<u>CMS - Carolyn Clancy</u>

Tom Reilly:
My name's Tom Reilly, and I'm the deputy director of the Office of Research Development and Information at CMS. And this morning you've heard from Peggy Cain [spelled phonetically], who discussed the key role that HEDIS has had in performance measurement for managed care plans and future steps, you've heard from Abby Block [spelled phonetically], who talked about the application of performance measurement in Medicare advantage plans, and now we're going to hear our luncheon speaker, Dr. Carolyn Clancy.

As most of you know, Carolyn is the director of the Agency for Healthcare Research and Quality. AHRQ's mission is to support research designed to improve the quality, safety, efficiency and effectiveness of healthcare for all of us. Carolyn is also a clinical associate professor in the Department of Medicine at George Washington University School of Medicine. She serves as senior associate editor of the *Journal of Health Services Research*. She's a member of the Board of Directors of the National Quality Forum. She's a member of the Institute of Medicine. In 2004, she was elected as a Master by the American College of Physicians. It makes me tired to just to say all of that.

Carolyn's major research interests include a number of dimensions of healthcare quality and patient safety, including women's health, primary care, access to care and impact of financial incentives on physicians' decisions. Today, Carolyn will be talking with us about value driven healthcare, so please help me in welcoming Carolyn Clancy.

[applause]

Carolyn Clancy:
Well, good afternoon, everyone. It's lovely to see everyone. In fact, I had no idea it would be such a big meeting. What I should have had Tom put in my bio is that I had the privilege and pleasure of working with him when he worked at AHRQ for too short a time in our view, but definitely left his mark. So, I have a whole lot to tell you and I could tell you all about AHRQ and we'd be here until midnight but I'm not going to do that.

Big news, though. When I talk to my family about quality, you know, they think it's important because I do it, not because they want to hear any of the details. Please no, too technical and you're not actually getting at anything I want to hear about. But very recently, CMS released sort of an updated and improved version of hospital compare, which included for the first time patients perspectives on care, and I could not wait to get home and hit e-mail because this is something that everyone can understand, right? Pain management, things explained to you in a way that you could understand them. Oh, now we're talking serious things and things that I care about.

Twenty percent of patients leave the hospital without written information. Now, you can argue back and forth as to whether that's a high number or low. In fact, in my view it

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might be actually an overestimate because people always leave with paper, right? Bills follow you everywhere and it's quite possible that some people think they're leaving with printed information about what they're supposed to do next when indeed it's actually much more about billing and follow-up appointments perhaps. But, you know, it's a problem because what happens when they don't have good information is about 15 percent of those folks come back either to the emergency department or for readmission. So, that's a critical opportunity.

So, we're very, very excited about that and what I'm really excited about though is that hospitals because they've seen the data before it goes public for everyone are already working this through. Don Berwick [spelled phonetically] and his colleagues at the Institute for Healthcare Improvement have been meeting with some of the hospitals that have done incredibly well on their survey to find out what are you doing right, how do we help others learn this.

So, what I want to talk about today is general perceptions of the U.S. healthcare system and the quality challenge. This is the season in Washington, perhaps Baltimore, but for those of you who are from the Washington area, everyone is now convening multiple parties, panel discussions and so forth to talk about healthcare reform, ready to be helpful for new administration, which is a really, really great thing. And I hope that we get it because we need it desperately and I think the work you do every day only underscores how much we need it.

I'm then going to tell you a bit about our roles and resources and what we're doing in health and human services with CMS and with many, many private sector partners to try to transform our system from one that's built and focused on volume to one that's focused on value. After all, our payment system says to people, "If you provide great, unexcelled, heroic care, that's great. And if you don't, that's great, too. In fact, if you provide harmful care today, we might pay more." That is not a system based on value. And then I'm going to talk about critically turning evidence into action.

So, with that, what is quality? First points, right? Everyone understands this, the right care for the right person at the right time and this is what all of our efforts are about. Even when we get very, very technical and abstract about measurement, the kind of thing that my family says, oh, I've heard enough, that's it; they understand the overarching vision here. What policymakers see increasingly is that we've got a huge disconnect, so we have the privilege of reporting every year to the Congress on quality of healthcare in this country, and this is our fifth report. And in fact, Tom was one of the leading architects, which is why we miss him to this day.

But, every year healthcare costs go up much, much faster than quality is improving. Now, I think we all suspected that for a long time but now we have data, and we actually track some core measures over time. So, last year, healthcare costs went up 6.7 percent. Now, Uve Reinhart [spelled phonetically] would tell you that's actually a low year because as long as we've been collecting data for over 40 years it's about eight percent a year. Now, some years it's a little more and then it slows down, but the healthcare beast, as he puts it,

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eats an eight percent increase every year. Now, other than gas prices and potentially prices of other items because of gas prices, most of us haven't been seeing anything go up like that, certainly not our salaries.

Healthcare quality, on the other hand, of all patients and settings last year went up about 2.3 percent. Now, if you recall Beth McGlen's [spelled phonetically] kind of famous paper from the [unintelligible] Corporation published almost five years ago saying on average Americans receive recommended care 54.9 percent of the time. That is slightly better than a coin flip, only slightly. I'll celebrate any momentum going forward, but that price-quality disconnect is what has everyone's attention.

Now, if you ask the public and I'm actually using data here from an AFL CIO survey, I'm told if you go on their Web site there are about 7,000 fairly detailed anecdotes because they gave people and opportunity to comment and share their stories and that they're pretty amazing. You can see that about four percent of people in this country are satisfied with the cost of healthcare, presumably those are movie stars and people doing incredibly well, as compared with about 35 percent satisfied with the quality of healthcare, but that means almost two-thirds of people are dissatisfied with quality.

If you look at the same survey what proportion of Americans think that our system needs to be completely rebuilt, just over half. Fundamental changes, this would be the moderate position or conservative position here, 43 percent. So, all of these forums and meetings and blue ribbon panels and so forth that we're starting to see in Washington, D.C. have a point because they're reflecting a growing sense of urgency among Americans that, my God, we are spending so much and we're not getting what we pay for.

Now, interestingly, one of the really exciting things over the past few years has been seeing the emergence of serious physician leadership here. Now, for years as a physician I must say I participated in lots of activities around quality of care efforts to improve measures and so forth and it was kind of hard to avoid this kind of between the lines theme of "And this time we're going to get those doctors." I don't think that was directly intentional, but they weren't always seen as incredibly cooperative and I'll take that point. They're not. I work with some of them, right? The people whose patients I had to cover, that I couldn't read their handwriting and, you know, had to have conversations that went something like, "I think I'd like to just hear this in your own words today," which means, "There's nothing written down here. I don't know what you've been seeing Dr. Jones for. I can't even make it up." Okay? So, I understand that, but at the same time I think that we're all better off if physicians are at the table and playing a very strong, proactive role.

So, the Commonwealth funded a survey a couple of years ago that asked, "Have you been involved in any collaborative efforts to improve quality of care?" Two-thirds said no and one third said they had been involved in at least one effort. The percentage who said that involvement in such an effort was very or somewhat effective in improving quality of care was about 76 percent overall, and you can see here that that number tends to be higher as the number of physicians practicing together increases. Many of you may

not be aware that about two-thirds of outpatient visits in this country are to physician practices where there's a very small number of docs practicing, four or less, so infrastructure there is kind of a nonexistent idea. There's no one walking around that's got a button on that says, "I do quality." So, the idea -- so, collaborative efforts with other practices can be incredibly important and my guess looking at these results is that physicians who practice in larger groups understand very clearly what you all know, which is that proving high quality care is a team sport.

Now, coordination of care. Let me -- this comes from a slide of blind people and elephants and so forth, and I think all of you are aware how challenging it is to coordinate care. We did a systematic review, funded and evidence report, find all the evidence you can and you know what the opening line of the report is? We don't even all have the same definition of what care coordination is. We fund the CAHPS surveys and the CAHPS teams have been trying for several years to figure out how could we get some additional items, I think we've got one or two core items now, that could get at people's perceptions about coordination of care because it would drive improvement. And patients have a hard time. They have a much easier time seeing the problem, but figuring out when a bad outcome is attributable to bad disease or bad treatment versus poor coordination is much, much trickier. This is I think one of the most fundamental challenges facing healthcare delivery today.

And where I get very worried about this is in our efforts to assess physician performance in particular or any particular silo of care delivery, right, hospitals, nursing home, home health and so forth, what I worry about is that if we in our efforts to make sure that we're assessing activities that are under the control of that clinician or provider that we'll widen the gap between what we know ought to be our goal of healthcare and what we're measuring. Obviously, that's no one's intent. It certainly is not why you get up and go to work every day in the morning, but that's my secret fear so we've got to do something about care coordination.

So, now I'm going to talk about my absolutely favorite subject for the moment, is where does AHRQ come into this. So, Tom, thank you immensely for clarifying our mission. Now, we are primarily a research agency and our mission statement used to be something like, "To conduct and support research that on a good day with the right tail wind and the stars aligned, if everything is in sync may lead to improvements in care," because we were very, very tentative about this. We don't provide care, we don't regulate it, we don't pay for it. This makes us an incredibly popular convener, and many people think we're incredibly nice because we're not like all those other big, nasty regulators, but it also means we have no leverage. But, it also means that we've got to make sure that the information we're producing is useful to all of you, to people who will receive care, people who provide it and so forth or this mission doesn't mean anything.

Now, our annual budget, as you'll see, is about $335 million this year, which is a high point for us. So, if you think about that budget against two trillion in healthcare, you'd have to say this mission statement is either psychotic or ambitious. I like to think it's right on that important fine line. But, again, the point is if the information we're

producing isn't meaningful and actionable and useful to people providing care and trying to improve that care then this mission means nothing.

So, one of the areas where we have been very involved in the past few years is health information technology. Okay, so how many of you have heard, I need a show of hands, health IT will solve everything wrong with healthcare? Right? You know, Hillary Clinton and Newt Gingrich hold a press conference because they can't agree on anything but this, that health IT is wonderful and, you know, that gets news for a couple of days, it's gone on and on. I think the really good news is we're getting back a little closer to the ground to realize that we're not going to close the gap between best possible care that we all want for ourselves and what gets routinely delivered without health IT, but it is not a silver bullet.

So, we've had the privilege for the past several years to evaluate a whole array of applications for their impact on quality and safety. Now, interestingly enough, if you talk to enough people who've adopted electronic health records, you know what you'll find out? They think quality and safety is somehow part of this, but not really. I mean, I don't know why they're doing it. Some of them are, particularly in primary care, I think are doing it for mental health. They are completely going crazy, or as one doc told me, "We knew we couldn't do our jobs because people would ask us very reasonable questions like, 'What was my cholesterol last year?' and I can't answer that question."

Or, and this was a very potent stimulus for a group I know of in Philadelphia, a drug is removed from the market, Vioxx. A lot of our patients are on Vioxx, right? Our traditional approach is to actually sit down together and have some phone scripts, so if people call in I'll give them a routine answer. I mean, this happens to an awful lot of things where we identify potential adverse events. Now that they had just adopted an electronic health record system, they could actually generate a letter. They could identify who was on Vioxx and contact them directly. Much, much more efficient, almost close to how it would work on TV, right? Did you ever notice they can always find those dead people by the devices they have in their bodies, and I think, whoa, this is really, really great.

So, that's the kind of research that we're supporting. We're doing so with a very clear eye on developing an evidence base for best practices. Most vendors will tell you hardware and software is about a third of the solution. The rest is all about getting messy humans to work together cohesively and to design and implement processes of care in settings where that is a foreign idea, right? A process of care I'll tell you as a physician is what I decide it is today, you know? Autonomy reigns. I might do it this way today; I might do it another way tomorrow. You can't get any value out of health IT unless you can figure out how to organize your practice to take full advantage of it and we work very closely with the Office of the National Coordinator, or the IT czar, and many others of the department, CMS included.

So, for fiscal year 2008, our high level priorities, we're continuing to support a lot of work in trying to make healthcare safer. For the past year and continuing on for another

year or two, we've been focusing a lot on ambulatory care settings not because we think all problems in the hospital have been solved but because there's so many opportunities to drop the ball. Think of blind people and elephants again. In addition, we've had an incredible opportunity starting in 2005 to support work on the comparative effectiveness of treatments and diagnostic interventions. Now, this is all about developing better evidence and it's all about at least getting that information to clinicians and patients in something close to real time. We're not there yet, but we are making enormous progress and, you know, it's a wonderful thing to be alive in this country today in 2008.

You often hear people say that we have the best healthcare system in the world and I think in terms of new interventions and clinical innovation we do. What we're not so good at is reliability, but every time -- there are more and more decisions where you've got a choice between two or more options and that choice should be up to the patient, but they can't be up to the patient. It's just a show or a shell if they don't have good information, so that's really our effort with comparative effectiveness and a whole array of other activities, including this year a very strong focus on working with hospitals to reduce healthcare associated infections. So this just says the same thing all over again.

One of the interesting areas we're working on right now is to examine the feasibility of creating a distributed network. Now, what do I mean by a distributed network? Well, imagine that electronic health records could also serve as electronic quality or electronic research records. So Richard Platt [spelled phonetically], a researcher from Harvard, has estimated that if we had had access to a distributed network, so think of many organizations across the country who were using either the same electronic health records system or multiple different ones, but they're using the same infrastructure, data definitions and so forth so that you can effectively Google 100 million records, we would have known about Vioxx in a couple of months. Now, it is always easy to look back and say, "Oh, I know how we could have avoided that problem." The reality is, though, Richard is not what you'd call a flamboyant kind of guy, so to that extent I take his estimate very seriously.

So, what we wanted to do was to try this out. So, the second model talks about the HMO research network and that's one that Dr. Platt is leading research efforts, and they're actually going to be developing a virtual data warehouse to assess the effectiveness and safety of different antihypertensive medications for between five and six million people. Now to create this kind of system, you actually have to at a very grunt level figure out common definitions. What do we mean by old people? What do we mean by children with special healthcare needs? All the kind of stuff that we leave as very fuzzy logic when we're writing in charts has to be crystal clear.

The other model, which is really interesting, is actually called DART for Distributed Ambulatory Research Network, these are the small practices in Colorado working with a couple of hospitals, so we think that that's going to be a very important opportunity. One of the reasons we think it's also going to be important isn't just to develop better evidence, although that's our primary interest here, but more and more there's interest in trying to use a similar approach to assess physician performance, right? You can't know

how physicians are performing or give patients good information which they've been asking for for a long time on the quality of doctors or doctors' practices unless all payers are working together.

So, you need a common set of metrics -- we've got that for plans, hospitals and so forth -- but you also need to be able to apply those metrics across 10, 12, 14 different plans. Oh, that sounds pretty easy, doesn't it? Give me the specs and let's go to work. Well, it turns out to be really, really tricky because these organizations have never had a need to aggregate across plans before. And the reason you've got to do it is pure statistics, right? Absent that, any insurer can know how a physician is treating their patients, which could range from one or two to many more than that and Medicare has to be part of this as well.

So, right now there's another effort ongoing to try to assess and improve the quality of physician care that uses exactly the same distributed approach. It's very tricky. Beth McGlen doing some work on this in Massachusetts found that one smallish plan had a million unique provider ID numbers. Well, that's interesting. There aren't a million unique providers in the country, so how they'd all be in this small plan in Massachusetts seemed puzzling. What is going on is that this particular plan would generate a new ID number every time someone was seen out of network. Now, for them that worked and, again, as long as they didn't have to actually work with others, this was perfectly okay. Aggregating across plans is very, very messy business, but I think you're going to be hearing more about it.

Now, I talked about health IT before. We were directed by the Congress to focus on the quality of care in rural, small community and safety net providers, something that we've been very, very excited about doing, and it's reinforced for me what I think many of you have learned probably in many experiences in your own careers, which is that often, although we sometimes talk paternalistically like we want to help the rural providers, often we learn as much from them as we have to share. But the bottom line is that we've had an opportunity to invest a little over $200 million. Now, for those of you who have heard about how much these systems cost, this is not a whole lot of money and you'd be right, but we're not buying hardware and software here. What we're buying and investing in is evaluating how do these applications work.

The ambulatory safety and quality program I mentioned and that has some very specific focus areas. One is enabling quality measurement through health IT. Now, if you've heard that health IT is going to save us, you've probably seen at least one document that says health IT will improve patient safety. No, health IT will not improve patient safety. People improve patient safety. Health IT is a critical enabler and health IT doesn't improve patient safety any more than it killed children in Pennsylvania. How many of you saw this study? CPOE increases mortality, right? There's a showstopper. Real thought provoking there. A research team actually looked at what happened to children transferred to the University of Pittsburgh, and what they found was that because of the way they implemented this new CPOE system there were two important delays in care, one en route and one when they got to the hospital because over half of these kids go directly to an ICU, not surprising. And because of those delays in care there was a higher

than expected mortality. Thankfully they were, like, on the ground examining this and they were able to make the right kinds of changes to their processes, but it isn't the computer that does harm or good, it's the context in how it's used.

But, right now most electronic health records do not support assessing quality of care. In fact, all over the country there are people who have bought new systems, spent a lot of money only to finally say to the vendor, "So, where is the quality module?" And, you know, the people say, "Oh, it's coming. It's, like, probably over there in that other box, but we'll get it hooked up for you." And then when they actually get down to business, they find out, oh no, no, no, no, no. Not only is it not here, we're not going to be able to build it for a while. Now, you all know why that is, right? It derives ultimately from how we document patient care, and it has a whole lot to do with exceptions, right? No computer wizard can program that this patient shouldn't get a beta blocker if the information exists in somebody's head or on a piece of paper, you know, across town in a folder in that practice. Not possible. This is not rocket science here; it just isn't possible. So, we're hoping that our projects will actually begin to take advantage of health IT to make the entire enterprise a little bit easier.

We're also looking at applications to improve quality of care and to enable patient centered care. Patient centered care thinking, I believe, is one of the six dimensions of the Institute of Medicine's definition of quality that we still have a long, long way to go. More and more these days, healthcare to me feels like the airlines, you know? Not in the good way, but more in the way of when you get on that plane you know who's in charge, and it wouldn't be you.

So, the specific types of health IT that are used in these projects range from personal health records to clinical decision support to telehealth and so forth. Just to give you an example right down the street in Hopkins, there's a project focused on medication monitoring for vulnerable populations via health IT, and what they're examining is the ability of health information exchanges and electronic health records to provide quality and safety measures for vulnerable populations served by a community health center. I mean, this can effectively extend our efforts in all kind of new ways. So, this relies on system integration as well as decision support.

Now, I mentioned a few minutes ago that every year we report to the Congress on quality and on disparities of care. So, some good news here. More than 93 percent of heart attack patients received the recommended hospital care in 2005, up from about 77 percent around 2000, so that's a significant jump and I think many people would argue that that's additional support for the premise that public reporting makes a difference, and it gets people's attention. The percentage -- this is really good -- the percentage of heart attack patients counseled to quit smoking increased from 43 percent to about 91 percent. This is huge. Now, when it was less than 50 percent I used to wonder what's going on here, although as a clinician I knew, right? On one level it's almost embarrassing, right? We know you had a heart attack because you smoke, and I don't even know how to start this conversation, or I conveniently think it's someone else's job. It is so important because people who are counseled at that teachable moment, this has been documented very

clearly, have a quit rate at one year of 50 percent. There is no other healthcare encounter where it makes such a difference.

Patient safety measures, and I can't say that we have a robust set of these, but to the extent that we have them, showed an average annual improvement of about one percent. Now, that's, again, headed in the right direction, but the rate had slowed down. Very recently we released state reports as well and in order to make this very, very clear to policymakers we used speedometers

[laughter]

-- and hope that they don't start thinking about tickets and new sources of revenue. That solid line here is actually this year's performance; the dotted line is last year's performance. This is entirely a Web based product. You can go to our Web site and play around with it if you like to do this kind of thing, ahrq.gov, but, you know, it allows state policy makers to actually look at how they compare to neighboring states, to the region or to the nation as a whole. Someone called me this morning from Delaware to say that their newspaper had gotten it wrong and reported that Delaware was doing better than they are. They misinterpreted the data and of course he was kind of upset about this, this is an old friend I hadn't talked to for a while, because he of course has been out there saying how much they need to do to improve quality. He said, "Did other people get this wrong too?" and I said, "Absolutely, every one of them." I've had members of Congress thank me for confirming that, you know, their state is providing terrific quality of care and I went home thinking, wait a minute, I don't think we did that.

Our point in all of this is mostly to get the data closer to where you're actually providing care because if it's national we can all blame other states. We're doing great but, you know, it's those other people dragging us down. The closer it gets to where care is provided, the more you have to say, you know, we've got a problem. So, just to give you an example in Maryland and to give you a sense of how the information is portrayed in these reports, Maryland did better than average for the percentage of heart failure patients who received recommended care, about average for appropriate timing of antibiotics and they're not doing as well in terms of HIV infection deaths per 100,000 population.

Now, many people believe and I often get to hear Dr. Zerhouni, who hails from Baltimore, say that in fact we don't need to worry about all this quality stuff because what's going to really transform our system and take care of all our budget problems is discovery. We'll discover more and more new interventions that will radically cure disease. Well, I mean, think about it in a really, really simplistic level, right? Monitoring oxygen levels. You know, when I was training, this involved sticking someone's artery and you thought of a lot of reasons to avoid doing it, right, because, my God, if you hit the nerve, which was very easy to do, some people really let you know about it. Sometimes they even almost hit you. But, now we've got this little technology, right? It makes it so easy. The rates are about 97 or 98 percent. I presume the other two percent is they've lost the little gadget, but by and large we do this routinely. So, if you start thinking about that same thing in clinical care, why not?

So, there's a lot, a lot of excitement about genomics. This'll transform everything. Soon there'll be designer treatments for every single individual. I literally had people at AHRQ yesterday telling me how they are starting a community study, everyone will get all of their genomic information, and they're trying to see with 1,000 patient whether this will save the system money, and I thought, oh whoa, wait a minute. The point is, there's very little of this that's ready for primetime, but we believe that the same assessment of the evidence is going to be very, very important, so already the preventive services task force that we sponsor is making recommendations about who should be screened for some of these tests and so forth.

So, now I'm going to turn to value driven healthcare. Now, I want to be on record as saying that I did not like this name only because I knew it would be shortened to VD Healthcare. Now, as the only clinician in the room for these discussions I was completely outvoted but I just wanted you to know.

In August of 2006, President Bush actually issued an executive order that said the feds are all going to speak with one voice when it comes to improving value. To use common, evidence-based consensus derived supported standards of quality, to use standards about pricing. That one is a little bit trickier, but I think it's hard everyone deserves to know what it is that they are paying for healthcare. How many of you have ever tried, by the way, to find out what a healthcare service costs? Okay. Can you keep your hands up if you were able to find out what it costs? Yeah. The last time I tried after that procedure you get when you turn 50, I was informed, we're all for informing patients now, about a week ahead of time that after waiting four months -- and I pulled strings here, okay -- after waiting four months for an appointment that the anesthesiologist they used no longer had a contract with my insurer so they just thought I'd like to know.

So, I figured, well, hmm, I've waited four months. I tried to call the practice and so forth. What am I going to be -- what might my risk be? What is the usual charge? I understand that if I have a heart attack or a cardiac arrest all bets are off in which case I probably won't care anyway, but, you know, in general what's the average price? After 14 calls I just totally threw in the towel, so it's completely unfair that people don't have good information about pricing. To support common standards that will support interoperability. And to use incentives that begin to realign payment with providing high quality care. They begin to help us transform to a system based not on volume but on value.

So, what my boss often says is that, similar to Tip O'Neill, I am from Massachusetts, is that all healthcare is local. And what he means by that is if you think about it we improve care one interaction at a time. It doesn't get much more micro than that. And at the end of the day what's very, very important in this whole enterprise is trust. Making measures is relatively easy, and I don't mean to make light of your work at all, but compared to making change and actually fixing the problems, it's easier. There's no question about it. We get off at AHRQ on making measures and making sure they're rigid and reliable and very, very robust and supportable and all of that stuff, too, but they're only a tool and the

tool is actually to improve healthcare, and we're not going to get to the kind of healthcare that we all want for ourselves and our families unless we get past finger pointing and arguing about, well, you've got the wrong count of who was in here for prenatal care or whatever the issue is at hand, so that's why we've been focusing a lot on the importance of local communities.

So, to that end in early February we actually chartered 14 communities across the country, which are shown here on this map. These are called value exchanges. Now, there's a reliable and robust history here about which I won't go into any great detail. The point is we were looking for communities that wanted to come together to work on these four cornerstones of improving value in healthcare and we wanted them to have either a demonstrable track record or a very credible commitment to engaging employers, payers, patients and providers to work together because it's only when you're working with people locally who you know and have to do business with in a whole variety of ways that you can build the kinds of relationships that are required to get beyond finger pointing and denial, yes we've got a problem but it's not my problem, it's your problem and all that kind of stuff.

Interestingly, can any of you guess which was the stakeholder group that a lot of aspiring communities couldn't quite bring along? No, not physicians. Consumers. Even in one community we actually had a big meeting, you know, to sort of launch and announce this and the secretary came and all, this was the end of February, and we were going to provide travel funds for up to six people from each community and even then a lot of these communities wanted to leave the consumers at home, right? Because the providers had, you know, kind of bonding to do en route and we kind of told them no, the consumers have to come. And in a couple of communities where I actually knew the consumers, I was quite impressed by that but that was actually probably the [unintelligible] limiting step in terms of being able to choose 14 of these communities out of 39. There'll be a couple of other rounds here.

And at the end of the day what we think it's going to take to improve quality one community at a time across the country is good measures and data, yes, but also both local and national benchmarks. How do we identify achievable benchmarks of care for this community and how do we begin to take the steps necessary to do that? To do that, you've got to have strong local coalitions, you clearly need evidence-based reporting and ultimately I think payment changes to support that.

Now, that said, again, it is easier to put out report cards than it is to figure out, okay, this is terrible, what do we do now. So, what we're hoping is that these communities can learn from each other and that we'll be able to provide technical assistance in some areas based on our other research about what does it take to improve care. This is in my mind the most neglected area of investment in research. We don't have really a science of improvements because everybody thinks -- a focus on transparency also brings with it the corollary that if we all agree on standards and just get those report cards right the rest will fall like dominoes. I don't think so. I think transparent information can be a powerful motivator. It really focuses the mind's eye and if you don't believe me, talk to any

teacher you know. They don't find it all that pleasant or fun either, but it doesn't actually improve how care is provided.

So, our learning network that we're sponsoring is going to encourage these communities to share experiences and lessons learned, to share best practices and frankly to identify some very clear gaps for us and for other funders about where we don't have a clue about how to improve care. My personal favorite, I'm not putting words in their mouths, would be potentially avoidable hospitalizations, right? Very easy to count these and a very important diagnostic tool about where we're seeing increased rates of hospitalizations that are potentially preventable. If anyone knows the evidence that shows me what you do to actually reduce these hospitalizations, please let me know because even when VA did a randomized trial it didn't make a dent, so I think it's important for us to be humble that measurement doesn't always necessarily point us to the interventions. And there'll be lots of face-to-face and interactive learning and so forth.

Now, this initiative actually followed closely on the heels of another initiative called the Better Quality Information Project. Now, this came from the AQA and is supported by CMS. The AQA is a quality alliance that actually focuses on physician performance measurements, and I must say do we have lively conversations or what? Some of these meetings are like 200 docs in a room all leading organizations, and it can be a little bit like a rodeo, but I've also been very impressed over the past several years that people are beginning to say, okay, how do we get this right, not why are we having this conversation, but how do we start to get it right.

So, these six regions were chosen. Now, they're using the same premise here that you've got to have data from all payers to assess physician performance, but in this instance they themselves are doing the data aggregation and learning some of the same painful lessons that Beth McGlen and other researchers have learned aggregating across multiple payers. The chartered value exchanges are actually going to get information aggregated by somebody else. Now, I don't see that for the CVEs as necessarily -- I see it as a prototype; I don't see it as a long term strategy because ultimately what we want, I think particularly when there's more and more health IT around, is to be able to get that information back to clinicians in something close to real time so that they can actually do the right thing to begin with. Our endgame isn't more better report cards, it's actually better care.

So, we've also seen some very exciting collaborations. I told you about hospital compare. You know, there were a few people who didn't think we should be doing HCAHPS. I think Tom was around for some of the earlier controversial aspects of that. There were vendors already out there doing surveys, satisfaction surveys for hospitals. You couldn't see them, but they had a good business going. And of course we think that HCAHPS is now actually going to increase their business quite dramatically. Many of them are taking the HCAHPS items and embedding them in their surveys. But, it was the support of the quality alliance, hospital quality alliance, multiple stakeholders all saying we want common measures to assess and improve hospital care and we now have a quality alliance steering committee, which actually brings ambulatory physicians, hospitals and

others together. I mentioned that hospital compare now has HCAHPS data I think it's from 2,700 hospitals nationwide.

So, now I want to talk about the really hard part, turning evidence into action and leave you with what I think are some challenges for all of us for the future. How many of you have heard of the Society of Thoracic Surgeons? Good, a lot of you. So, many of you I'm guessing are also aware of their efforts and the registry they've created and they have done some fine work. You know, I've been pushing them a lot to say, "So, why did you do this? I mean, we're thrilled that you did, but why?" And they kind of had the sense around the time people were talking about outcomes in the late 1980s that if they didn't someone else would.

But as computing power becomes cheaper and cheaper, many professional organizations, particularly docs and surgeons, are very, very interested in using a registry-like approach to collect data so that they can give individual surgeons feedback over time and get better and frankly learn new information as well. So, as part of our work on effective healthcare we actually published a user's guide for developing patient registries. Now, I think the endgame here is going to be when many of these registries can be pre-populated with data from the clinical information systems in hospitals and other settings. We're not there yet. There's a few very sophisticated systems that are doing some pre-population of data for the Society of Thoracic Surgeons. That's, like, really the only tangible example I can point to.

We also, as I mentioned, in effective healthcare are experimenting with a variety of different guides. Anyone who has a problem with insomnia, the research report would be for you because it's very, very detailed and very, very clear because we believe that in giving people information about alternatives it's important to be as transparent as possible, not only about the findings, but about all the methods used to develop those findings. There are shorter guides for clinicians and even very differently framed information for consumers because trying to give individuals, particularly those with limited health literacy, information about potential benefits and harms of treatments in a way that they can understand is a big, big challenge. I'm pleased to say that we're funding some folks out at Oregon who I think know more about this than anyone in the country, but the endgame here is when individual consumers are playing a much, much more active role in their own health and healthcare. That's easy to say. The harder part is giving them tools and the space to actually do that.

Now, I said before that I thought that one of the neglected areas here was actually building the science of improvement and what I think is also a huge missed opportunity is how many people are innovating and coming up with very creative solutions every day. So, to that end I think its Monday our new database the AHRQ Healthcare Innovations Exchange will go live. Now, Greg Paulson [spelled phonetically], who is the senior vice president of NCQA actually chairs an editorial and technical expert panel for us and they've really struggled. What do we mean by innovation? Which of these are we going to accept or not? I mean, some people will send in something that says here's my PIN. Is that an innovation? Well, no, that's kind of more of a symbol of people working together

and that's great, but it requires a lot of thought. But, to the extent that in your work you see people who come up with very promising interventions that they're willing to share publicly, we would love to hear them. So, it's innovations.ahrq.gov and again this goes live on Monday. It's not just a database of stuff you can do, although there will be that and a lot of -- hopefully enough detail that others could replicate it, but there will also be literally exchange in the form of learning communities and so forth.

You know, at the end of the day we're talking about greater use of information and hopefully greater use of better quality information to help get us to better quality of care. To do that, transparency is one important tool, but without trust and without working in an environment where we're all focused on the same goals, we're not going to get there at all. So, when I think about the near term frontier in terms of our aspirations here, what I would like to suggest are first that we don't lose sight of the very important opportunity to reduce disparities in care as a core part of our efforts to improve quality.

Now, mathematically this is very straightforward, right? If you want to improve quality of care you would target your efforts for those at highest risk of poor quality. We know that too often those subgroups are comprised of groups who are members of racial or ethnic minorities, people who are poor, not well educated and so forth, but sometimes we forget. We think disparities are important but then we get very wrapped up in quality measurement and other things. We think and our reports that we submit every year underscore the opportunity to be addressing both at once.

Where we get data for all of this is huge and I know it is a huge part of many of you in your daily work. The only data that are ubiquitous right now are billing data. Now, billing data are really good to pay bills, and they can occasionally be helpful in identifying specific cohorts of patients for whom you're going to apply measures to, but they were designed to pay bills. We think there's a huge opportunity before we get to a place where the whole country is wired of selectively adding what I'm going to call mobile clinical data elements that are electronic, right? We've got good standards for labs; we've got good standards for pharmacy and so forth. Just getting the pharmacy data in a way that's workable I think would make a huge difference and would save us all a lot of time and effort in terms of finding those charts and so forth.

Ultimately what we want to do is build the quality reporting functionality and decision support into certified electronic health records. Now, what I mean by that is right now there is a certification commission that is supported by HHS where essentially electronic health record vendors come to get a seal of approval, and they have to meet certain requirements and so forth. One of those requirements right now is not that they be able to report on quality, but as part of the work that we're doing in close cooperation with the Office of the National Coordinator, we're trying to figure out what it's going to take.

Ultimately what it's going to take is some reengineering both of developing IT applications and frankly developing quality measures. If I tell IT people that doctors and quality measure people develop guidelines and measures without ever thinking of a data source, they look at me like, hmm, didn't I just read that there's a medication for this kind

of dementia? Maybe you need to be on it. But, all the physician organizations that I know aren't thinking about a data source, so we literally need to change the supply chain of how we develop guidelines and measures. This is not going to happen overnight, but the reason it's important is that ultimately this same architecture can support not only being able to hit F7 and upload all of the quality measures, but also the decision support you need to make sure that if you forget to do the right thing, there's a reminder there. I know I'm making that sound way easier than it is, but I do think it's possible and worthy of our best efforts.

And ultimately we've got to figure out how to build a system focused on value at the local level, which is going to be incredibly interesting to me. When we've got, you know, a little bumper sticker or series of them that say, you know, "National goals, neighborhood solutions," and that kind of thing, but where those boundary lines are between what should be national and common across the country, you know, shared goals and where we want local innovation I think is going to be an ongoing source of debate and one from which I think we can learn a great deal.

So, with that I'd like to solute all of the work that you're doing. Chris Haffer [spelled phonetically] remains one of my favorite people in government, and I'm really, really excited to see so many of you here today and I'd be happy to take any questions if we have time.

[applause]

[end of transcript]