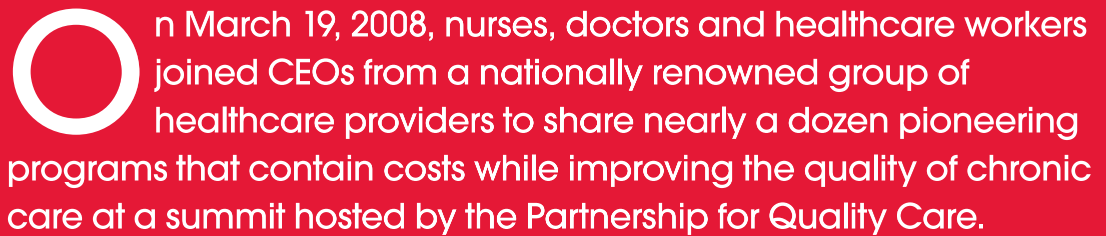
QUALITY
COST CONTROL
UNIVERSAL
HEALTHCARE

Case Studies of Innovations in Chronic Care to Improve Outcomes and Contain Healthcare Costs

PQC
PARTNERSHIP FOR QUALITY CARE
America's health providers and caregivers



On March 19, 2008, nurses, doctors and healthcare workers joined CEOs from a nationally renowned group of healthcare providers to share nearly a dozen pioneering programs that contain costs while improving the quality of chronic care at a summit hosted by the Partnership for Quality Care.

The summit, Confronting the Chronic Care Challenge, was the first in a yearlong series of events designed to bring quality—a topic that encompasses access, affordability, efficiency, and cost containment—to the center of the healthcare debate, by presenting practical solutions to some of the most difficult problems in healthcare today.

The PQC is a national coalition, whose members work at the federal, state, and local level to advance reliable and affordable access to healthcare for all Americans within a reformed healthcare system that aggressively promotes improved quality and efficiency.

The coalition includes public, private, religious, teaching and nonprofit hospitals and integrated health systems as well as more than a million healthcare workers across the country. Members of the partnership care for more than 60 million patients nationwide.

More information including transcripts, video, and presentation slides, is available at www.pqc-usa.org.

Partnership for Quality Care
Principles of Reform

1. Ensure universal healthcare coverage for all Americans.
2. Improve the quality and efficiency of healthcare services by adopting clinical best practices and promoting organized systems of care.
3. Establish a stable, equitable, broad-based, and predictable healthcare financing system.
4. Promote affordability and address rising healthcare costs by advancing opportunities to achieve the greatest value for our healthcare dollars.
5. Provide meaningful individual choice of providers and plans while promoting preventive care, protecting consumers from the costs of major illnesses, and improving the management of chronic conditions.
6. Achieve greater reliability in healthcare coverage, including improved portability of coverage and continuity of care.

Thank you to our Speakers & Moderators

Dennis Rivera
CHAIRMAN OF SEIU HEALTHCARE & CHAIRMAN, PQC

Andy Stern
PRESIDENT OF SERVICE EMPLOYEES INTERNATIONAL UNION (SEIU)

George C. Halvorson
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Focusing on Quality:

Findings of Partnership for Quality Care Summit, March 19, 2008

It is well known the United States invests more of its wealth in healthcare than any other industrialized nation, yet faces an access and cost crisis deeper and more profound than any other industrialized nation.

Numbers that used to shock are now routine: The average family insurance policy now exceeds $12,000 annually and national healthcare costs are at $2.3 trillion and counting. Yet the more we spend, the more the number of those without insurance continues to grow, reaching 47 million last year.[1,2,3]

Where do we start reforming our healthcare system to ensure that everyone in America has affordable access to the best possible care?

Americans also face a crisis of quality that is inextricable from the problems of cost and access. The United States has extraordinary healthcare workers and hospitals, but care is too often uncoordinated, fragmented, and inconsistent with patients' needs. Millions of men, women, and children are locked out of the best care—preventive, comprehensive and outcomes-oriented—because they cannot afford health insurance, and others face bankruptcy when they find their insurance is not sufficient to cover all the costs of illness.[4,5]

Despite these challenges, there is good news. Not only can we improve healthcare delivery at a cost we can afford, this change has already begun.

To highlight real examples of promising healthcare reform, the Partnership for Quality Care (PQC) convened a national summit in Washington, D.C., on March 19, 2008, to address the issue of chronic care. Leading healthcare

providers and caregivers shared real-world initiatives that, across different financing systems (fee-for-service, capitation, charity care), have restrained costs and improved patient care.

At the summit, we identified cross-cutting similarities in these innovations. We found that they used information technology. They focused on the individual patient. They were created in partnership between labor and management. And they did not treat patients as mere consumers, but as members of a larger community with a key role in supporting or hindering their individual ability to maintain and improve their health.

Most important, we discovered that the driving force in all of these innovations was not cost-cutting, but quality. Though embraced, containing cost was secondary to improving the quality of healthcare delivered to patients with complex conditions—a finding deeply relevant to our current healthcare debate.

This finding was not surprising. We focused on innovations in chronic care because 75% of our nation's healthcare spending is on treatment of chronic disease, but our healthcare system remains oriented towards sporadic, acute illness. The way we choose to address chronic illness will impact not only the health of our nation, but the cost of our healthcare system for decades to come.

In this report, the PQC makes a number of high-level reform proposals—against the backdrop of these case studies—designed to improve both healthcare delivery and patient outcomes.

All of these recommendations are anchored in the core value of quality. As our nation is driven to action by increasing costs and decreasing access, improving the quality of healthcare as it is delivered on the ground must be the engine that drives reform.

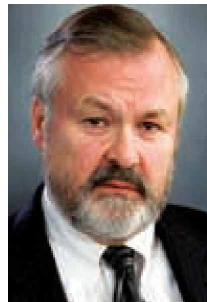
Focusing on quality will enable us to create sustainable long-term improvements in our healthcare delivery system. It will help marginalize the ideological debates that have so often stymied real healthcare reform. And it will help us avoid the trap of simply shifting costs from one party to another.

Focusing on quality is also vital to ensuring that dizzying advances in communications, information technology, systems engineering, and human behavioral and organizational engineering are fully adapted into the healthcare system.

We strongly believe that we can make significant and long-lasting improvements to our healthcare system. But we cannot be distracted by short-term interests or ideological battles. We must stay focused on a clear, singular goal: improving the quality of our healthcare system to ensure that the most efficient, most effective care is affordable and available to everyone in America.

Dennis Rivera

PARTNERSHIP FOR QUALITY CARE CHAIR & CHAIR OF SEIU HEALTHCARE



George Halvorson

PARTNERSHIP FOR QUALITY CARE SECRETARY & CHAIRMAN & CEO OF KAISER FOUNDATION HEALTH PLAN AND KAISER FOUNDATION HOSPITALS

Partnership for Quality Care Policy Recommendations

Guaranteed coverage: The vital first step to addressing a broken healthcare system is ensuring that everyone has access to healthcare through comprehensive and affordable insurance—quality care is simply not possible if it is not accessible. As this is achieved, we also recommend that the reform process include the following policies to further enable providers and workers to improve the quality of care and contain costs:

Focus Area 1

Hardwiring Effectivness to Deliver Better Heath at a Lower Cost

- National healthcare information technology interoperability standards
- Engagement of workforce in healthcare information technology implementation
- Facilitate "team-based" medicine
- Unique patient identifiers with strong privacy protections
- Support for confidential care registries

Reimbursement systems that support:

- Longitudinal reviews and tracking of patients by healthcare providers & caregivers
- Investment in healthcare information technology
- E-Prescribing & computerized physician order entry
- Protocols that make evidence-based care part of the standard delivery of care

Focus Area 2

Changing Delivery Systems to Address Healthcare Disparities

- Enhanced payment rates for facilities empirically demonstrating a decrease in healthcare disparities
- Increased federal support for translation services

Reimbursement systems that support:

- Financial reward for quality and outcome Improvements, especially when improvements create cost savings in other parts of the healthcare system that cannot be recouped directly by the implementing institution
- Voluntary institutional tracking of race, language, country of origin, and ethnicity for quality improvement purposes
- Community partnerships to address healthcare disparities whose origin is non-medical and rooted in broader social challenges

Focus Area 3

Empowering Consumers and Patients to Share Responsibility for Cost and Quality

- Protect patients from high out-of-pocket costs, especially in primary and preventive care settings
- Encourage the development of a coordinating care provider, through medical homes or similar programs
- Support patient-accessible electronic health records

Reimbursement systems that support:

- Provider reimbursement for non-office visit care (such as email, telephone)
- Integration of care delivery across different settings (hospital, home, physician office), including access to capital
- Facilitating appropriate use of care through shared decision-making with patients and their families
- Education of patients

While representatives of many organizations joined the PQC in discussing opportunities to address the chronic care challenge through health system reform, the policy recommendations in this report are solely those of the PQC.

Introduction

This report provides an overview of a conference sponsored by the Partnership for Quality Care on health reform—not just health financing reform. This pressing topic demanded a serious engagement with the critical issue of how our healthcare system addresses the problem of chronic disease.

What better way to start a discussion on health reform than around the issues of quality and affordability? As we go forward in reform, we must create a healthcare system that can address the real health challenges our nation faces—paramount among them, chronic disease.

The reality is that chronic diseases are the most prevalent and costly healthcare problems in the United States, as well as the most preventable. They account for seven out of 10 deaths in America and consume 75 cents of every dollar spent on healthcare. Nearly half of the people in America suffer from a chronic condition, such as high blood pressure, diabetes, or asthma.

This means that first, we must update our healthcare system, which was built to address the health problems of the 1950's, into one that can address 21st Century challenges. Second, we must create a new way to pay for healthcare, one that really allows—even encourages—new delivery models to prosper and develop. Third, we must give our providers and healthcare workers the tools and information technology to actually manage patients.

The case studies outlined in this report provide clear evidence that improving our healthcare delivery system to better treat chronic disease not only improves the lives of patients, but also provides a real route to addressing healthcare costs. It can be done, and it must be done.

Dr. Kenneth E. Thorpe
EDITOR

Background:
The Case for Quality Care

Symptoms of our Broken Healthcare System: High Costs and Restricted Access

From 2001-2005, the cost of health insurance rose 10 times faster than the median worker's income.[6] By 2007, the number of uninsured had risen to 47 million, including almost 9 million children.[7]

Millions more are finding it increasingly difficult to maintain comprehensive health insurance coverage at an affordable cost. As premiums increase, more employers are shifting costs to workers in the form of co-pays and other forms of cost-sharing. Countless others discover that when they become ill, there are surprising, expensive gaps in their insurance coverage.

The health consequences of these high costs and restricted access are clear. In a recent poll, 42% of respondents reported that they had problems accessing healthcare due to its cost, with 66% of that group reporting that their conditions worsened as a consequence.[8] Older, chronically ill adults who were uninsured prior to receiving Medicare have a "pent-up" demand for healthcare services, seeing doctors and being hospitalized more often, and with greater medical expenses, than people who were insured before receiving Medicare.[9] Tragically, it has been found that uninsured children admitted to the hospital are twice as likely to die as those with insurance.[10]

The instability of our healthcare system is even compromising healthy Americans' ability to make important life choices. In a recent poll, 23% of respondents said a household member had decided to stay with an employer, or switch to a new one, because of health insurance coverage. Some respondents even said they, or someone in their household, had gotten married to obtain health insurance through their spouse.[11]

This difficult situation will likely worsen in the near future. Employer-sponsored health coverage is the backbone of our insurance system, but between 2000 and 2006, the percentage of workers getting healthcare through their jobs fell from 68.4 percent to 62.2 percent.[12] As the current economic downturn deepens, it is estimated that for every point of unemployment increase, 2.5 million people will lose their job-based health insurance, 1.4 million of whom will end up on public insurance programs.[13]

Building on America's Strong Legacy of Quality

Quality is what matters most in healthcare.

In the United States, the past 50 years have seen huge improvements in healthcare quality, and Americans are living longer and better as a result. Hip replacements have turned what used to be crippling arthritis into a minor inconvenience. Within a decade, HIV/AIDS was transformed from an untreatable, lethal disease into a treatable chronic ailment for millions.

It has been estimated that half the gains in life expectancy over the past 50 years are due to medical advancements in treating disease.[14] Cross-nationally, United States mortality rates for heart attack and trauma victims are lower than in other countries.[15] We have better survival rates for severely pre-term infants.[16] In addition, the United States has the highest rates of heroic healthcare interventions such as transplants.[17] Finally, we are the undisputed leader in high technology biomedical innovation, especially in the translation of academic findings into commercial products that can be used in the clinical setting.

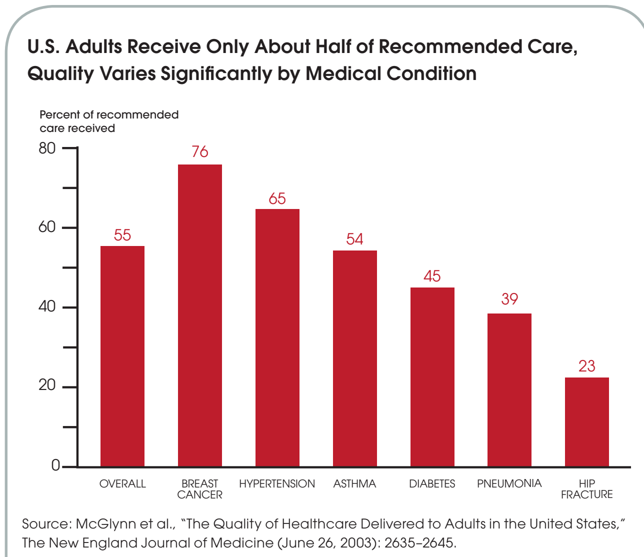
Our healthcare system is even compromising healthy Americans' ability to make important life choices—jobs and even marriages are affected.

Yet for all our successes, it is becoming clear that our nation's progress is stalling. Our health gains are coming at an ever-increasing cost.[18] Additionally, we are failing to triumph over new health challenges like the health consequences of obesity, especially in places where there is less access to the highest quality healthcare.[19]

Our nation can no longer rest on its laurels, simply making incremental progress along the paths that were laid out by the visionaries of a prior generation. It is time for a paradigm shift in healthcare, one that builds on our nation's legacy of hard-won quality. We must improve access to healthcare advances, and, at the same time, we must develop a delivery system in which every patient receives the right care at the right time. This can be done by fostering day-to-day excellence in healthcare delivery.

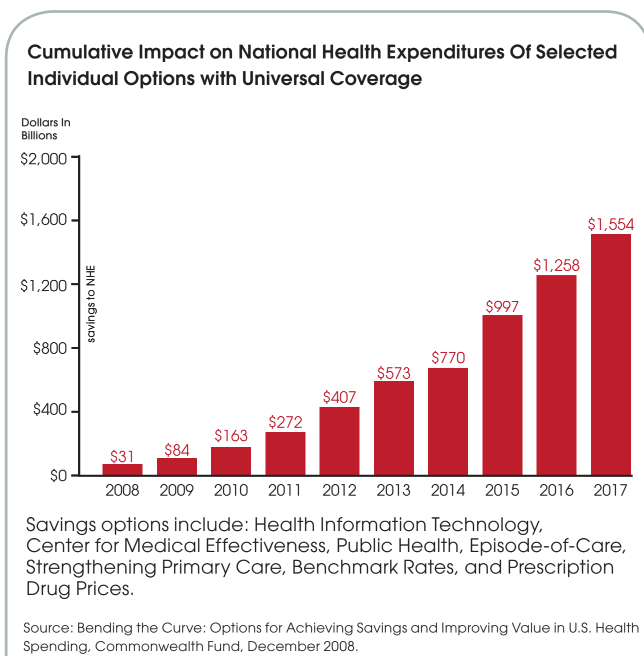
New Opportunities to Improve Quality Are Key to Containing Costs and Increasing Access

Despite dramatic technological advances that have led us to a new frontier in medicine, health systems delivery research has revealed that we do not apply our medical knowledge for patients' benefit as effectively as we should. Nationwide, patients receive only half the recommended care, with wide variations.[20] (Graphic: Chart 1)



Source: McGlynn et al., "The Quality of Healthcare Delivered to Adults in the United States," The New England Journal of Medicine (June 26, 2003): 2635–2645.

Chart 1



Savings options include: Health Information Technology, Center for Medical Effectiveness, Public Health, Episode-of-Care, Strengthening Primary Care, Benchmark Rates, and Prescription Drug Prices.

Source: Bending the Curve: Options for Achieving Savings and Improving Value in U.S. Health Spending, Commonwealth Fund, December 2008.

Chart 2

Charts as presented by Stuart Guterman, 3/19/08

There is an enormous lag between the development of proven, more effective treatments and consequential care practices. There are systemic care delivery inequities—disparities not only between those who have comprehensive insurance and those who are uninsured or underinsured, but also by race and ethnicity.[21] Too frequently, the healthcare system fails to use our knowledge of human behavior to enlist active patient participation to most effectively improve their health and guide the care process.

None of these problems are new. What is new is that today we have the systems engineering, information technology, and insights into human behavior to see how large and consequential these problems are, and how we can address them. Analogous to the way the application of statistics to healthcare revolutionized epidemiology by allowing researchers to determine the true causes of disease and how to minimize its transmission, the application of these fields will enable major breakthroughs in the quality of our nation's health.

There is compelling evidence that improving quality in our delivery system will yield substantial savings over the long term. A recent Commonwealth Fund study estimated savings for various approaches targeted at improving healthcare delivery and determined that cumulative savings over a 10-year period were in the trillions of dollars.[22] (Graphic: Chart 2)

> Improving quality in our delivery system will yield substantial savings over the long term.

Estimated savings aside, there is still skepticism that systems delivery improvements can really create a new frontier in health quality. Every new innovation faces this question: can success in vitro be repeated in vivo? And can it be achieved for the most pressing health conditions, yielding savings and health improvements that significantly reduce the burden of disease in the United States?

We Must be Able to Treat Chronic Disease

To address the skepticism of whether we can achieve a new frontier in health quality by transforming our healthcare delivery system, the PQC focused on ways our healthcare system has already been improved on the ground to fight chronic disease.

Today, chronic diseases such as cardiovascular disease, asthma, diabetes, depression, and cancer are responsible for 75% of healthcare costs and 70% of deaths in the United States annually.[23] Nearly 45% of Americans

have at least one chronic disease, and rates are on the rise.[24] According to the Centers for Disease Control and Prevention, chronic conditions cause major limitations in activity—productivity at work, family time, and enjoyment of leisure—for more than one in 10 Americans.[25]

Chronic disease treatment should be responsive to innovations in information technology and systems engineering.

Chronic disease treatment should be responsive to innovations in information technology, systems engineering, and new insights into human behavior. The day-to-day excellence enabled by these advances should improve disease screening rates, better integrate care, increase patient empowerment, create more equality in our healthcare system, and enhance data collection and analysis in ways that should lead to measurable improvements in the quality of life for patients. They should lead to measurable productivity gains, and cut down on presenteeism and absenteeism in our workforce and schools. Given the staggering economic burden of chronic disease, these innovations should also be cost-saving over the long term.

March 19, 2008, Summit on Cost and Quality

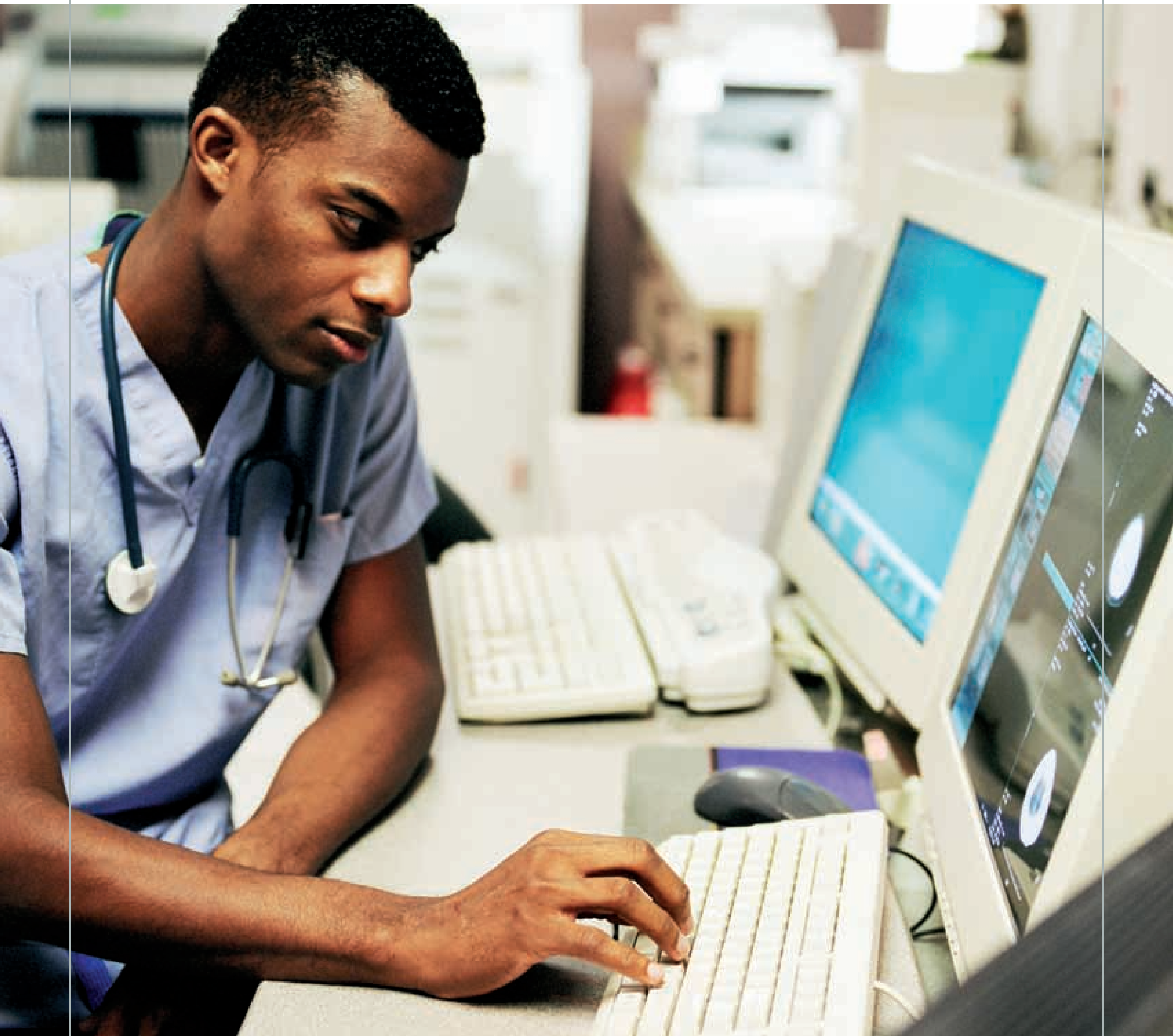
On March 19, 2008, the PQC sponsored a summit on healthcare cost and quality in Washington DC. Its purpose was to bring quality to the center of the healthcare reform debate, by discussing case studies of real-world innovations in our healthcare delivery system. The goal was to identify commonalities that would yield policy recommendations to help transform the healthcare system.

Key focus areas included initiatives to hardwire quality improvements through practice change and information technology, initiatives to reduce healthcare disparities, and initiatives that empowered patients to share responsibility in their care.

Participants included:

- **SEIU United Healthcare Workers-West** and **Kaiser Permanente** presented their implementation of an electronic health record that has led to a 57% reduction in hospital medication errors.
- **Montefiore Medical Center** demonstrated their Clinical Looking Glass, an information technology tool that uses real-world data to develop and implement best standards of care.
- **Massachusetts General Hospital** provided an overview of its model for reducing persistent ethnic and racial disparities in the treatment of chronic disease through its Disparities Solution Center.
- **Catholic Healthcare West** presented a post-discharge support program that reduced the cost of care by 28% for patients by aiding them in monitoring and managing their disease.
- **Jackson Health System** profiled the separate intake clinic it created to intervene and assess congestive heart failure patients, reducing hospital readmittance by 80%.
- **The Mayo Clinic** explained an asthma quality improvement initiative that shifts from traditional process-based measures to a focus on patient-centered outcomes.
- **Daughters of Charity Health System** provided an overview of the Asian Pacific Liver Center, created to address high rates of Hepatitis B in the greater Los Angeles area.
- **HealthPartners** explained how electronic medical records were used to collect patient race/ethnicity and language preference data, and how that data was built into quality metrics to identify, develop, and evaluate strategies to eliminate disparities.
- **Group Health Cooperative** demonstrated its use of health technology to create customized preventive care programs that take into account an individual's personal health needs by using the information in their medical record.
- **Nurses of SEIU Healthcare 1199NW** in Washington State discussed how they worked with Group Health management to improve care for patients even after the patients had been discharged from the hospital.
- **Kaiser Permanente** presented an initiative that has helped reduce heart disease mortality among its members in northern California by 30% through a combination of preventive programs and evidence-based medicine.

1 Hardwiring Effectiveness to Deliver Better Health at a Lower Cost



A significant flaw in our healthcare system is our inability to ensure that optimal care is delivered in every case, for every condition. More than half the time we fail to meet this standard of effective care. Likewise, the prevailing approach to care does not create a healthcare system that can easily integrate new breakthroughs and ensure that every healthcare decision is made by practitioners with access to a patient's full body of medical information, allowing them to make the best decisions.

Before beginning a discussion of hardwiring quality, it is important to note what it is not. Hardwiring quality is not "cookbook medicine" whereby experts simply develop a list of practice instructions for caregivers and providers to follow. Instead, it is a dynamic process, aimed at empowering all caregivers—physicians, nurses, paraprofessionals, and others—to better use their clinical expertise and judgment. It is to ensure that every variation in care is a deliberate decision made by a clinical expert drawing on the most current information. It is also aimed at giving providers and caregivers the tools they need to create and evaluate improvements in care delivery, leading to better patient outcomes.

Hardwiring Quality: Conclusions

The approaches profiled here share many transformational characteristics. All rejected the paradigm of healthcare as a reactive profession in which practitioners waited for a patient to come to them in crisis. Rather, they focused on building multidisciplinary teams, using technology to increase their efficiency, ensuring longitudinal care of patients across conditions, and ensuring that caregivers had the necessary tools to make the best possible decisions. These innovations represent a new kind of quality, a dynamic one that actively spurs the development and adoption of new improvements. And in addition to the short-term returns on investment that have already been achieved, there will almost certainly be many future returns on investment as well, as best practices compound and spur quality improvements that are simply unimaginable in the current care setting.

Kaiser Permanente

Philip R. Madvig, M.D.

Dr. Philip R. Madvig is Associate Executive Director of The Permanente Medical Group. He joined Kaiser Permanente in 1983 as an internist at the San Francisco Medical Center. He was appointed Physician-in-Chief at the Medical Center in 1988. In 1997 he became an Associate Executive Director for The Permanente Medical Group. In this role, he is accountable within Northern California for quality, utilization, regulatory compliance, accreditation, research, and hospital operations. He co-chairs the Northern California Quality Oversight Committee and the Joint Operating Group, and chairs the Executive Compliance Committee.

In Northern California, Kaiser Permanente began an investment in chronic disease treatment that focused on changing the care delivery system to ensure that healthcare providers made better and more efficient use of treatments known to be effective.

The results were remarkably successful. The percentage of patients with effectively controlled hypertension skyrocketed between 2001 and 2006, from 36%, the national average, to 75%. Mortality from cardiovascular disease plummeted 25% over a 10-year period, and from 2004–2007 more than 9,600 diabetic patients had controlled their cholesterol, averting an estimated 300 heart attacks and strokes.

Perhaps most tellingly, and in stark contrast to the general population, heart disease is no longer the leading cause of death in Kaiser's patient population.

These improvements produced significant savings. Hypertension alone is an exceptionally prevalent condition, with more than 36.8 million reported cases. It is estimated that lost workdays and lower productivity caused by uncontrolled hypertension cost the U.S. $279.5 billion in 2003, and its direct medical costs are $32.5 billion annually. Hypertension is also a significant contributor to heart attack and stroke, which combined account for $127 billion in lost productivity and in $79 billion in direct health costs.[26]

It is estimated that lost workdays and lower productivity caused by uncontrolled hypertension cost the U.S. $279.5 billion in 2003, and its direct medical costs are $32.5 billion annually.*

*Medical expenses are a conservative estimate and do not include institutionalized populations.

Kaiser Permanente and SEIU United Healthcare Workers-West

Linda Beckman

Linda Beckman is Northern California Labor Coordinator for KP HealthConnect, the largest civilian deployment of electronic health records. She has been a Kaiser Permanente employee and a SEIU-UHW member since 1970. Linda has worked as a receptionist, appointments clerk or medical secretary in numerous outpatient departments at Kaiser Permanente. In 1997 she took a leadership role in the Labor Management Partnership, the largest labor partnership in the United States today, covering more than 20,000 managers, 12,000 physicians, and 92,000 employees in 30 unions. She was the labor lead in opening new call centers for Kaiser Permanente's Northern California region. Since 2003 she has been on the leadership team for the design and implementation of Kaiser Permanente's EHR system.

In the later phases of its initiative to improve care, Kaiser Permanente instituted what will ultimately become the nation's largest civilian electronic health record, encompassing more than eight million members in nine states and the District of Columbia. This record had to support a new model of care, one which is focused on empowering every member of the healthcare team—physician, nurse, lab tech, etc.—to more effectively communicate and take a more proactive role in improving patient care.

Electronic health record implementation has been a significant challenge nationally, with a failure rate of up to 30% and healthcare system capital losses in the hundreds of millions.[27] But through the active partnership of labor and management, not only were significant implementation challenges overcome at Kaiser, additional and unexpected improvements were realized.

Employee turnover was minimized by creating training programs for workers in jobs made obsolete by new technology. In the face of a substantial healthcare workforce shortage in healthcare, it enabled the organization to retain employees already familiar with the corporate culture, and minimized disruption. In Northern California alone, more than 760 workers were redeployed, with fewer than 10% choosing severance.

Building on the partnership created by medical record implementation, further implementations of technology increased efficiency and decreased error. For instance, new technology enabled prescribing processes to drop from 14 steps (six of them handwritten) in 2004, to four steps in 2007. The improved process led to a 57% reduction in hospital-based medication errors.

Improved communications also produced unexpected benefits. The top patient complaint in hospitals is of too much noise. Improved communications due to IT meant there was less need to clarify physician orders with calls, which led to reduced noise on the wards.

Employee turnover was minimized by creating training programs for workers in jobs made obsolete by new technology.

Mayo Clinic

Kaiser Lim, M.D.

Dr. Kaiser Lim is a consultant at the Mayo Clinic Rochester Department of Medicine, Division of Pulmonary & Critical Care Medicine. He is board certified in Internal Medicine, Pulmonary and Critical Medicine and Allergy and Immunology. A fellow of both the American College of Chest Physicians and the American Association of Asthma, Allergy and Immunology, Dr. Lim is the project leader of the Mayo Clinic Department of Medicine Asthma Initiative. Trained at the Cleveland Clinic Foundation for Internal Medicine, he went to Boston University for specialty training in pulmonary, critical care, and allergy and immunology, and completed a basic science research fellowship at Harvard at the Beth Israel Deaconess Hospital in Boston. Prior to joining the Mayo Clinic, he was director of the Asthma Program at Michael Reese Hospital in Chicago.

As an organization attempts to hardwire quality, the question inevitably arises: "How do we know when we're doing a good job?"

At Mayo Clinic in Rochester Minnesota, a focus on better measures of quality ultimately led the organization to launch an initiative to improve the way they tracked and treated asthma in patients.

Asthma is a significantly under-treated disease, in spite of effective medications and treatment protocols.[28] Affecting approximately 20 million Americans, it is responsible for roughly 1/4 of all emergency room visits annually and over 39 million days of missed work and school.[29, 30]

At Mayo Clinic, researchers mined patient data and found that they needed to go beyond traditional measurements of quality care for asthma patients. Many integrated care delivery organizations use Health Plan Employer Data and Information Set (HEDIS) scores, a standardized set of measures maintained by the National Committee for Health Quality Assurance, to measure the effectiveness of their treatments. For their population, patients with good HEDIS scores still missed work and suffered health complications due to asthma at rates that were mostly indistinguishable from patients with poor HEDIS scores.

After additional research, Mayo determined that they needed to use control of asthma as their measurement of quality. They further determined through evidence-based protocols the key questions to ask of asthmatic patients to find out if their asthma was effectively controlled. Information technology was used to integrate these questions and other clinical interventions into the patient visit protocol.

Ultimately, Mayo found that 30% of the patients in the study did not have their asthma under control. The intervention is moving to its next phase, which is to make full use of the disease registry that has been created, offer more aggressive treatment for these patients, and continue to track how well the organization is treating asthma.

A key factor in this intervention was the ability to reinforce changes to healthcare providers' standard protocol for asthma patients by using information technology systems. Hardwiring these new questions into the care process made it possible to collect far more robust data on patients' health than had been collected in the past. It also made it possible for researchers to wade through the data that was collected and empirically determine which questions were the most important when it came to finding out if a patient's asthma was under control or not—making care more efficient for both patients and doctors.

Greater New York Hospital Association, Montefiore Medical Center

Eran Bellin, M.D.

Dr. Eran Bellin is the Vice President of Clinical IT Research and Development at Emerging Health Information Technology, a wholly owned subsidiary of the Montefiore Medical Center. Boarded in Internal Medicine and Infectious Disease, and trained in Clinical Epidemiology at the Robert Wood Johnson Clinical Scholars program at Yale, Dr. Bellin served as Director of Infectious Disease Services at Montefiore's Rikers Island Health Service from 1989 through 1994. He was responsible for the Infectious Disease Care for the over 100,000 unique inmates seen annually. He developed and supervised a 140-bed negative pressure respiratory isolation facility for TB care on Rikers, developed protocols and supervised the directly observed TB therapy and HIV care program. In 1994, Dr. Bellin became the program director and supervised the medical and psychiatric service composed of 1,100 Montefiore clinicians and administrators and lead the program ultimately to JCAHO certification with commendation in 1997.

Another healthcare delivery innovation was pioneered by Montefiore Medical Center in the Bronx, New York, a member of the Greater New York Hospital Association. A large urban provider with three hospitals, 21 clinics, two million clinical visits, and over 210,000 emergency room visits annually, Montefiore focused on building a database that aggregated all patient records in conjunction with a complex statistical system that enabled physicians, caregivers, and researchers to quickly perform complex longitudinal studies.

In the short term, this technology has enabled providers to perform longitudinal reviews of all the patients under their care. They are able to determine which patients are not meeting treatment goals, and take proactive steps with their healthcare team to reach out to these patients and determine why they are falling through the cracks. The system demonstrated that those diabetics achieving clinical targets experienced a 1/3 reduction in hospitalizations. With an estimated national cost per hospitalization for a diabetic of $9,400 nationally, the cost savings here are significant.[31]

In addition, when the state of the art in healthcare changes, providers no longer have to passively wait for patients to come in and be told about this new information. When nurses have important news for patients about new and more effective treatments, they can perform precision searches of the database to find all patients whose specific conditions indicate they may benefit from this new treatment. Likewise, if a medication is recalled, they can quickly contact all patients who need to discontinue.

This tool also has the ability to profoundly transform healthcare over the long term. Healthcare research has historically been an arduous process, requiring a dedicated quality improvement department to construct questions, pull and extract data from paper charts, and analyze results, with a typical data cycle for a specific question lasting 6-8 weeks. This new technology has enabled any clinical provider or caregiver to perform complex statistical analyses of current data in a matter of minutes.

For the first time, physicians who suspect a medication has under-reported side effects can empirically test these suspicions. They can investigate their own patient population to find unknown factors that explain why treatments work so well for some patients, and not at all for others. In essence, every caregiver has the potential to become a robust clinical researcher, pushing the frontier of medicine as he or she delivers care.

Every caregiver has the potential to become a robust clinical researcher, pushing the frontier of medicine as he or she delivers care

2 Changing Delivery Systems to Address Healthcare Disparities

In 2003, the Institute of Medicine issued a landmark report documenting pervasive inequities in healthcare access, quality, health status, and outcomes between whites and non-whites in the United States.[31] Additional research clearly demonstrates that issues of socioeconomic status, ethnicity, language, and race work together to create distinct and overlapping disparities in healthcare access and quality. Certain populations of color are more likely to be low-income, living in neighborhoods with unique health risks and where healthy behaviors are more challenging.

Others of similar income may have neighborhoods that better support healthy behavior, but may be more likely to suffer certain chronic diseases, or to work in occupations with less access to health insurance. There is also evidence that the healthcare system itself is driving some of these disparities: even controlling for other factors, persons of color are more likely to receive sub-optimal care than whites.

Although these disparities are often the result of social forces outside the healthcare system, it is indisputable that the healthcare system must aggressively move from being part of the problem to part of a comprehensive solution.

Eliminating Disparities: Conclusions

The profiled interventions clearly demonstrate the potential for cost-saving improvements in healthcare quality that can be achieved by effectively addressing healthcare disparities. All interventions showed an institutional commitment to address disparities as part of their core mission. They all collected, monitored, and measured data, and used evidence-based interventions. Changes were routinized into the care delivery process, as was the tracking of disparities. Finally, there was an openness to public data reporting as part of a mutually supportive partnership with local communities and leaders.

HealthPartners

Donna Zimmerman

Ms. Zimmerman is the Vice President of Government and Community Relations for HealthPartners, a nonprofit, consumer-governed healthcare organization in Bloomington, Minnesota. HealthPartners provides healthcare coverage to about one million members in medical, dental, individual and Medicare/Medicaid products. Ms. Zimmerman is responsible for directing public policy, community affairs, and Medicare sales and marketing for the HealthPartners organizations. She was previously the Director of Government Programs, with responsibility for the health plan Medicare and state public programs, including strategic planning, product development, and state and federal government relations. Her background is in community health administration, with leadership experience in public and nonprofit sectors. She has held national association leadership positions and consulted extensively across the country in the areas of public and private health partnerships. She is on the boards of the Minnesota Council of Health Plans, the HealthPartners Research Foundation, the Minnesota Citizens League, the St. Paul Conservatory of Music and the Minnesota Chapter of the March of Dimes Birth Defects Foundation.

Based in Minnesota, HealthPartners is an integrated care delivery system that includes two hospitals and over 790,000 patients, approximately 90,000 of whom are publicly insured through state Medicaid programs or Medicare.

Minnesota has experienced an immigration surge in recent years, and in 2005 received more immigrants than in any year since comprehensive record-keeping began.[33] Today, Minnesota has the largest Hmong and Oromo populations in the U.S., and the largest population of Somalis outside of Somalia. In response to this demographic shift and the healthcare disparities it could create, HealthPartners addressed the challenge.

A first key step was to collect voluntary patient data on race, ethnicity, and language, to go beyond the established literature on disparities and drill down to their specific challenges, proactively tracking care and seeing where disparities were most prevalent. HealthPartners then voluntarily publicly released this information, in concert with outreach efforts to community organizations to reduce these disparities

Central to this initiative was integrating disparities reduction as part of the standard quality improvement process at HealthPartners. It reinforced the message that resolving healthcare disparities was of the highest priority to the organization, and would be an ongoing metric upon which performance was judged.

By testing and applying different strategies, in partnership with community organizations, HealthPartners has increased the cultural competence of its care through a standardized improvement process, and made progress in alleviating some healthcare disparities. Disparities in heart attack care and in pneumonia care in the hospital, for example, have been virtually eliminated. Other disparities, however, have proven more challenging. While interventions in diabetes control have succeeded in significantly improving the percentage of both white patients and patients of color whose diabetes is controlled, they have improved both groups equally and do not seem to have closed the gap between them.

Resolving healthcare disparities is of highest priority, and it will be a continuing metric upon which performance is judged.

Given the higher rates of health conditions like diabetes in many communities that also suffer from health disparities, it is vital to ensure that healthcare systems are not “one size fits all,” but able to appropriately treat patients from many ethnic and economic backgrounds. HealthPartners has found it spends $5,000 annually on patients with controlled diabetes, and $60,000 annually on those whose diabetes is not controlled. There is opportunity for additional investment to ensure that health disparities do not become entrenched as Minnesota’s population becomes more diverse.

Daughters of Charity Health System's Asian Pacific Liver Center

Tse-Ling Fong, M.D.

Dr. Fong is the Program Director for the Asian Pacific Liver Center at St. Vincent Medical Center and an associate professor of medicine and medical director of the liver transplant program at the University of Southern California (USC) Keck School of Medicine. A graduate of the USC School of Medicine, Dr. Fong completed a residency in internal medicine and fellowships in hepatology and gastroenterology at LAC/USC Medical Center. He also served as a clinical associate in the liver diseases section at the National Institutes for Health, where he conducted research on hepatitis. Dr. Fong is board-certified in Internal Medicine, Gastroenterology and Transplant Hepatology. With more than 50 publications in peer-reviewed medical journals, he continues to conduct research in viral hepatitis and liver transplantation.

Daughters of Charity Health System is a regional health system of five hospitals including St. Vincent Medical Center, the oldest hospital in Los Angeles. The Daughters of Charity Heath System opened the Asian Pacific Liver Center to focus on Hepatitis B in the immigrant Asian community. It offers patients, physicians, and community groups the resources and services necessary to prevent, detect, and treat Hepatitis B infection.

Effective treatment largely obviates the need for a liver transplant, which costs $300,000 and includes a lifetime of anti-rejection medications.

It is little known that Hepatitis B, a virtually asymptomatic degenerative liver disease, disproportionately affects Asians. Of the roughly 400 million individuals infected, approximately 70% reside in Asia. In the United States, the Hepatitis B prevalence rate for immigrant Asians is estimated at 10-15%, depending on country of origin, a rate approximately 35 times higher than the general population.[34] Of those infected, approximately 30% will develop hepatocellular carcinoma or cirrhosis, for which a liver transplant is the only clinical treatment.

While mandatory vaccination now protects those born in the United States, few low-income Asian immigrants know that this disease is prevalent, and 70% have not been protected through vaccine. Less than 60% of those infected with Hepatitis B are diagnosed, and many find they have the infection only when they present with end-stage liver disease.

At the center, the only one of its kind in Southern California, thousands have been screened for Hepatitis B. It has also served an important role raising awareness among the public and among policymakers—in Los Angeles and beyond—of the special challenge Hepatitis B poses for Asian communities. But funding remains an ongoing challenge, as 90% of patients are uninsured, and effective antiviral treatment costs approximately $10,000 annually. However, the net savings to the healthcare system of screening, vaccination, and treatment is clear, as effective treatment largely obviates the need for a liver transplant, which costs $300,000 and includes a lifetime of anti-rejection medications.

Partners HealthCare—Massachusetts General Hospital Disparities Solutions Center

Joseph R. Betancourt, M.D., M.P.H.

Dr. Betancourt's primary interests include cross-cultural medicine, minority recruitment into the health professions, and minority health/health policy research. He has served as Principal Investigator on grants from the Centers for Medicare and Medicaid Services and the Commonwealth Fund, and is currently Principal Investigator on projects funded by the California Endowment and The Commonwealth Fund, in addition to being co-investigator on projects funded by the National Cancer Institute and the Health Resources and Services Administration.

Dr. Betancourt has served on several Institute of Medicine (IOM) Committees, including those that produced "Unequal Treatment: Confronting Racial/Ethnic Disparities in Healthcare", "Guidance for a National Healthcare Disparities Report", and "In the Nation's Compelling Interest: Ensuring Diversity in the Healthcare Workforce." He also sat on the Physicians for Human Rights Blue Ribbon Panel on Racial/Ethnic Disparities in Health. Dr. Betancourt served on the CDC's National Expert Council for the Diabetes Today Program, and currently Co-Chairs the MGH Disparities Committee. He is also reviewer for the American Medical Association's Journal Consortium and Annals of Internal Medicine. Dr. Betancourt has written peer-reviewed articles on topics including racial/ethnic disparities in health and healthcare; hypertension, diabetes, and cerebrovascular disease in minority communities; cross-cultural care and education; ethics; workforce diversity; and the impact of language barriers on healthcare. Dr. Betancourt also teaches cross-cultural medicine, health disparities, and health policy to medical students and residents at MGH-Harvard Medical School and to students at the Harvard School of Public Health.

Partners HealthCare, located in Boston, is an integrated health system founded by Brigham and Women's Hospital and Massachusetts General Hospital. In addition to its two academic medical centers, the Partners HealthCare System also includes community hospitals, specialty hospitals, community health centers, a physician network, home health and long-term care services, and other health-related entities.

It has addressed healthcare disparities three ways. First, on a national level, it has raised the visibility of the issue through the creation of a dedicated Disparities Solutions Center, housing it in one of the nation's leading academic medical institutions.

Second, this health disparities center has served as a resource base for healthcare providers nationwide to learn effective techniques and interventions to address disparities in their own institutions.

Third, it has pioneered proof of concept in its own clinical care delivery programs, demonstrating that even for the most challenging clinical conditions, improvements in care can be achieved for vulnerable populations.

The cost-saving potential in addressing disparities is significant. Patients with limited English proficiency are far more likely to receive an unnecessary $600 CT scan for a sinus infection than those with whom the provider can communicate and take a more full patient history.

One clinic initiative saves an estimated $54,000-$135,000 annually.

There are less obvious cost savings as well. Because racial and ethnic minorities often bear a disproportionate burden of more severe disease and are less sensitive to generic healthcare interventions, interventions focused on resolving disparities in chronic disease yield greater results than those targeted across the entire chronically ill population.

A disparities initiative at Massachusetts General Hospital Chelsea HealthCare Center (outside Boston) targeting 350 patients using clinically appropriate standardized interventions is estimated to have saved $54,500-$135,000 annually, mostly by decreasing hospitalizations. Because this population is at higher risk of multiple hospitalizations, closing the disparities gap through a culturally appropriate and effective intervention yielded greater anticipated savings than in a population that was not suffering disparities in care.

It is also important to note that these direct medical savings do not include productivity gains, likely to be significant as diabetes has a nationwide productivity cost of over $105 billion annually.[35] Such productivity gains are more likely to be seen in persons of color who are chronically ill, as they are typically younger than their white counterparts and more likely to be part of the workforce.

Jackson Health System

Kathy Hebert, M.D.

Dr. Kathy Hebert is an associate professor of medicine in the division of cardiology at the University of Miami, Miller School of Medicine. She received her medical degree from the Louisiana State University Health Sciences Center in New Orleans, Louisiana, a Masters in Medical Management from the Tulane School of Public Health and a Masters of Public Health from the Harvard School of Public Health. Dr. Hebert also served as a Robert Wood Johnson Health Policy Fellow in the U.S. Senate Subcommittee on Bioterorism and Public Health Preparedness and at the National Institute of Medicine in the Fogarty International Center as well as at the Office of Global health Affairs at HHS. She has worked for President Bush's Millennium Challenge Corporation in Mongolia and in the country of Georgia with USAID. Her interests are in population medicine, disparities in care and indigent care using disease management models.

Jackson Health System, a Miami, Florida-based integrated healthcare delivery system, includes: Jackson Memorial Hospital; 12 primary care centers and two primary care mobile vans; multiple school-based clinics; two long-term care nursing facilities; six Corrections Health Services clinics; a network of mental health facilities; Holtz Children's Hospital; Jackson Rehabilitation Hospital; Jackson North Medical Center, and Jackson South Community Hospital.

Jackson is a critical safety net provider for Miami-Dade County, providing more than $500 million in charity care annually. In its community, there are significant barriers to comprehensive care for the indigent, who not only lack health coverage but are also disproportionately non-English speaking. Health disparities are especially profound for those attempting to manage a complex chronic disease like congestive heart failure (CHF), debilitating both mentally and physically.

In the first six months, 115 patient visits for emergency CHF occurred in the low cost clinic instead of the emergency room, generating a net savings of $500,000.

Jackson Health System implemented a program created in the Charity Health System in New Orleans, Louisiana. All CHF patients were eligible to enroll in a free, culturally appropriate CHF education program, and access to a special, free CHF treatment clinic in emergencies. The results, first in Louisiana and again in Florida, have been impressive. Upon discharge, use of beta blockers approached 100%, compared to a national average of 68%.

In Florida, the cost savings were immediate. In its first six months, 115 patient visits for emergency CHF treatment occurred in the low-cost clinic instead of the emergency room, generating a net savings of $500,000. At an average inpatient cost for CHF of $26,400, if clinic visits diverted half these patients from inpatient admission, the cost savings would be an additional $1 million.

There are secondary benefits beyond the control of CHF, as other disparities have been addressed through the clinic. Patients enrolled in the program have received recommended flu and pneumonia shots at rates higher than in the general population, creating an unexpected disparity in which some ethnic minorities are actually receiving flu shots more often than whites. The organization will, of course, continue to track this new disparity to ensure it does not become persistent.

3 Empowering Consumers & Patients to Share Responsibility for Cost & Quality

In contrast to office or hospital-based acute care, much chronic disease prevention and treatment occurs in the patient's home. The traditional healthcare model—providers issuing prescriptions and orders with which the patient was expected to comply—has never been a particularly successful approach to chronic disease. Patients with chronic disease routinely fail to take prescribed medications, including 40-50% of diabetics and 40% of hypertensive patients.[36]

In addition, many patients express significant frustration with the medical profession. Patients routinely complain about not feeling "listened to," and there is empirical evidence that many patients, especially those with severe illness or at the end of life, undergo medical treatments they would decline if they better understood the risks and likely outcomes.

As we take advantage of technological progress and systems engineering advances to re-organize our healthcare delivery system, the focal point must be patients and their meaningful empowerment.

Empowering Patients: Conclusions

All of these interventions share a philosophy in which patients are the center of a reformed healthcare system. They are the unquestioned directors of their own care, but with comprehensive support from the healthcare system.

The healthcare system should include human and technology supports to provide them with meaningful options, and information and education to guide their decisions. The healthcare system can also serve as an integrator of social services.

Catholic Healthcare West

Kathleen Farrell, R.N., B.S.N.

Ms. Kathleen "Kathi" Farrell, RN, BSN, joined Catholic Healthcare West in 2002 as the program coordinator of Marian Medical Center's new disease management program for community-based patients with congestive heart failure. Ms. Farrell has seen over 3,000 patients with CHF since the program's inception and has been instrumental in achieving fewer re-admissions, shorter lengths of stay if re-admitted, and high patient satisfaction for patients enrolled in this program.

Catholic Healthcare West (CHW), headquartered in San Francisco, California, is a system of 41 hospitals and medical centers in California, Arizona and Nevada. Founded in 1986, CHW is the eighth largest hospital system in the nation and the largest not-for-profit hospital provider in California.

Marian Medical Center, located in Santa Maria, California, serves 90,000 people annually, 20-24% of whom lack health insurance. Congestive heart failure (CHF) is consistently one of the center's top two admitting diagnoses, and those with the condition face enormous challenges, including a demanding diet and debilitating effects such as increased forgetfulness and confusion caused by decreased blood flow to the brain.

To prevent re-hospitalizations, Marian Medical Center created an educational, nurse-staffed case management program to help patients manage their health conditions after discharge. Patient support services were initiated in hospital and, to ensure the inclusion of home health workers and off-site physicians, integrated into an electronic medial record. The care management program includes additional non-clinical patient services to ensure they have the resources to maintain their health.

The program has been extremely successful. Readmission rates over 30 days for CHF patients at Marian Medical Center not enrolled in this program are 18%, consistent with the national average. Readmission rates for patients in this program are 1%, and when patients are admitted, they have shorter lengths of stay. The cost savings per case are $1,800. There have also been secondary benefits. Prior to this program, only 53% of CHF patients received discharge instructions on managing their own care. Since the program was instituted, this percentage has climbed and now 98-99% of patients receive discharge instructions.

There are continuing challenges. The program receives no direct healthcare funding and relies on operational grant funds. Lack of capital funding means that as hospital IT systems upgrade, this program is in danger of being left behind. It also means new technologies cannot be used to make care more efficient.

Case In Point

""I had mailed a patient information, but found out later he was legally blind. I arranged for a local organization to send a volunteer to go out and help him. Now, the volunteer visits twice a month and helps my patient pay his bills, read his mail. As a nurse, empowering a patient so much is tremendously rewarding."

— KATHI FARRELL, R.N., CATHOLIC HEALTHCARE WEST

Group Health Cooperative

James Hereford, M.S.

As executive vice president of Strategic Services and Quality at Group Health, Mr. Hereford oversees technology, quality, and human resources for operational and clinical improvements. Before assuming this position, he served as executive director of informatics and executive director of customer services. Mr. Hereford is a faculty member at the University of Washington, serves as chair of the Washington State Healthcare Authority Health Information Infrastructure Advisory Board—commissioned to create a statewide clinical data sharing infrastructure—and serves on the board of OneHealthPort, a shared security service.

Founded in 1947, Group Health is a consumer-governed, nonprofit healthcare system that coordinates care and coverage, and serves more than half a million residents of Washington and Idaho.

As part of a consumer empowerment initiative, Group Health has rebuilt its office visit and developed new ways for patients to improve their health. It has used information technology and new understandings of decision-making processes and behavioral science to move patients to the center of the care delivery process.

Group Health focused on ways technology could maximize the effectiveness of the provider-patient relationship, moving it from one where physicians issued orders to a partnership in which patients and physicians jointly developed a care plan that better reflected the patient's priorities, preferences, and health desires.

One innovation typical of this process was that electronic health records were designed for patients to use—to access, update, and control this information. The patient education process was also integrated into the health record, which meant that at home, patients could review their visits and refer back to educational materials that were part of their care plan. 47% of patients access these records on-line, looking at 50,000 test results monthly, and 13,000 times a month patients refer to their educational materials. Roughly 6,400 messages are exchanged monthly. 7% of patients have reported that without this system, they would simply have let the question go unanswered.

The implementation cost was roughly $25 million, which will be recouped over seven years through business efficiencies ($2.5 million annually on paper records, $4 million on transcription, etc.), and from more easily prescribing appropriate low-cost generic medications to patients. These are direct returns and do not even include estimates of savings from improved health.

Case In Point

"Years ago, I saw a patient who was failing rehab because he had been prescribed a ridiculous exercise regimen that lasted 23 hours a day. As providers, we cannot simply issue orders—we must work in partnership with patients to come up with something that makes sense."

— DR. MATT HANDLEY, GROUP HEALTH COOPERATIVE.

Matt Handley, M.D.

Dr. Matt Handley is associate medical director, Quality and Informatics, Group Health Cooperative. In addition to his private practice, he has also developed clinical guideline programs nationwide and in New Zealand, and lectured extensively on evidence-based medicine and implementation of clinical guidelines. Previously, Dr. Handley was medical director of Health Informatics at Group Health, where he led the country in sharing the EMR with patients. He studied applied mathematics and engineering at Northwestern, received his M.D. at the University of California at Davis and completed residency in Family Practice at Group Health.

SEIU Healthcare 1199 Northwest

Gerda Cunningham, R.N., C.C.M.

Gerda Cunningham graduated from Agnes Karll School of Nursing in Frankfurt, Germany, in 1972. Ms. Cunningham has worked for Group Health since 1983, and is a member of 1199SEIU Northwest. As a discharge planner, she became aware of high readmission rates for patients with heart failure and with several colleagues began a pilot project emphasizing patient education and symptom recognition. Soon after Group Health began a broader initiative and Ms. Cunningham joined that program as CHF Case Manager, a position she has held for the last 9 years.

Ms. Cunningham is a member of the American Association of Heart Failure Nurses, and holds a certification by the Commission for Case Management Certification (CCMC). She has extensive knowledge of the German healthcare system and exploring differences between national systems is of great interest of hers.

In 1999, an SEIU Healthcare nurse at Group Health Cooperative saw promising literature on case management services for congestive heart failure (CHF) patients, and took the lead in creating a rudimentary care program for her patients. Shortly after, Group Health built these efforts into a fully-integrated CHF case management program.

A key element of this care delivery program is working long term with patients and their families to manage this condition, with an emphasis on improving health, managing the chronic co-morbidities that can exacerbate the underlying condition, and focusing on the future.

Connecting patients with practical exercise programs tailored to their health challenges has led to significant improvements. Even minor improvements are significant for this population—regaining the ability to walk from one's bed to the bathroom, and to leave the home on short trips is a substantial improvement in the quality of life. Across the program, 84% of participants saw their conditions stabilize or improve.

32% of these patients also have diabetes, and up to 50% have coronary artery disease. By managing these co-morbidities, there is a greater ability to prevent hospital admissions. In this population, aggressive management was able to yield a 32% decrease in hospital readmissions.

In this intervention, the mutual partnership of labor's front line workers and management were a powerful force for putting patients' health first. Both organizations supported the innovation of front-line workers, and because of the environment of respect and support, the workers closest to the challenge were not only able to instigate real changes to improve patients' health, but to see these supported and enhanced by their managers.

Aggressive management was able to yield a 32% decrease in hospital re-admissions.

Conclusion

Our nation's investment in healthcare should encompass not only our pragmatic needs and expert knowledge, but also our values and compassion. There is a significant opportunity for a new revolution in healthcare, one that takes advantage of new innovations in information technology and systems engineering to redefine healthcare delivery. This process is patient-centered, highly accurate, brings the best knowledge to the point of care, and allows for customization to a patient's specific needs. And as the examples above demonstrate, healthcare reform will not only improve quality, but be cost-neutral and even cost-saving over the long run.

Creating this new healthcare delivery system requires meaningful reform, and must include America's political, business, labor, and healthcare leaders. Our focus cannot be simply on cost containment or increasing access, but on the larger goal of improving quality.

In addition to the specific reforms outlined on page four, our efforts should proceed according to the following principles:

1. Ensure universal healthcare coverage for all Americans.
2. Improve the quality and efficiency of healthcare services by adopting clinical best practices and promoting organized systems of care.
3. Establish a stable, equitable, broad-based, and predictable healthcare financing system.
4. Promote affordability and address rising healthcare costs by advancing opportunities to achieve the greatest value for our healthcare dollars.
5. Provide meaningful individual choice of providers and plans while promoting preventive care, protecting consumers from the costs of major illnesses, and improving the management of chronic conditions.
6. Achieve greater reliability in healthcare coverage, including improved portability of coverage and continuity of care.

Healthcare reform must be an inclusive process in which expert advice is actively solicited. The history of healthcare reform is littered with the carcasses of sweeping financing reforms that failed to lower costs, increase access, and improve quality. We must create a path that enables our healthcare delivery system to be defined by those three goals.

Thank you to our Moderators

Dr. Kenneth E. Thorpe

PROFESSOR AND CHAIR OF HEALTH POLICY AND MANAGEMENT AT EMORY UNIVERSITY

Dr. Kenneth Thorpe currently serves as Robert W. Woodruff Professor and Chair of the Department of Health Policy & Management, in the Rollins School of Public Health of Emory University, Atlanta, Georgia. Dr. Thorpe also co-directs the Emory Center on Health Outcomes and Quality. Prior academic positions include the Vanselow Professor of Health Policy and Director, Institute for Health Services Research at Tulane University; a Professor of Health Policy and Administration at the University of North Carolina at Chapel Hill; an Associate Professor and Director of the Program on Healthcare Financing and Insurance at the Harvard University School of Public Health; and Assistant Professor of Public Policy and Public Health at Columbia University. Dr. Thorpe has also held Visiting Faculty positions at Pepperdine University and Duke University. Dr. Thorpe was Deputy Assistant Secretary for Health Policy in the U.S. Department of Health and Human Services from 1993 to 1995. In this capacity, he coordinated all financial estimates and program impacts of President Clinton's healthcare reform proposals for the White House. He also directed the administration's estimation efforts in dealing with Congressional healthcare reform proposals during the 103rd and 104th sessions of Congress.

Dr. Thorpe has authored and co-authored over 85 articles, book chapters, and books and is a frequent national presenter on issues of healthcare financing, insurance, and healthcare reform at healthcare conferences, television, and the media. He has worked with leading groups and policymakers to develop and evaluate alternative approaches for providing health insurance to the uninsured, and serves as a reviewer on several healthcare journals. Dr. Thorpe is a frequent commenter on healthcare issues in the print media and television. He has appeared on Nightline with Ted Koppel, NBC News with Tom Brokaw, ABC World News Tonight with Peter Jennings, CNN, CNBC, and Newshour with Jim Lehrer. Professor Thorpe received his Ph.D. from the Rand Graduate School, an M.A. from Duke University and his B.A. from the University of Michigan.

Dr. Mohammad Akhter

EXECUTIVE DIRECTOR OF THE NATIONAL MEDICAL ASSOCIATION

Mohammad N. Akhter, M.D., was appointed Executive Director of the National Medical Association in May of 2007. He has a long history of leadership in public health, including six years as Executive Director of the American Public Health Association (APHA). He has also served as President and Chief Executive Officer of the American Council for Voluntary International Action (InterAction), the largest alliance of U.S.-based international development and humanitarian non-governmental organizations. He has held governmental positions as Director of Health for the State of Missouri; Commissioner of Public Health for the District of Columbia from 1991-1994; a Senior Advisor to the Secretary of the U.S. Department of Health and Human Services; and as a member of the United States delegation to the World Health Assembly of the World Health Organization.

A native of Pakistan, Dr. Akhter received his medical degree from King Edwards Medical College in Lahore, Pakistan. He received a Masters in Public Health from Johns Hopkins University in 1973. He is board certified by the American Board of Preventive Medicine (1976). Dr. Akhter's academic appointments include working for several years as an Adjunct Professor in the Department of Global Health at George Washington University's School of Public Health, and as a Clinical Professor in the Department of Community and Family Medicine at Georgetown University School of Medicine. He was Professor and Chairman of the Department of Public Health and Hospital Administration, College of Community Medicine in Lahore, Pakistan.

Mitra Behroozi

MEDPAC COMMISSIONER AND EXECUTIVE DIRECTOR OF SEIU1199 NATIONAL BENEFIT FUND

Mitra Behroozi, J.D., is the executive director of 1199SEIU Benefit and Pension Funds. Ms. Behroozi oversees eight major benefit and pension funds for healthcare workers. Collectively, the funds are among the largest in the nation. Previously, Ms. Behroozi was a partner with Levy, Ratner & Behroozi, PC, representing New York City unions in collective bargaining negotiations and proceedings. While at the firm, she also served as union counsel to Taft-Hartley benefit and pension funds. Ms. Behroozi has a law degree from New York University and an undergraduate degree in sociology from Brown University.

In May, 2006, Comptroller General David M. Walker appointed Ms. Behroozi to the Medicare Payment Advisory Commission (MedPAC). Ms. Behroozi is one of 17 commissioners on this independent body who analyze issues affecting Medicare and provide recommendations to the United States Congress.

She grew up in New Jersey, the daughter of immigrant parents from Iran and Holland. Ms. Behroozi is married to a New York City public school teacher and has two sons who attend public school.

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About Us

The Partnership for Quality Care is a unique coalition of healthcare providers and healthcare workers dedicated to guaranteed, affordable, high quality healthcare for every man, woman, and child in America.

The coalition includes public, private, religious, teaching and nonprofit hospitals and integrated health systems as well as more than a million healthcare workers across the country. Members of the partnership care for more than 60 million patients nationwide.

The PQC is a national coalition, whose members work at the federal, state, and local level to advance reliable and affordable access to healthcare for all Americans within a reformed healthcare system that aggressively promotes improved quality and efficiency.

More information including transcripts, video, and presentation slides, is available at *www.pqc-usa.org.*

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