEAKER: As a card carrying independent thinker, I guess I'll do this. [Laughter] You know I've spent a lot of time with various purchaser groups and I respect the activist purchasers who are becoming good buyers of health care service and I've been impressed at how wary and cautious they are about doing anything that intervenes in the care process. I see a substantial amount of delegation to help finance into other intermediaries to be able to address this and 10 years ago when I wrote a Harvard business review article about that topic I said I'd come back to. Well I've come back to it in the past 8 months and it hasn't changed very much. So I don't see, I see tinkering. I see some companies that are creating new business cases for intervention around their populations but that's probably limited to 20 or 30 major companies and certainly not a widespread trend. So I would not be encouraged that the current model we have would be something that would be addressed, at least from the purchaser perspective.

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