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**Viewpoints: The Health Care Debate
American College of Cardiology CEO Jack Lewin
September 23, 2008**

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JACKIE JUDD: Jack Lewin, thank you for being here with us today.

JACK LEWIN: It's a pleasure to be here.

JACKIE JUDD: The cornerstone of the college's reform plan is something called Quality First. What is that about?

JACK LEWIN: Well, to get at Quality First, maybe I should say in preface, that the college supports expanding access to care to cover all Americans and to fixing the problems of the underinsured as well.

We certainly believe that we've got to slow the rate of cost increase in health care, and focus on efficiency. But we think the main area of responsibility and accountability for physicians and other professionals in health care is to deal with the quality of care issues that only we can fix and handle.

Quality First is about reaching inside the health care systems and processes; care delivery, and to improve the quality of care through application of guidelines and performance measures at the point of care, through adoption of electronic medical records and clinical decision support systems through which the guidelines and performance measures we so painstakingly developed are actually applied to patients in a systematic fashion.

And through then taking the information, measuring how we are doing and giving continuous quality feedback to clinicians to improve quality and then educating around specific measured deficiencies of care.

Quality First is really is really a whole comprehensive package of translating science into guidelines of performance measures, which the college by the way has done for 25 years with the American Heart Association and in a very sophisticated way. Then embedding those measures in the point of care so that they're applied to every patient, measuring the extent to which quality, outcomes and performance measured adherence really occurs in the system, and then educating around measured gaps.

JACKIE JUDD: And so much of what you just described can, and I presumed is being driven by the profession itself. But when it comes to the larger issues, where you started out with the access to care, affordable care, et cetera, where does the college land in terms of what the Federal Government—particularly a new administration—should be looking at?

JACK LEWIN: Well, we're lobbying to create a system of universal access and universal coverage—

JACKIE JUDD: By what means?

JACK LEWIN: Well, you know, we don't believe that physicians are going to be called to the table as the economists to decide how society chooses to finance these

challenges. I think we are there to help advise in any way that we can, but these societal issues. I mean how we finance, or when we finance access to care for those who aren't covered or underinsured is something that we have to decide as a nation, as a society through Congress, through state legislatures. Quite frankly, physicians and nurses are probably not going to be central in some of the key decisions there are. If they desired to do that it may be something we can push for, but how we finance it and the specifics of how we do it will be much broader kinds of discussions and decisions that will involve all of us, and should involve all of us, patients as well as doctors.

We hope for a patient centered system that is based on evidence and science. And that is, if you will, embedded with continuous quality improvement and transparency in those regards, so that everybody can see how we're doing, can choose to participate in a care delivery system that is actually achieving higher quality performance.

JACKIE JUDD: But certainly the financing of this system impacts number one, the access to the system. Number two, the quality of what the patients get. So I guess I still want to know what the college feels, I presume not a single payer plan.

JACK LEWIN: There are members of the college, like in any constituency that would like a single payer, but not the

majority. The college would like public and private system, a pluralistic system, much as we have now, with some of the problems in it fixed.

We would in fact, see some positiveness in continuing employer based coverage if we could fix some of the deficiencies in employer coverage, such as making employer coverage portable, such as insuring more choice in employer coverage. And that might be achieved through purchasing cooperatives, for example, and through some other mechanisms that would provide the benefits that often are described around the individual coverage, for example.

We believe that the funding for this needs to be divided up among constituencies, individuals are going to be responsible for a significant part of the care. Employers could be the accountants, and also contribute to the care, like they do now. And government obviously has a significant role. So we'd see it pluralistic in terms of a public/private system. A system funded by individuals, employers and government in some organized and consistent fashion. And a system that gives people choices and options for care that meets their needs.

JACKIE JUDD: What would you say about the Medicare program? Because given the age of those people who are on Medicare, a lot of them use the services of cardiologists.

JACK LEWIN: Sure.

JACKIE JUDD: So, what needs to be done to that program to service the doctors and the patients better?

JACK LEWIN: Well, Medicare has some bureaucratic features that frustrate everybody; patients, doctors, probably the people in the centers for Medicare and Medicaid—

JACKIE JUDD: The threats of payment cuts.

JACK LEWIN: Sure, the unsustainable growth rate formula that's used to pay physicians is obviously broken. To fix it is going to cost 300 billion dollars over the next five to ten years, which is like an amount of money equivalent to a year of the Iraq and Afghanistan military efforts, for example. It's an enormous amount of money not likely to be funded. To some extent, we probably need to go fund the SCHIP Program re-authorization in March as a first priority.

But, you know, we believe that you could fix quality of care issues, you could create a business sense that would cause physicians to feel okay about adopting electronic medical records and clinical decision support systems to take on the quality challenges I mentioned earlier, by simply adding a 5% or 6% payment bonus for doctors in Medicare that would facilitate that.

JACKIE JUDD: A bonus for using the IT?

JACK LEWIN: For electronic reporting to an accredited registry or system that would capture the data, in exchange for making the results of that transparent.

While we can't measure outcomes at the level of the individual doctor, and do that with valid data, because it's kind of a technical thing, but most doctors don't have enough patients in any one category of diagnosis to really validate outcomes at that individual doctor level. You can validate outcomes across a hospital medical staff or a medical group, but when you get down to one doctor, the data stops being valid because the patients may be so different from one practice to the next, for example.

But, you can measure adherence to guidelines performance measures, the extent to which doctors practice evidence based care. Beth Macklin at Rand [misspelled?], reported to us all dishearteningly I guess, a few years back, that only about half the time when we go even to the best clinics in America, do we get evidence-based care.

So, there's a lot to be gained there and we've got practices at the colleges working with, who are out in front, who are actually using electronic medical records plus clinical decision support that reminds them if they are not abiding by the guidelines and performance measures that we've taken so much effort and time to develop, and reminds them about that. So that the patients in those practices, 100-percent of the time, get the evidence-based care. The doctor doesn't have to follow every step of the guideline, but he or she simply needs to record why they've departed, which is a way of creating a

learning system. So that we can see when and how we need to update the guidelines to meet the needs of patients across the community.

Now that kind of quality system, would have a major impact on reducing disparities in care, on reducing ineffective care, inappropriate care. We could do a lot by just measuring our way to quality success, and that's something that the professions can do, and it's really our accountability.

JACKIE JUDD: And you've returned to this several times in our interview.

JACK LEWIN: Sure.

JACKIE JUDD: So I have to ask if it is a point of frustration to you that it's not farther ahead then you may think it should be.

JACK LEWIN: Well you know, it's a point of determination for me and for the college. The ACC has registries that measure quality up in 2,400 hospitals and medical centers across the country today. So we are measuring quality in inpatient care, and we are giving the hospitals feedback on how they each do with respect to all the others in the system, and that's powerful.

We've been able to demonstrate, for example, in the nation over the last year, in something we call the Door to Balloon Campaign—and it's really the door to the emergency room to balloon being angioplasty, or a stent, or a CABG surgery.

When somebody's having a documented heart attack, and there's just no doubt about it, we call that in medicine a ST elevation myocardial infarction or a STEMI. When you're diagnosed with this certain heart attack, we need to get the blockage in your coronary artery opened up within 90 minutes, or you will have damage to the heart muscle beyond the blockage that will be a scar and won't heal. That damage will put your heart at risk for heart failure and other problems throughout your life, probably causing you to have serious morbidity later.

So getting that done in 90 minutes is important, and if you ask the best centers in America if they achieve the goal, that's what the science says, they will all say to you, yes. But when we measured, using our registries, how we're actually doing, we found that two-thirds to 70-percent of America's hospitals were not reperfusing, not getting the blocked artery opened up in 90 minutes.

As soon as we gave all of the hospitals the data, within a year, almost all of those hospitals had in fact achieved reperfusion, clearing the blockage, in 90 minutes. So here's something, this is a powerful thing. No money was exchanged, nobody got any payment rewards, but what happened by just simply giving the people the data about how they're doing, was enough to radically reform the care to the benefit of patients.

JACKIE JUDD: Okay, fair enough, but I do want to end this interview going back to the idea of national health care reform. And on that point, if the college could ask the next President to do one thing in the next year, what would it be?

JACK LEWIN: Well, we would say, expand access to those who do not have coverage, and make sure they are included in the system. Take them out of the emergency room as their medical home, and provide a way to take care of them.

JACKIE JUDD: Okay.

JACK LEWIN: But I'm going to just put a little bit of an asterisk on that, because I don't think we have the money. I think after we have authorized the SCHIP program next year, and we fiddle around with some of the things that we have to do that are on the table, I don't think the dollars and cents will be there this year or next year. So I would suggest we spend a little bit of money on advancing quality of care, and creating a business case for doctors and nurses and practices to do some of the things I've talked about, which will start saving dollars, improving care, and reforming the system in ways that incentivize quality, patient safety, the end of disparities and so forth.

These are all very important things that we can do while we are waiting to come up with the dollars for the big fix.

JACKIE JUDD: That's a really interesting approach, because so many of the people I've talked to in this interview series, the phrase I keep using is they want to go big and bold, which by definition I guess is expensive. And yet you're saying something very different, based you say in realism that the money isn't there, or won't be there.

JACK LEWIN: Maybe it will be there in five years. Maybe we'll get these conflicts resolved, the economy improves and we'll be ready. And that gives us some time to think about how to solve the big problems in the most effective way. But in the short term, there are things we can be doing that really will positively impact the system and prepare us for a less expensive big fix.

JACKIE JUDD: Okay, very interesting, thank you Dr. Jack Lewin.

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