QUALITY & EQUALITY in U.S. HEALTH CARE

A Message Handbook

July 2010

Robert Wood Johnson Foundation
Route 1 and College Road East
P.O. Box 2316
Princeton, NJ 08543

www.rwjf.org

Robert Wood Johnson Foundation

CONTENTS

PREFACE

The Quality/Equality Message Handbook was created to facilitate consistent messaging about the work of *Aligning Forces for Quality* and other programs and grantees in the Robert Wood Johnson Foundation's Quality/Equality portfolio to lift the quality of health care in America.

The Quality/Equality Message Handbook has messages, facts and figures to tell the story of what is wrong with the quality of health care in America and how we can fix it, with a summary of the work of Aligning Forces for Quality.

The handbook's messages and proof points provide a quick reference and guide for writing talking points, speeches, letters or articles, presentations, or other communications. The research is current as of the publication date, and the handbook will be reviewed continually to update the facts and figures used to support the messages or to reflect changes in the program.

In some cases, the Message Handbook takes different angles to address the same topic to offer choices about language.

Where applicable, the messages are presented with supporting facts and figures known as proof points, generally as indented second and third level bullets. We have indicated sources with endnotes, so users who want to explore the topic on their own can do so with the source.

In most cases, these messages are drawn from research about both what's wrong with the quality of our health care system and how to fix it. In some limited cases, such as the messaging about how to talk to the general public and physicians about quality health care and the Aligning Forces for Quality approach to improving quality, the messages have been tested with the target audience through research including focus group and surveys.

CORE MESSAGES

- **Quality care is getting the care you need when you need it—no less and no more.**
- **American health care faces a quality crisis. There is a dangerous divide between the high quality of care our health care system is capable of delivering and the uneven quality that it is actually delivering.** People are not getting care they desperately need, and the system harms and sometimes even kills those who seek help.
- **In every community, doctors' offices and hospitals deliver both good health care and bad health care.** There are too many mistakes, too much miscommunication and too much inequity. We can do better, and we must.
- **As a country, we are not getting our money's worth for the $2.3 trillion a year we spend on health care.**[1] Because we spend so much—16 percent of our economy—many Americans mistakenly assume that the U.S. health care system is the best in the world. Despite this spending, Americans don't live as long as people in many other major developed nations—and we have a higher infant mortality rate than most.
- **The soaring cost of health care and the growing number of uninsured Americans are the visible problems with the U.S. health system. The *invisible* problem is poor quality.** As we work to make sure everyone can see a doctor when they need to, we must also make sure they get the right care once they do.
- **Poor-quality care comes in three forms: overuse, underuse and misuse.** We give people care they do not need, we fail to give people care that we know works, and we make mistakes that harm or kill people. We must address all three problems to create a more efficient, equitable and high-value health care system in America.
- **We must lift the quality of care for everyone, everywhere.** The quality of health care people receive too often depends on where they live and the color of their skin. This is unacceptable.
- **More health care is not always better care.** In fact, too much care can harm people by subjecting them to unnecessary dangers and treatments. We need to stop giving and paying for care people do not need. A whopping 30 percent of the care we deliver—nearly $700 billion a year—goes for tests, procedures, doctor visits, hospital stays and other services that may not improve people's health.[2]
- **Health care is delivered locally, but influenced by national AND local factors.** We must take action at every level to fix what is not working well enough.
- **To improve quality, we need better information about the actual performance of doctors and hospitals.** We don't always know who is doing a good job and who should be doing better because we can't see inside the health care system.
- **Our fee-for-service health care system rewards providers for volume, not value.** To achieve high-value health care, we must fix our payment system to reward providers for giving patients the right care at the right time in the right way.
- **Everyone who gets care, gives care and pays for care must work together.** First, we must understand the quality of care that is being delivered in every community by measuring and reporting on the performance of doctors and hospitals. Then we must implement strategies to help them improve quality. Finally, we must encourage people to act like consumers when it comes to health care to build demand for high-quality care, and we must encourage patients to become better partners with their doctors in managing their own health care.

- **While almost everyone recognizes the need for improvement, we need a clear vision and strong leadership for how we will get there.**
- **We know we can do better because there is a great deal that is *right* about our health care system.** We have world-class doctors, nurses, hospitals and researchers. With hard work and ingenuity, we can continue to encourage all that is right about American health care while we work to fix what is wrong.

WHAT IS QUALITY CARE?

Quality health care means getting the care you need when you need it—no less and no more. It helps people stay well, and it helps them get better when they are sick.

- **Quality care makes the best use of current medical knowledge to achieve health outcomes that patients want.**[3] Quality care avoids giving people treatment they don't need, provides them the treatment they do need and does no harm. It is doing the right thing for the patient at the right time and in the right way to get optimal results.[4]
- **Quality health care is:**[5]
  - **Safe:** It does not injure patients; it is supposed to help.
  - **Effective:** It provides services based on sound science to all who can benefit and refrains from providing services to those who are not likely to benefit.
  - **Patient-centered:** It is respectful of and responsive to patients' preferences, needs and values.
  - **Timely:** It reduces waiting time and potentially harmful delays.
  - **Efficient:** It does not waste resources.
  - **Equitable:** It does not vary because of someone's race, gender, income or location.
- **Quality care is care that works—based on the best medical research about what has made you ill and what will make you better.** It is getting care when you need it. It is getting all the care you need, and not getting care you don't need. It is safe—only helping, not harming you. It is tailored to you. And it is delivered by professionals who respect you, communicate clearly with you, and involve you in decisions about your care.
- **For many people, having quality care also means getting peace of mind, beginning with their relationship with their doctor.** The key is finding the right doctor—one who values relationships based on openness and trust, and who provides high-quality care.
  - For people in good health, quality care means care that balances prevention and treating illnesses.
  - For people with chronic conditions, quality care means understanding which treatments are proven to work—and getting that level of care.
  - For people with loved ones who get sick or hurt, quality care means knowing where to go to get the best care without a lot of delays, hassles or mistaken information.
  - For people who give care, quality means being able to do your job and help patients, using systems that are designed to help.
  - For everyone who receives health care, we need to learn and act on the differences between good and bad care—just as we would choose where we want to live based on the quality of the schools or the safety of the neighborhoods.

THE QUALITY CRISIS

THE BROAD SCOPE OF THE PROBLEM

Americans are not receiving high-quality health care.

- **The quality of health care in America is at best imperfect and at worst deeply flawed.**[6]
- **Compared to care in other wealthy countries, U.S. care is high-cost and low-quality.**
  - We spend 50 percent more on health care per capita than any other country in the world.[7] But the United States has shorter life expectancies and worse infant mortality rates than most other wealthy countries.[8]
- **One problem with quality is UNDERUSE:** We do not give people the care they should get. We neglect to give them medically necessary care or to follow proven health care practices—such as giving people with diabetes the right battery of blood tests and eye and foot exams.
- **You stand a better chance of getting "heads" on a coin toss than U.S. children have of receiving all of the care that is recommended for them**—that is, the right care, delivered when they need it—from basic immunizations to care for kids with asthma. The situation is only slightly better for adults, who receive a little more than half of recommended care.
  - As many as 91,000 Americans die each year because they don't receive the right evidence-based care for such chronic conditions as high blood pressure, diabetes and heart disease.[9]
  - Children receive less than half (46.5 percent) of recommended care. The percentages of recommended care delivered for some of the most common illnesses include:[10]
    - Upper respiratory tract infection 92.0
    - Allergic rhinitis 85.3
    - Acne 56.8
    - Fever 51.4
    - Childhood immunizations 49.8
    - Urinary tract infection 47.8
    - Vaginitis and sexually transmitted diseases 44.4
    - Asthma 45.5
    - Well-child care 38.3
    - Acute diarrhea 37.8
    - Adolescent preventive services 34.5
  - Adult patients receive only half (55 percent) of recommended care. The percentages of recommended care delivered for some of the most common illnesses include:[11]
    - Breast cancer 75.7
    - Low back pain 68.5
    - Coronary artery disease 68.0
    - Hypertension 64.7
    - Congestive heart failure 63.9

- Chronic obstructive pulmonary disease 58.0
- Depression 57.7
- Colorectal cancer 53.9
- Asthma 53.5
- Diabetes mellitus 45.4

- **Another important problem with quality is MISUSE:** We make errors throughout the health care system. Some errors are human, but systems within hospitals, doctors' offices and elsewhere can be designed to greatly reduce the risk of error.
  - Between 44,000 and 98,000 people die annually from preventable errors—more than from motor-vehicle accidents, breast cancer or AIDS.[12]
  - Health care-associated infections in hospitals account for an estimated 1.7 million infections and 99,000 associated deaths each year.[13]
  - Health care providers make more than 1.5 million medication errors each year, causing an estimated 7,000 deaths annually.[14]
  - Medication errors for hospitalized patients cost roughly $2 billion annually.[15]
  - We tolerate margins of error in health care that are orders of magnitude higher than in other sectors of the economy.
    - Most processes within health care experience 6,000 to 300,000 defects per million opportunities. This compares to error rates of 230 or fewer per million opportunities for world-class manufacturers and fewer than five errors in every million financial-service transactions. The "six-sigma" approach to quality improvement embraced by many leading manufacturers strives for an error rate of no more than 3.4 errors per million opportunities by systematically identifying and removing the causes of mistakes.[16]
- **A third problem is OVERUSE:** Americans get a lot of health care that we know doesn't help them. We often treat people without medical justification—for example, giving antibiotics for simple infections—or fail to follow equally effective options that cost less or cause fewer side effects. No one likes the idea of being denied health care that is necessary and life-saving. But by the same token, we should not want health care that costs far too much without generating any results.
  - Antibiotics are prescribed inappropriately for children's ear infections 13 million times a year—802 times out of every 1,000 doctor visits—despite the finding that more than 80 percent of infections get better within three days without antibiotics.[17]
  - From 1993 to 2003, spending for lumbar fusion (a type of back surgery) rose 500 percent—from $75 million to $482 million—despite a lack of evidence supporting the effectiveness of back surgeries.[18]
  - As many as 78 per 1,000 Medicare patients are hospitalized for conditions such as poorly controlled diabetes or worsening heart failure that could have been managed on an outpatient basis.[19]
  - Some regions of the country use vastly more resources to treat patients with similar illnesses without achieving better outcomes. A whopping 30 percent of health care spending—nearly $700 billion a year—is for services that may not improve people's health.[20]

The health care system itself is antiquated and fragmented.

- **Health care is stuck in the past.** While the rest of the U.S. economy has gone digital—using information technology to increase efficiencies, cut costs and deliver mass-customized products and

services to consumers—health care continues to operate as an industrial-era throwback. Doctors still write prescriptions with famously illegible handwriting. In emergency rooms, they can't quickly access patients' medical histories. Nurses must decipher stacks of paper charts on clip boards. And patients don't have timely access to their test results.

- Less than 2 percent of U.S. hospitals have full health information technology systems in place to improve how they deliver care.[21]
- About 8 percent of hospitals have at least one basic electronic health record in at least one unit, which includes physicians' or nurses' notes.
- Only 4 percent of doctors have full electronic health records.[22]
- About 17 percent of doctors use some form of electronic health records.

- **Because the health care system is largely paper-driven, delivery is slower, more error-prone and harder to measure and coordinate than it should be.**
- **In sectors of the economy that have been digitized—from hospitality to mortgage banking—savvy consumers have driven rapid changes in the market by making informed choices.** Health care is late to this party for a variety of reasons, not least of which is a lack of readily available information about providers.
- **Our fragmented health care system fails to coordinate patients' care among different doctors' offices and hospitals.** Without that coordination, patients discharged from hospitals don't get support and encouragement to take their pills, follow their diets, show up for follow-up appointments or otherwise follow the regimens that doctors have prescribed during their hospital stays. Patients with more than one doctor face the daunting prospect of giving multiple medical histories, retaking tests and keeping track of their own medications—and they don't always get it right.
- **A prime example of the consequences of fragmentation in our health care system is the way hospital doors revolve for patients with chronic disease:** One in four heart attack patients and one in five heart failure patients are back in the hospital within 30 days of leaving the hospital.[23] These preventable readmissions cost Medicare alone more than $17 billion in 2004.[24]

Our flawed payment system feeds the quality problem.

- **The fee-for-service system doesn't encourage better quality or support care coordination or prevention; it rewards volume over value.**
  - Instead of paying for the outcomes we want, we pay for whatever happens.
  - We pay providers for the number of treatments and procedures they provide and pay more for using expensive technology or surgical interventions even if they are not warranted.
  - Beyond encouraging volume over value, we even pay more when things go wrong.
  - Consider just one example of how our current reimbursement system can create perverse outcomes:
    - There are 24 million Americans with diabetes.[25] Nationally, many insurers will not pay $150 per visit for a patient with diabetes to have routine preventive-care visits with a podiatrist.[26] However, nearly all insurers will pay $30,000 for the foot amputation that is all too common in advanced cases of diabetes.
- **The way we now pay for care, whether through government programs or private insurance, rewards hospitals and physicians for providing expensive procedures, with little attention to quality and outcomes.**

- **As in everything else, you get what you pay for in health care.** We have a system that has traditionally paid providers for *doing* things—procedures or tests—but not necessarily for doing the *right* things, like helping prevent or manage chronic illnesses such as diabetes and asthma. So we get a high volume of health care services, not high value.

RACIAL AND ETHNIC DISPARITIES

Health and health care is worse for specific racial and ethnic groups than for whites.

- **Although the quality of health care is poor for many Americans, some patients of specific racial and ethnic groups continue to experience lower-quality health care than white patients.** This is unacceptable. We will not be able to say we have succeeded in improving the quality of health care in America until we have closed the gap between the quality of care minority patients receive and the quality white patients receive.
  - Racial and ethnic minorities suffer from worse health and receive lower-quality care than whites—regardless of where they live, their income or their health insurance coverage.[27]
  - At no time in U.S. history has the health status of minority populations equaled or even approximated that of whites.
  - The evidence of these disparities in treatment is strongest for African Americans and Hispanics in the United States, and is growing for American Indians.
  - With few exceptions, all racial and ethnic minorities experience higher rates of illness and death than non-minorities. For example:[28]
    - African Americans die more frequently from heart disease, cancer, diseased blood vessels in the brain and HIV/AIDS than any other U.S. racial or ethnic group.
    - American Indians disproportionately die from diabetes, liver disease and cirrhosis, and unintentional injuries.
    - Hispanics are almost twice as likely as non-Hispanic whites to die from diabetes.
- **Even when access to care is equal, racial and ethnic minorities tend to receive a lower quality of health care than whites.** For example, research has shown that:[29]
  - Minorities are less likely to be given appropriate cardiac medications or undergo bypass surgery.
  - African Americans are significantly less likely than whites to receive major therapeutic procedures in almost half of 77 disease categories.
  - Hispanics are less likely than non-Hispanics to receive major procedures in 38 of 63 different disease categories.
  - Racial and ethnic differences in cardiovascular care convincingly demonstrate the evidence of health care disparities:[30]
    - African Americans with coronary artery disease or heart attacks are significantly less likely than whites to receive appropriate procedures or therapies.
    - African Americans are less likely to be catheterized—and if they are catheterized, they are 20 to 50 percent less likely than whites to undergo a revascularization procedure like angioplasty.
    - African Americans are less likely to receive such recommended medications as beta blockers, blood clot drugs or aspirin.
    - Roughly similar but less consistent disparities have been found for Hispanic patients.

- African Americans are more than four times as likely as whites to undergo a leg amputation (a devastating complication of diabetes) or develop peripheral vascular disease (an illness of the blood vessels).[31] A broad array of environmental, social and behavioral factors place patients at risk, including smoking, obesity, a sedentary lifestyle, high blood pressure and lack of access to high-quality primary and specialty medical care.
- The 5 percent of hospitals with the highest volume of African-American patients care for nearly half of all elderly African-American patients, and the 25 percent of hospitals that are the most crowded care for nearly 90 percent of elderly African Americans.[32]
  - Those hospitals provide marginally worse quality of care than hospitals that care for a low proportion of African-American patients.
  - Demographic concentration presents an opportunity to improve care for African Americans by targeting efforts toward a small group of hospitals.
- The 5 percent of hospitals with the highest proportion of elderly Hispanic patients care for more than half of elderly Hispanics.[33]
  - Those hospitals are more often for-profit, with higher rates of Medicaid patients and low nurse staffing levels.
  - They provide modestly lower quality of care for common medical conditions.
  - As with African Americans, the demographic concentration of Hispanics in a few hospitals presents an opportunity for targeted efforts to improve care.

REGIONAL VARIATIONS

Care varies widely depending on where you live, for both quality and quantity.

- **Geography can be destiny in health care.** Across the United States, there are striking variations in the way medicine is practiced, which affect both the quality and quantity of the health care patients receive.[34]
  - These variations have nothing to do with how ill patients are. Rather, the variations arise from local, regional and state patterns of medical practice—for example, how often patients see physicians, how often they are referred to specialists, how often the hospital is the site of care for patients with chronic illness and how many days patients spend in intensive care.
  - If your grandmother lived in Bend, Ore., she'd likely spend 10 or 11 days in the hospital during the last two years of her life. If she lived in Manhattan, she'd spend more than a month in the hospital during the same period. These kinds of variations are even more striking for chronically ill patients in the last six months of life. An elderly person with a chronic illness in Ogden, Utah, would likely see the doctor 15 or 16 times in the last six months of life. In Los Angeles, the same elderly person would see a doctor about every third day—nearly 60 times—during those last six months.[35]
  - These variations in the quantity of services translate to similarly wide variations in cost. Medicare on average spent $46,412 to care for chronically ill patients in their last two years of life from 2001–2005. The most costly state was New Jersey, at $59,379—or 28 percent higher than the national average. The least costly state was North Dakota, at $32,523—or 30 percent lower than the national average.
  - There is even greater variation in spending at the local level, as seen in the nation's 306 regional health care markets, known as hospital referral regions. Spending in the three highest-spending regions—Manhattan, the Bronx and Los Angeles—exceeded spending in the three lowest—Mason City, Iowa; La Crosse, Wisc.; and Dubuque, Iowa—by almost $46,000 per patient.[36]

- In many places, people do not receive the treatment they should get to help them stay healthy or effectively manage their chronic diseases.[37]
  - There are significant differences in whether people get basic recommended care—such as women getting recommended mammography tests or patients with diabetes getting essential blood tests.[38]
  - A Mississippi woman in her late 60s is far less likely to get regular mammograms than a woman the same age in Maine. In fact, 57 percent of female patients aged 65–69 in Mississippi got regular mammograms in 2004–2005 compared to 74 percent in Maine. (The national average was 64 percent.)
  - Similarly, if you have diabetes and live in Alaska, you are far less likely to get important tests to control your blood sugar than if you live in Vermont. In fact, only 71 percent of Alaskans with diabetes got those tests in 2003–2005, while 91 percent of Vermonters with diabetes did. (The national average was 84 percent.)
  - African Americans are far less likely to receive recommended tests than whites. Sixty-four percent of the white women got mammograms in 2004-2005, compared to 57 percent of African-American women. The study shows 85 percent of white patients with diabetes got blood sugar tests, compared to 79 percent for African Americans.
- There are significant differences in how often patients are admitted to hospitals because chronic conditions such as diabetes and heart disease are poorly managed outside hospitals.[39]
  - In the worst state, West Virginia, 116 of every 1,000 patients were admitted to hospitals in 2003–2005 because their chronic conditions were badly managed (nearly 50 percent higher than the national rate of 78 per 1,000). Hawaii fared best with 32 per 1,000.
- There are significant variations and disparities in whether Medicare beneficiaries face tragic health outcomes, such as losing a leg to amputation—a sad complication of poor blood circulation and diabetes—and the reasons go beyond poor health care.[40]
  - The rates of major leg amputations vary dramatically, and they are far worse for African Americans than whites.
  - An African American in Louisiana is nearly five times more likely to lose a leg to amputation than a white person. (It's 6.14 per 1,000 African-American Medicare beneficiaries versus 1.26 per 1,000 white Medicare beneficiaries.) The statewide average for everyone in Louisiana is three times worse than it is for people in Utah. (It's 1.66 of every 1,000 Medicare beneficiaries in Louisiana versus 0.50 per 1,000 in Utah.)
  - In the United States overall, African Americans are losing legs to amputations at a rate nearly five times higher than whites (4.17 per 1,000 African-American Medicare beneficiaries, compared to 0.88 per 1,000 white Medicare beneficiaries).
- There are wide regional variations in how often people undergo major medical procedures.
  - If you have heart disease, you are far more likely to have a procedure such as angioplasty or stents in some regions than others. Rates varied more than tenfold in 2003 among Medicare enrollees—from a high of 42 per 1,000 enrollees in Elyria, Ohio, to a low of 3.7 per 1,000 enrollees in Honolulu.[41]
  - Likewise, people with back pain get spine surgery far more often in some parts of the country than others. The overall spine-surgery rates among Medicare enrollees in 2002–2003 varied more than six-fold, from a low of 1.6 per 1,000 enrollees in Honolulu and 1.7 per 1,000 in Newark, N.J., to a high of 9.4 per 1,000 in Casper, Wyo.[42]
  - Joint replacements for Medicare patients are growing rapidly, and there is widespread variation in how likely patients are to undergo this type of surgery. Rates of shoulder surgery, for example, varied

more than tenfold – from 3.0 per 1,000 enrollees in Provo, Utah, to a low of 0.3 per 1,000 enrollees in Syracuse, N.Y.[43]

More health care does not mean better health care.

- **There is a significant problem of overuse of health care in America.** This includes putting people in the hospital who may not need to be there, having patients see specialists more often than they may need to, or using tests or imaging that patients do not need.
  - The extent of over-care is apparent by looking at spending and outcomes. Some regions of the country use vastly more resources—hospital stays, doctors' visits, imaging and tests—to treat patients with similar illnesses without achieving better outcomes. As a result, researchers estimate that a whopping 30 percent of health care spending is for services that may not improve people's health—nearly $700 billion a year.[44]
- Higher spending does not achieve better outcomes.
  - Both doctors and patients often assume that more "care"—that is, using every available resource such as specialists, hospital and ICU beds, diagnostic tests and imaging—produces better outcomes for patients. This is wrong.
  - The regions of the country that spend the most money on health care per capita deliver more health services. In higher-spending regions:[45]
    - There are one-third more hospital beds and physicians per capita.
    - Patients have more hospital stays, doctor visits, specialist referrals, imaging, minor tests and procedures.
  - Higher spending does not produce better outcomes. In higher-spending regions:[46]
    - Patients get the care recommended by experts less frequently.
    - There are slightly higher death rates following heart attacks, hip fractures and colorectal cancer diagnoses.
    - Patients have worse access to care and longer waiting times.
    - There is no difference in patient-reported satisfaction with care.
- **Evidence that the quality of care—and health outcomes—tend to be better in regions that use fewer resources carries important policy implications** for Medicare and U.S. health care in general. Health care providers serving low-cost regions are not withholding care that patients really need. On the contrary, they are simply more efficient. They achieve equal and often better outcomes with fewer resources. They offer a benchmark of performance toward which other systems should strive.
  - If the entire U.S. health care system treated chronically ill patients the way the prestigious Mayo Clinic does, Medicare could have saved $50 billion in 2001–2005. The savings would be far greater for Medicare as a whole.[47]
  - These potential savings are highly significant given the current Medicare fiscal crisis—especially since not spending this money would not have compromised the quality of care.
  - The current payment system rewards higher volumes of services, whether they are warranted or not. We must reward, rather than penalize, provider organizations that successfully reduce excessive care and develop broader, community-based strategies for managing patients with chronic illness.

SOLUTIONS TO THE QUALITY PROBLEM

Health care is a national issue, but it is delivered locally. We must take action at every level to fix it.

- **Everyone who gives, gets or pays for care should care about improving quality.** Getting quality health care is a national issue. It's a local issue. It's everyone's issue.
  - Consumers and patients should care about quality because they want to get better, not worse when they see a doctor or go to the hospital.
  - Doctors and nurses should care about quality because they want to provide the best possible care.
  - Employers, the government and everyone else who pays for health care should care about quality because they expect greater value for their money.
- **We must drive quality improvement by aligning key players in local communities.** No single person, group or profession can improve health and health care throughout a community without the support of others. All must work together.
- **If we want high-quality, high-value care, we must change the fundamentals of our health care system.**
  - We must make the quality of care delivered by doctors' offices and hospitals transparent to everyone by measuring and reporting on their performance.
  - We must help consumers and patients make better-informed decisions about their health care.
  - We must help providers implement proven techniques and protocols for delivering high-quality care.
  - We must fix the way we pay for care to reward value instead of volume.
  - And we must move a system buried in paper into the digital age.

PERFORMANCE MEASUREMENT AND PUBLIC REPORTING

To improve quality, we need better information about the actual performance of doctors and hospitals. You cannot improve what you do not measure.

- **Improving quality requires sharing information about what is happening inside our health care system with everyone who gets, gives or pays for care.** We don't always know who is doing a good job and who is not because we can't see inside the health care system.
  - **Patients need information about the quality of care that doctors and hospitals provide** if they are going to make informed choices about their own care.
  - **Doctors and hospitals need information on their own performance** to identify areas for quality-improvement efforts, evaluate the results of those efforts and compare their performance to others.
  - **Consumers and purchasers need information about the quality of care they pay for and receive** to determine the value they are getting.
- **Measurement is an important building block for improving quality.** It gives providers the information they need about their own performance to identify areas that are ripe for quality improvement, evaluate the results of those efforts and compare their performance to others. It also allows payers and consumers to make judgments about the quality of care they pay for and receive.
- **Making health care patient-centered starts with giving consumers accurate information that they can use to make informed choices.** Choosing the right doctor or hospital is one of the most important

health care decisions consumers will ever make, yet they have precious little information to guide the decision:[48]

- Only 20 percent of Americans surveyed in 2008 said they had seen information about the quality of care hospitals provide, and only 7 percent said they used the information to make a decision.
- Only 12 percent of Americans surveyed in 2008 said they had seen information about the quality of care doctors provide, and only 6 percent said they used the information to make a decision.

- **Consumers want information to support their health care decision-making.**[49]
  - Eighty-eight percent of consumers say they would search for information on treatment options if they were diagnosed with a medical condition.
  - Four out of five consumers (81 percent) believe that, if needed, they would search for information on their own about physicians or hospitals.
  - Nearly two-thirds of consumers surveyed (64 percent) feel it is important to obtain health information from sources in addition to their doctor.
  - Two-thirds of consumers who have made various health care decisions in the past year—such as selecting a primary care physician, specialist, hospital or treatment option—have sought out information to make that decision.
- **Consumers are comfortable with the idea of using objective rating systems to choose hospitals and doctors based on how successfully they have treated patients for specific conditions.**
  - One out of five consumers say they are "very comfortable" with using objective rating systems in that way, and nearly six out of 10 say they are at least "somewhat comfortable" with the idea.[50]
- **Online resources are important to consumers in making decisions about treatments and providers.**[51]
  - Six in 10 consumers say they looked online for information about treatment options in the past year.
  - In a 2009 survey, 30 percent of consumers reported they had compared doctors before choosing one in the previous 12 months. That was an improvement from a 2008 survey in which 23 percent said they had done so in the previous 24 months.
- **Most doctors lack information about the quality of care they or their colleagues provide.**[52]
  - Only one in three doctors gets any data about performance.
  - Only one in four gets patient-survey data.
  - Only one in five gets data about the care their patients received, such as recommended tests, screenings and checkups.
  - Fewer than one in five get data about how their patients are actually doing, such as a diabetes patient's blood sugar level.
  - Only one in seven solo practitioners has access to any quality data.
  - The overwhelming majority of doctors in practices with fewer than 10 M.D.s cannot generate internal data.
- **We should develop robust collection systems for data on the quality of care delivered by doctors, medical groups, hospitals, nursing homes and other providers.**
- **Reporting systems must be independent and trusted by physicians and consumers alike.**

- **Doctors are understandably concerned about measurement and reporting.** But leading physicians also recognize the problems with health care quality and understand the need for medicine to embrace quality-improvement techniques. We must work together for measurement and reporting that is fair and accurate.
- **Measurement and reporting are critical starting points for quality-improvement efforts.** The saying "you can't improve what you don't measure" certainly applies to health care. Physicians, nurses, clinics and hospitals need this information to help them identify areas to target for their quality-improvement efforts.
- **Measuring and reporting on the performance of doctors and hospitals is here to stay.** Medicare, employers and health plans have made it part and parcel of reimbursement strategies and benefit design. The number of regional organizations also reporting on the performance of hospitals and doctors is growing.
- **Programs to measure doctors' and hospitals' performance must be consistent nationally.** We don't want "good health care" to mean one thing in Miami and another in Seattle. At the same time, we must strike a balance between standardization and innovation. We want measurement based on sound national standards and methodology, but we must also recognize the different needs of different communities.
- **At the community level, we can improve the quality of health care by:**
  - **Providing information on the quality of care local doctors and hospitals provide so that consumers can make better decisions** about where to get care for themselves and their families.
  - **Helping people take an active role in learning about their health and local health providers** so they have the information they need to choose the right doctors and hospitals.

Measuring the quality of care is especially important for reducing racial and ethnic disparities.

- **Measuring how care is delivered to different patient populations can help address racial and ethnic disparities in health care by targeting efforts to close the gaps in care.**
  - There are many causes of disparities, but some are easier to fix than others. Poverty, racism and personal health behavior are very difficult to influence. But how or whether a doctor or hospital delivers consistent, quality health care can be evaluated and influenced through specific systemic changes.
  - One way to effectively reduce racial disparities in health care is to collect and track patient data by race and ethnicity, evaluate the disparities in treatment that are found, and design interventions that will appropriately and consistently improve quality.
  - Identifying and testing specific interventions to improve quality—then measuring the impact of these interventions when they are consistently delivered to each racial and ethnic group—can help determine what works best for specific racial and ethnic populations.
- **Health care systems need better tools to address racial and ethnic disparities in health care**—such as programs that effectively use data to target disparities and improve language access.

CONSUMER ENGAGEMENT

There is a lot that people can do to improve the quality of care they receive, such as making informed choices about their health care and becoming better partners with their doctors in managing their own health.

- **The choices people make about their health and health care profoundly affect outcomes and costs.** We can improve the quality of care people receive by helping them:
  - Understand the behaviors that put them at risk and, for those who have an illness, understand how they can help manage it.
  - Work with their doctors to understand and make informed choices about treatments.
  - Understand the difference between good care and bad care—and demand good care.
  - Where possible, choose doctors, clinics and hospitals based on information about their ability to deliver effective care.
- **People who are actively engaged in their health care have better outcomes.**
  - The degree to which people are willing and able to take on the role of managing their health and health care plays a critical role in their health outcomes.
    - The more activated patients are, the more likely they are to obtain preventive care such as health screenings and immunizations, and to adopt healthy behaviors such as eating right, exercising, monitoring conditions and following treatment, asking questions of providers, and using quality information to select a provider.[53]
  - Some health care delivery systems are better at supporting patients in self-management activities than others. Those that focus on the patient—such as practices built on the "medical home" model, or those that use the Chronic Care Model—do best because they can offer coordinated and customized care aimed specifically at activating patients, such as dedicating specific staff to support patients.
- **At the community level, we can improve the quality of health care by:**
  - **Exploring new ways to improve communications and coordination** between hospitals, doctors, nurses and patients.
  - **Giving people information that helps them be better partners with their doctors** in managing their own health.

QUALITY IMPROVEMENT

We must accelerate the effort to help doctors' offices and hospitals adopt the latest and best techniques and protocols to improve the quality of the care they deliver.

- **Across the country, doctors, nurses, allied professionals and health care leaders are joining a growing movement to improve the quality of health care.** They are increasingly using techniques refined by world-class manufacturers such as Motorola to improve the delivery of care from bedside to exam room. These quality-improvement efforts are essential. Trying harder to make our current systems work better will not raise the quality of care; instead, we must reinvent our current systems of care.[54]
- **There is an ethical imperative for quality improvement.** We cannot tolerate systems of care that not only fail to measure up to the highest standards of quality but sometimes even harm or kill people.
- **There is a financial imperative for quality improvement.** Unless we move rapidly to implement quality improvement, we will continue to squander precious resources on a broken system.

- **There is also a business imperative for quality improvement.** Take the example of investing in patient-safety improvements:[55]
  - For hospitals serving a lot of Medicare patients, investing in safety can produce a substantial return on investment because the Medicare payment system in many cases gives no additional reimbursement for treating adverse events such as a serious postoperative infection. So hospitals need to prevent those adverse events from happening if they don't want to be stuck with the costs.
  - Likewise, there is a business case for Medicare to invest in patient-safety efforts, because even though in many cases it doesn't reimburse hospitals for treating adverse events, there are plenty of cases when it does—and the costs for those cases add up to a substantial expenditure.
- **There is a 17-year lag, on average, between the discovery of effective treatments and their incorporation into routine patient care.**[56] Quality-improvement efforts can help close the gaps between clinical research and routine practice.[57]
- **Health care should follow in the footsteps of industries from aviation to nuclear energy by striving for zero defects.** We can no more tolerate giving a patient the wrong dose of medicine than we can tolerate having faulty hydraulics in an airplane.
  - We should redesign care settings to encourage medical providers to work in teams, making better use of physician assistants, nurses, nutritionists and dietitians.
- **Many efforts to improve care have resulted in real, measurable changes in hospitals and doctors' offices.** These changes have resulted in more patients getting the care they need when they need it. Now, health care needs to be transformed on a bigger scale. We must make excellence the rule, not the exception.
- **Evidence-based quality improvements have begun to take hold—progress that is saving lives and money.** Across the country, new models of care are emerging, built on fast-expanding knowledge about effective and efficient delivery of care.
  - Examples of these tangible improvements include innovations to prevent people in hospitals from getting infections, making sure heart attack patients get the right medications when they enter the emergency room, using health information technology to remind patients with diabetes to get vital tests and checkups, and cutting waiting-room time to zero.
- **Institutions can apply quality-improvement techniques to health care on an ongoing basis and spread lessons throughout their systems.** They can study how their systems permit and even facilitate errors. They can improve care by measuring their practices against proven best practices and determining where they fall short or exceed those standards of care.
- **Nurses play a central role in ensuring the quality and safety of hospital care because they are highly trained professionals who are regularly at patients' bedsides.** In fact, nurses are at the forefront of the quality-improvement movement in hospitals.
  - Hospitals' pursuit of high-quality patient care is dependent, at least in part, on their ability to engage and use nursing resources effectively.[58]
- **At the community level, we can improve the quality of health care when we:**
  - **Show doctors and hospitals how they can make improvements in patient care,** so that people receive better care and have closer relationships with their doctors.
  - **Pinpoint areas in the health system where medical errors often occur and developing solutions** to reduce those errors.

Rewarding Quality Care

Our payment system should reward providers for giving patients the right care at the right time in the right way. We must reward value, not volume.

- **Payment and delivery reform are inextricably linked** because health care is like most things in life—you get what you pay for. So instead of rewarding the quantity of services providers deliver, we must reward the quality of the care patients receive. This means we must replace the broken fee-for-service system with one that pays for performance. That is the heart of the high-value health care agenda.
  - We must quit paying for volume and instead pay for value.
  - We must pay for what we want to happen, not whatever happens.
  - We must reward quality, cost-effective and affordable care that is patient-centered and reduces disparities.
  - We must reward care that doesn't depend on where it is delivered, but rather whether it is the best care for an individual patient.
  - We must push public and private systems to reward care similarly.
  - We must listen to the voices of everyone who gets and pays for care—as well as those who provide it—as we make these decisions.
- **Providers who deliver high-quality, cost-effective care or who improve significantly should be rewarded.** For example, providers should be fairly compensated for delivering preventive care, coaching patients and coordinating care for those with chronic conditions.
- **There are many promising models for payment reform that we should try as we work to end the failed fee-for-service system.**
  - **We can reward care coordination** by paying for "medical homes" with extra reimbursement for providers responsible for coordinating a patient's total care.
  - **We can pay for episodes of care**—paying once for the total package of treatments necessary for a medical condition, rather than paying separately for each treatment, based on the medically accepted method for best treating the condition from beginning to end.[59]
  - **We can pay providers to become accountable for the overall costs and quality of care for the populations they serve**—and share in the savings they create by improving quality and slowing spending growth—through so-called "accountable care organizations."[60]

Health Information Technology (HIT)

Digitizing the U.S. health care system will help speed up delivery, reduce errors and improve measurement and coordination.

- **Electronic health records are not a silver bullet for the problem of poor-quality health care, but they can contribute to the fix.** HIT can help providers change the way they deliver care but it can't improve flawed processes of care. Our challenge is to make the system better first, and use HIT to help make it easier to improve care.
  - HIT can make it easier to coordinate care by giving providers in any setting instantaneous access to a patient's complete medical history.
  - HIT can make it easier for doctors to know which of their patients haven't had important tests or checkups and generate reminders.

- HIT can make it easier to measure and report on the quality of care—information vital for implementing payment reform as well as achieving quality improvement.

QUALITY AND HEALTH REFORM

Now more than ever, improving the quality of health care in America is critical. Poor-quality health care hurts people and robs the system of precious resources—in both dollars and services—that could be used to expand access and coverage.

- **The problems of poor-quality health care in America and the millions of uninsured Americans are inextricably linked.**
- **The soaring costs of U.S. health care—more than 16 percent of our GDP—has been putting access to health care out of reach for many ordinary families, and putting programs like Medicare and Medicaid at grave risk.**[61] Health insurance for a family averaged $13,375 in 2009.[62]
- **Poor or uneven quality of health care robs the system of precious resources—in actual dollars and services—that could potentially be used to expand access and coverage.**
  - Researchers estimate that a whopping 30 percent of health care spending—nearly $700 billion a year—is for services that may not improve people's health.[63]
- **If policy-makers want to help more people get better care, especially in the context of an economic recovery, we must stop wasting money on inappropriate or unnecessary care, and start delivering the care that people want and need.**
  - The current payment system rewards both oversupply of certain health care services and volume. We must reward, rather than penalize, health care providers that successfully reduce excessive care. We must also reward health care providers for providing the right care at the right time.
  - Poor-quality care comes in three forms: overuse (too much health care, based on available supply), underuse (not enough health care for people who need it) and misuse (medical mistakes). We need to address all three problems to create a more efficient, equitable and high-value health care system in America.
- **Improving the quality of care for patients with chronic illness will go a long way toward freeing up dollars for expanding coverage and promoting a healthier economy.**
  - Care for people with chronic conditions such as diabetes, asthma, heart disease or depression accounts for 85 percent of today's medical spending[64]—which is more than $2 trillion. Research shows that these patients receive only 50 percent of the care recommended by experts and doctors.[65]
  - In 2004, hospital costs for potentially preventable chronic conditions totaled nearly $29 billion—one out of every $10 of total hospital expenditures. As many as 4.4 million hospital stays might have been prevented by taking better care of people outside the hospital, by improving access to effective treatment or through patient adoption of healthy behaviors.[66]
  - And the more chronic conditions a person has, the more health care spending is required to treat him or her. In 2002, Medicare beneficiaries with five or more chronic conditions accounted for three-quarters of all Medicare expenditures.[67]
- **Right now, we do not have an easy way to reallocate the dollars that are going into poor-quality health care and apply them to other causes, like expanded access.**

- To get to health care that is high-quality AND delivers better value for everyone, we need to make sure that the stakeholders who give care, get care and pay for care are part of the solutions. Otherwise, reform efforts will be doomed by the morass of economic and political incentives that often cause health care stakeholders to operate at cross-purposes.

QUALITY AND THE UNINSURED

High costs and the uninsured are the visible problems with U.S. health care. The invisible problem is poor-quality care.

- **Being uninsured is hazardous to your health.**
  - People without insurance do not get the care they need, and as a result too many people live sicker and die sooner.
    - Adults without health insurance are much less likely to get preventive care that can reduce unnecessary sickness and death. They are more likely to die from trauma or serious conditions such as heart attacks and strokes.[68]
    - Adults with chronic illnesses such as diabetes, asthma or heart conditions often delay or skip seeing doctors or taking their medicine.[69]
- **Children with health insurance get better care.**
  - With coverage, they are more likely to have regular access to care, get their immunizations and receive appropriate care for illnesses like asthma. Serious heath problems are more likely to be diagnosed early, and children are less likely to go to the hospital, more likely to take care of their asthma and less likely to miss school.[70]
- **When millions of Americans are uninsured, everyone is affected.**
  - Insured adults in communities with high rates of uninsured residents are less likely to be satisfied with the quality of their care and their choice of health care providers.
  - Insured adults who live in communities with high rates of uninsured residents have a harder time getting the care they need and are less satisfied with the care they do receive.[71]
- **The problems of poor-quality care and lack of coverage are inextricably linked, even though the linkage is not widely understood.**
  - Improving quality and managing costs go hand-in-hand. Poor-quality care robs the system of precious resources—dollars and services—that could be used to expand access and coverage.
- **The soaring cost of U.S. health care is putting access to health care out of reach for many ordinary families and putting programs like Medicare and Medicaid at risk.**[72]
  - Health insurance for a family of four rose from an average of $12,680 in 2008 to $13,375 in 2009.[73]
  - For most people, health care reform is about getting everyone access to care, and the debate has been over how to slow fast-rising costs and increase the number of people with insurance coverage.
- **As we think about how to cover more Americans, we must also effectively implement changes in the way we deliver and pay for health care in this country.**
  - We know that improving the quality of care—getting people the right care at the right time, especially if they are chronically ill—will cost us less, not more, over time.

- We also know that the same health care system that gives some people too little care too late also gives some people more care than they need.
- The extent of inefficiency in the U.S. health care system can be seen by examining health care spending versus results, especially across geographic regions.
  - Some regions of the country use vastly more resources—hospital stays, doctor visits, imaging and tests—to treat sick patients. Others use far fewer resources to treat similarly ill patients, and get the same results.
- Researchers estimate that a whopping 30 percent of health care spending—nearly $700 billion a year—is for services that may not improve people's health.[74]

- **Good health is not only equitable—it is also efficient, effective and safe.** What happens to patients after they get in the doctor's office or hospital is as important as getting them in.
- **To get to health care that is high-quality AND delivers better value for everyone, we need to make sure that the stakeholders who give care, get care and pay for care are part of the solutions.** Health insurance is important to getting quality care for children. Children in states with the lowest rates of uninsured children are more likely to get preventive care like medical and dental checkups and see doctors who coordinate their care.[75]

MESSAGES FOR SPECIFIC AUDIENCES

MESSAGES FOR DOCTORS

- **The most trusted figure in health care today is the physician.** And the cornerstone of quality care is a "healthy" physician-patient relationship that helps patients become more knowledgeable about and involved in their health behaviors and medical care.
- **We must close the gap between the quality of health care that people now receive and the even better care that we know doctors and other health care providers are capable of delivering.** We want to go from good to great, and no one is more important than doctors as we reach for the next level.
- We need doctors to:
  - Help fellow physicians and health care providers improve their own care delivery.
  - Help patients understand their responsibility to recognize and seek high-quality care, improve their health behaviors, and comply with treatment plans.
  - Help measure and publicly report their performance.
- **We understand the frustration of doctors who feel squeezed by today's payment system, pressured to see more patients, and burdened by growing administrative requirements.** We want to work toward a system that rewards doctors for giving patients the high-quality care they need—care that is known to improve health and reduce unnecessary risks.
- **In the past, some systems that collected data on the quality of health care were flawed.** To improve quality, we need physicians to help design a system that is fair, inclusive and gets it right.
- **Publicly reported information about the performance of individual doctors, physician groups and hospitals is critical for improvement.** As performance measures are developed, they must be:
  - Transparent in methodology.
  - Specific about the data used to develop the measures and any limitations presented by the data.

- Produced in partnership with physicians from the beginning.

- **In every community, both good and bad care is being provided in hospitals and doctors' offices.** If we can all agree on a reliable, comprehensive and accurate way to measure physician performance, that's a worthwhile goal.
- **Many physicians look for new ways to improve their skills and provide better quality care.** Sharing performance data among providers often generates conversations about proven techniques that lift the quality of care.
- **Performance measurement data can help physicians assess what is working in their own practices.** Most physicians don't have accurate, complete data on the care provided in their practices. Without measurement, it is hard for providers to know if the steps they are taking are as effective as they want them to be.
- **Performance measurement could benefit most physicians.** It could result in identifying ways to improve the quality of care in their entire practice. It could also help them assess the quality and effectiveness of the care that they provide and how it compares to evidence-based standards.
- **The efforts now underway in many communities emphasize improving patient compliance, instead of just focusing on physicians.** These efforts include educating patients to better manage their diseases and take more responsibility for improving their health.
- **Doctors must be key members of the teams that design measurement systems**, to help ensure that they are fair, inclusive, flexible and actually measuring the right things.
- **While reviewing and acting on performance data requires extra attention from physicians, the added effort will lead to better care for patients.** In some communities, efforts to implement performance measurement involve aggregating data from various health plans to give physicians a simple, comprehensive picture of their care.
- **Our work also includes quality-improvement training** (i.e., continuing medical education) about how to use and act on performance information to help physicians make practice improvements.
- **Every physician knows there are different ways to measure care and different sources of data to look at, and that much of it is contradictory.** Competing requests to report data have become increasingly burdensome for physicians and often meaningless for improving patient care. We need to streamline the process and get everyone who collects data on the same page to aggregate their results so that we get a comprehensive and accurate look at trends that we can act upon.
- **Some of the nation's leading medical societies are working on performance measurement because they recognize the inevitability of it and want to shape it.**
- **We need physicians to be part of a team that designs the performance measurement system**, instead of leaving it only to administrators, actuaries and politicians.

MESSAGES FOR THE PUBLIC

- **One of the most powerful forces driving improvement in health care is the educated consumer.** Consumers who make informed choices and are engaged in their own care not only experience better health outcomes, they also help reward doctors, hospitals and health plans that deliver better care and service.[76]
- **Finding the right doctor can be confusing in our health care system.** Many people don't have close relationships with their doctors anymore, and trying to get or stay healthy can leave some people feeling uneasy about the care that they receive.

- **In every community, both good and bad care is being provided in hospitals and doctors' offices.** There are too many mistakes and too much miscommunication in the health system that can negatively affect people's lives.
  - We need to explore new ways to improve communications and coordination between hospitals, doctors, nurses and patients.
  - We need to give people information that helps them be better partners with their doctors in managing their own health.
- **Most doctors are pressed for time these days, and patients feel like they don't have time to really talk and ask their doctors questions.** Rushed doctor visits can leave people with lingering concerns about their symptoms, treatments or medications.
- **Getting good medical care is a worry for many people.** There are too many choices and not enough clear, trustworthy information.
- **Getting peace of mind about health care begins largely with finding the right doctor—one who values relationships based on openness and trust and provides high-quality care.** We need to provide consumers with information on the quality of care local doctors and hospitals provide, so they can make better decisions about where to get care for themselves and their families.
- **We need local teams of doctors, nurses, hospitals, employers, insurance plans and residents working together to make improvements that will help people get better care.**
  - These teams can show doctors and hospitals how they can make improvements in caring for patients, so that people receive better care and have closer relationships with doctors.
  - These teams can pinpoint areas in the health system where medical errors often occur and develop solutions to reduce these errors.
- **Given today's complicated health system, it is hard to believe that anything can actually change—but we are confident that we can improve health care if we have everyone's help.** No one is more important to this effort than consumers:
  - Quality health care happens when people take an active role in their own care, becoming partners with their doctors to create a more effective, trusting relationship that helps them stay healthy or determine the right care when they need it.
  - Regardless of what kind of relationship they have with their doctors, there is a lot that people can do on their own to manage their own health, such as watching what they eat, exercising and limiting stress.
  - People can improve their care by learning more about their doctors and their own conditions—asking questions, sharing their medical histories, making sure they understand their doctors' recommendations and taking the necessary steps to feel better sooner.

MESSAGES FOR EMPLOYERS

- **As the largest purchaser of health care in America, private employers are footing the bill for poor-quality care and must demand better quality.**
- **High-quality care makes better and more efficient use of employers' health care dollars.** Improving the health care delivery system's outcomes now creates an opportunity to reduce premiums in the future.

- **We need businesses—the people who purchase health care—to help create a healthier and more productive workforce, and increase accountability for the delivery, purchase and consumption of health care.**
- **Employers pay a price for poor-quality care.** About six in 10 Americans get health insurance through employers, and employers pay for nearly three-quarters of premiums. At the same time, poor-quality care costs a typical employer between $1,900 and $2,250 per employee every year.[77] A staggering 30 percent of U.S. health care spending is the result of poor-quality care, chiefly overuse, misuse and waste.[78, 79]
  - Nearly three-fourths of the money spent by private insurance goes to treat people who suffer with chronic illnesses such as diabetes, asthma, heart conditions and depression. Yet, Americans get only half of the recommended care for their chronic conditions—and too many people do not take personal responsibility for managing their health.
- **Helping employees manage their health is a sound investment in human capital.** Health promotion and disease management can lift the quality of the workforce. Put simply, employees who feel good work better. Employees who are well are more likely to show up and be productive than employees who are sick.
  - Poor-quality care leads to as many as 45 million avoidable sick days, the equivalent of 180,000 full-time employees—the working population of Salt Lake City—calling in sick every day for a full year.[80]

ABOUT ALIGNING FORCES FOR QUALITY (AF4Q)

AF4Q is the Foundation's signature effort to lift the overall quality of health care in targeted communities, reduce racial and ethnic disparities, and provide models that will help propel national reform.

- **Aligning Forces for Quality, a national initiative of the Robert Wood Johnson Foundation (RWJF), is working to lift the overall quality of care in 17 communities** by focusing on three things:
  - Engaging stakeholders to measure performance and publicly report on the quality of care;
  - Helping doctors, nurses and other health care professionals learn how to deliver better care; and
  - Helping consumers and patients become more engaged in the quality of care they can demand and receive.
- **While health care quality is a national problem, health care is delivered locally and fixing it requires local action.**
- RWJF's unprecedented commitment of *resources, expertise and training* is turning proven practices for improving quality into real results in communities.
- Seventeen regions across the country have already been selected to participate in this program, and other regions may be added.
- These communities are making fundamental and cutting-edge changes to rebuild their health care systems.

We are taking specific actions to improve the quality of health care in communities.

- **Aligning Forces for Quality asks community stakeholders to work toward fundamental goals that will lead to better care.**

- **It helps physicians improve the quality of care they provide** by adopting the latest and best medical practices, techniques and protocols.
- **It encourages people to become better partners with their doctors** by giving them the tools and information they need to more effectively communicate and act in the best interests of their own health and health care.
- **It helps improve care inside hospitals,** with a special focus on the role nurses play.
- **It reduces inequality in care for patients of different races and ethnicities** by pinpointing what causes disparities and implementing solutions.

Together we will align forces to improve the quality of health care.

- **RWJF seeks to drive higher-quality care by aligning the key players and market forces within particular geographic regions.**
- Doctors, nurses and hospitals want to deliver high-quality care, but the fragmented nature of our health care markets and delivery systems often prevent key players from working together toward that common goal.
- RWJF is teaming up with those who get care, give care and pay for care to deliver lasting change for entire communities.
- We know that given today's complicated health care system, it is hard to believe that anything can actually change—but we are confident that this effort will work in communities if we have everyone's help.

AF4Q builds on a legacy of research and development focused on the quality of health care.

- **The Foundation's research and development efforts in quality health care have defined the field.** Over the years, we have invested in:
  - The Dartmouth Atlas Project's research on geographic variations in the quality and quantity of U.S. health care services.
  - The RAND Corp.'s research into the spotty provision of recommended health care to both adults and children.
  - The Institute of Medicine's recommendations for improving health care quality, *Crossing the Quality Chasm*.
  - The National Quality Forum's endorsement of quality measures.
  - Pay-for-performance experiments by the Leapfrog Group.
  - Improvements in patient safety and outcomes in hospitals through programs like *Pursuing Perfection*, *Urgent Matters, Transforming Care at the Bedside* and *Expecting Success*.
  - The McColl Institute's development of the Chronic Care Model to treat people with chronic disease.
- Building on this legacy, we decided to move beyond working with one clinic or one disease at a time, and take a community-based approach. We crafted the strategy for Aligning Forces on this premise—that there is no single approach that can improve the quality of care.

TALKING POINTS: THE QUALITY CRISIS AND HOW TO SOLVE IT

- Anyone who has paid attention to the health care debate knows that costs have been soaring and millions of Americans lack insurance. But there is another dimension to the health care crisis: poor quality. Too frequently, even when people *have* insurance, they get inadequate or inappropriate care.
- That's one reason why we're not getting our money's worth for the $2.3 trillion we spend on health care every year in this country. In fact, we have shorter life expectancies and worse infant mortality rates than other developed nations.
- While we work on making sure everyone can see a doctor when they need to, we also need to make sure they get the *right* care once they do. That's what quality care is: getting the care you need when you need it—no less and no more. Today's system often falls short of that standard.
- The quality crisis has three main dimensions: overuse, underuse and misuse. That means giving people treatments they don't need, failing to give people care they should be getting, and making mistakes that harm or kill people. All of those quality problems are rampant, and they rob the system of precious resources—dollars and services—that could be used to expand access and coverage.
- The scope of the quality crisis varies depending on who you are and where you live. Racial and ethnic minorities suffer from worse health and receive lower-quality care than whites. And while every community has some doctors' offices and hospitals that consistently deliver high-quality care and some that do not, there are broad variations in the way medicine is practiced in different places. For example, women in their late 60s are far less likely to get regular mammograms in Mississippi than in Maine.
- The way we pay for health care deserves a lot of the blame for the quality crisis. Today's fee-for-service system rewards providers based on the number of tests and procedures they perform, not the results patients get. We need to flip that around and start rewarding value, not volume.
- Improving quality starts with measuring it. Everyone needs better information about the performance of doctors and hospitals. If you are paying for health care, you need the information to determine the value you're getting. Providers need the information, too, so they can see how to lift the quality of care they deliver. And patients need it so they can make informed choices to better manage their own health.
- Everyone with a stake in the health care system has an important role to play in solving the quality crisis. Policy-makers, payers, providers and consumers all need to work together to measure performance and publicly report on the quality of care the system delivers. Doctors, nurses and other health care professionals need to learn how to improve their performance. Payers need to reward them for it. And consumers and patients need to get more engaged in demanding high-quality care.
- The quality crisis is a national problem, but health care is delivered locally, so fixing it requires local action. That's the logic behind the Robert Wood Johnson Foundation's Aligning Forces for Quality initiative.
- Aligning Forces operates in 17 communities where the local stakeholders have shown themselves to be ready to drive a comprehensive reform effort. The program's goals are to lift the overall quality of health care in each community, reduce racial and ethnic disparities, and provide models that will help propel national reform by providing resources, expertise and training to help providers, payers and consumers all do their part.
- At the end of the day we know we can fix what is wrong with our health care system because there is a great deal that is *right* about our health care system—starting with our world-class doctors, nurses, hospitals and researchers. With hard work and ingenuity, we can continue to encourage all that is right about American health care while we work to fix what is wrong.

ELEVATOR SPEECH

Everyone knows health care costs are soaring and millions of people lack insurance. But we've got another problem, too: poor quality. The little-known fact is that even when people *have* insurance they often get inadequate or inappropriate care.

Quality is getting the care you need when you need it—no less, no more—and today's system often falls short of that standard. The way we pay for care deserves a lot of the blame, because the fee-for-service model rewards providers based on the number of tests and procedures they perform, not the results patients get. We need to flip that around and start rewarding value, not volume.

The way to start is by measuring quality. If you're paying for care, you need good information about the performance of doctors and hospitals to understand the value you're getting. If you're a provider, you need the information so you can see how to improve. And patients need it, too, so they can make good choices to manage their own health.

Everyone with a stake in the system has a role to play in solving the quality crisis. Providers need to learn the best techniques and protocols to improve their performance. Payers need to reward them for it. And consumers need to get more engaged in demanding high-quality care.

This is a national problem, but health care is delivered locally, so that's where the action is. It's why the Robert Wood Johnson Foundation's Aligning Forces for Quality initiative focuses on communities.

At the end of the day we know we can resolve the quality crisis because there is a great deal that is *right* about our health care system—starting with world-class doctors, nurses, hospitals and researchers. We must continue to encourage what's right while we work to fix what's wrong.

FREQUENTLY ASKED QUESTIONS

How do you define quality?

In the simplest terms, quality means getting the care you need when you need it—no less, no more. That may include preventative care, ambulatory care, acute care, post-acute care or long-term care. But in all cases, quality care makes the best use of current medical knowledge to achieve the health outcomes patients want.

The Institute of Medicine gives a more comprehensive definition of quality health care: It is safe, effective, patient-centered, timely, efficient and equitable.

What does quality have to do with affordability?

The problems of poor-quality care and lack of coverage are inextricably linked, because poor-quality care involves, among other things, wasteful overuse of health services and unnecessary medical errors, which drive up the overall cost of care in America. This robs the system of precious resources—dollars and services—that otherwise could be used to expand access and coverage.

How is the problem of the uninsured linked to the problem of poor quality?

Aside from the fact that poor-quality care robs the system of precious resources that could otherwise be used to expand access and coverage (see above), there is the more fundamental fact that being uninsured is hazardous to your health. People without insurance do not get the care they need, and as a result too many live sicker and die sooner. Adults without health insurance are much less likely to get preventive care that can reduce unnecessary sickness and death. They are more likely to die from trauma or serious conditions such as heart attacks and strokes. Adults with chronic illnesses such as diabetes, asthma or heart conditions often delay or skip seeing doctors or taking their medicine.

What is underuse?

"Underuse" is when proven health care practices are not followed and people don't get the care they should get—for example, when elderly people suffering heart attacks are not given beta-blocker drugs. The Institute of Medicine, in its seminal report *Crossing the Quality Chasm,* identified underuse as one of three main dimensions of the quality crisis in U.S. health care. The other two dimensions are misuse and overuse.

What is misuse?

"Misuse" of care is another way of describing medical errors, which include badly executed treatment plans—and plans that were the wrong choice from the start. Misuse can lead to adverse reactions to drugs, surgical injuries and other serious harms to patients, and bring steep financial costs. Along with underuse and overuse, misuse is one of three main dimensions of the quality crisis in U.S. health care that the Institute of Medicine identified in *Crossing the Quality Chasm*.

What is overuse?

"Overuse" refers to health care resources and procedures being used even when there is no reason to believe they are the best way to help patients—for example, prescribing advanced antibiotics for simple infections. Quality problems such as these contribute to rising health expenditures, but diminishing value for the country's health care dollar. Along with underuse and misuse, overuse is one of three main dimensions of the quality crisis in U.S. health care that the Institute of Medicine identified in *Crossing the Quality Chasm*.

How does quality differ in different parts of the country?

Greatly. Across the United States, there are striking variations in the way medicine is practiced, which affect both the quality and quantity of the care patients receive. These variations have nothing to do with how ill patients are. Rather, the variations arise from local, regional and state patterns of medical practice—for example, how often patients see physicians, how often they are referred to specialists, how often the hospital is the site of care for patients with chronic illness and how many days patients spend in intensive care.

Why are measurement and public reporting important?

You cannot improve what you do not measure. With good data, providers can identify aspects of their practices that are ripe for quality improvement, evaluate the results of those efforts and compare their performance to others. Meanwhile, payers and consumers can use the same information to make choices and judgments about the quality of care they pay for and receive.

Why is it important to engage consumers in efforts to improve health care quality?

For one thing, people who are actively engaged in their health care have better outcomes, because they tend to make more informed choices about their health care options and become better partners with their doctors in managing their own health. But more broadly, consumers can drive quality improvement throughout the health care system by becoming more discriminating shoppers—whenever possible choosing doctors, clinics and hospitals based on information about their ability to deliver effective care.

To what extent is quality improvement happening in practice?

Across the country, doctors, nurses, allied professionals and health care leaders are joining a growing movement to improve the quality of health care. They are increasingly using techniques refined by world-class manufacturers such as Motorola to improve the delivery of care from bedside to exam room.

New models of care are emerging, built on fast-expanding knowledge about effective and efficient delivery of care. These have resulted in real, measurable changes in hospitals and doctors' offices, saving lives and money as more patients get the care they need when they need it.

What does payment reform have to do with improving quality?

Our current health care payment system—the fee-for-service model—rewards providers for the volume of tests, procedures and other services they provide, regardless of whether or not those happen to be the most medically appropriate treatments. In this way, the system encourages overuse of health care services and forgives misuse, two fundamental markers of poor-quality care.

Thus, payment reform is essential to improving quality. At the most basic level, we must stop paying for volume and instead pay for value. For example, that is the rationale for paying for episodes of care—paying once for the total package of treatments that are accepted as the most medically appropriate for a given condition, rather than paying separately for each phase of treatment.

Is there a silver bullet for improving quality?

No. Lifting the quality of U.S. health care requires implementing a robust set of well-coordinated reforms. It starts with measuring and publicly reporting on the quality of care doctors' offices and hospitals deliver. Providers must then use that information to benchmark their own performance as they implement quality-improvement techniques and protocols. Consumers and providers must have tools and coaching to drive further improvements by making informed choices and becoming better partners with doctors in managing their own health. Finally, public and private payers must incorporate quality data into a new system of compensation for health care services that rewards good outcomes instead of just reimbursing every test and procedure.

Is *Aligning Forces for Quality* just another quality-improvement program?

No. Aligning Forces for Quality is holistic reform initiative that brings together all stakeholders in the health care system—those who give care, get care and pay for care—in a coordinated effort to lift the overall quality of health care in targeted communities while reducing racial and ethnic disparities, and providing models to propel national reform.

Rather than focusing on a narrow solution to a single aspect of the quality problem, AF4Q simultaneously advances four big, interrelated reforms that experts believe are essential to improving health care quality: measuring and reporting on the quality of care doctors and hospitals provide, engaging consumers to build demand for higher-quality care and help patients take a more active role in their own health, helping providers implement quality-improvement techniques and protocols, and reforming our payment system to encourage and reward high-quality care.

APPENDIX I: CORE Q/E TALKING POINTS

- **Americans are not receiving quality health care.**
  - The quality of health care in our country is at best imperfect, and at worst deeply flawed.
  - Across America, doctors' offices and hospitals are delivering both good health care and bad health care. There are too many mistakes, too much miscommunication and too much inequity.
  - Right now in America, it's a coin flip whether you'll get the right care for what's wrong with you. It only happens about half the time.
- **As a country, we are not getting our money's worth for what we spend on health care.**
  - Despite spending $2.3 trillion a year on health care as a nation, Americans don't live as long as people in many other major developed nations—and we have a higher infant mortality rate than most.
  - The soaring cost of health care and the growing number of uninsured Americans are the visible problems with the U.S. health system. The *invisible* problem is poor quality.
- **Quality health care means getting the care you need when you need it. It helps people stay well, and it helps them get better when they are sick.**
  - Quality care is care that works. It means you get the care that is recommended for your condition, based on the best available evidence. It means you don't get *more* tests or care than is needed, nor do you get less.
  - It means care that is safe and free from mistakes and dangerous medical errors.
  - Quality care avoids giving people treatment they don't need, provides them the treatment they do need and does no harm. It is doing the right thing for the patient, at the right time and in the right way to get the best results.
- **Health care is delivered locally, but it's influenced by national AND local factors. We must take action at every level to fix what is not working well.**
  - We are making progress at the local level.
  - [**INSERT examples**].
- **Everyone who gets care, gives care and pays for care must work together.**
  - We must understand the quality of care that is being delivered in every community by measuring and reporting on the performance of doctors and hospitals.
  - We must implement strategies to help improve quality.
  - We must encourage people to act like consumers when it comes to health care and build demand for high-quality care, and we must encourage patients to become better partners with their doctors in managing their own health care.
- **The Robert Wood Johnson Foundation's research and development efforts in quality health care have defined the field.**
  - As the nation's largest philanthropy focused on health and health care of all Americans, the Robert Wood Johnson Foundation has invested hundreds of millions of dollars in exploring gaps in the quality and equality of American health care services. They have supported the development of

measures of quality, experimented with new payment models, studied how to improve patient safety and care in hospitals, improved the way we care for chronically ill patients, and helped identify how to reduce racial and ethnic disparities in care.

- Now RWJF is taking a community-based approach to improve the quality of care with Aligning Forces for Quality—its signature effort to lift the quality of health care in targeted communities across the country.

- **There is a lot that people can do to improve the quality of health care—their own care—in America.**
  - **Physicians can improve the quality of care they provide** by adopting the latest and best medical practices, techniques and protocols.
  - **People can become better partners with their doctors** by giving them the tools and information they need to more effectively communicate and act in the best interests of their own health and health care.
  - **Hospitals can improve the care they provide** by focusing on improving safety and consistency and by paying special attention to the vital role nurses play.
  - **Policy-makers can help us reduce inequality in care for patients of different races and ethnicities** by encouraging efforts that we know help pinpoint the causes of disparities—and then implementing solutions.

APPENDIX II: CORE AF4Q TALKING POINTS

- **Health care quality is a national problem, but health care is delivered locally and fixing it requires local action.**
  - Even in [COMMUNITY], there is good health care and bad health care. There are too many mistakes, and there is too much miscommunication and too much inequity in our health care system.
  - That is why we are leading the effort to improve health care quality in [COMMUNITY].
- **Aligning Forces for Quality is the Robert Wood Johnson Foundation's signature effort to lift the quality of health care in 17 targeted communities, reduce racial and ethnic disparities, and provide models to propel national reform.**
  - The Robert Wood Johnson Foundation is the nation's largest philanthropy dedicated to improving the health and health care of all Americans.
  - The Foundation searched the nation to identify communities that were poised for real change in their health care systems. We were hand-picked to participate in this prestigious program, and the expectations for our community are very high.
- **Aligning Forces for Quality works with everyone who gets care, gives care and pays for care to lift the overall quality of care in the community. We must all work together.**
  - We must understand the quality of care that is being delivered in every community by measuring and reporting on the performance of doctors and hospitals.
  - We must implement strategies to help improve quality.
  - We must encourage people to act like consumers when it comes to health care and demand high-quality care, and we must encourage patients to become better partners with their doctors in managing their own health care.
- **AF4Q is a long-term, comprehensive commitment to improve the quality of care on the ground. In addition to [COMMUNITY], 16 other regions are working as "local laboratories" to make fundamental changes to rebuild their health care systems.**
  - We are taking specific actions to improve the quality of health care in our community.
  - [**INSERT example of action and success**].
- **Aligning Forces for Quality [or INSERT alliance name] asks [community stakeholders] to work toward fundamental goals that will lead to better care. We are taking specific steps:**
  - **We are helping physicians improve the quality of care they provide** by adopting the latest and best medical practices, techniques and protocols.
  - **We are educating people about how they can become better partners with their doctors** by giving them the tools and information they need to more effectively communicate and act in the best interests of their own health and health care.
  - **We are helping improve care inside hospitals**, with a special focus on the role nurses play.
  - **We are working to reduce inequality in care for patients of different races and ethnicities** by pinpointing what causes disparities and implementing solutions.

NOTES

[1] Centers for Medicare & Medicaid Services. "National Health Expenditures 2008 Highlights." Data updated January 5, 2010. *www.cms.hhs.gov/NationalHealthExpendData/02_NationalHealthAccountsHistorical.asp* (Accessed January 6, 2010.)

[2] Orszag P. "Increasing the Value of Federal Spending on Health Care." Washington, DC: Congressional Budget Office, 2008.

[3] Hurtado MP, Swift EK and Corrigan JM (eds). "Envisioning the National Health Care Quality Report." Washington, DC: Institute of Medicine, 2001, p.6.

[4] Agency for Healthcare Research and Quality. "Guide to Health Care Quality: How to Know it When You See It." Rockville, MD: Agency for Healthcare Research and Quality, 2005. (No authors given.)

[5] Committee on Quality of Health Care in America, Institute of Medicine. "Crossing the Quality Chasm: A New Health System for the 21st Century." Washington, DC: National Academies Press, 2001.

[6] National Committee for Quality Assurance. "The Essential Guide to Health Care Quality." Washington, DC: National Committee for Quality Assurance, 2007. (No authors given.)

[7] Organisation for Economic Co-operation and Development. "OECD Health Data 2009: How Does the United States Compare?" France: Organisation for Economic Co-operation and Development and the Institute for research and information in health economics, 2009. (No authors given.)

[8] Organisation for Economic Co-operation and Development Web site. *www.oecd.org/health/healthdata* (Accessed December 11, 2009.)

[9] National Committee for Quality Assurance. "The Essential Guide to Health Care Quality." Washington, DC: National Committee for Quality Assurance, 2007. (No authors given.)

[10] Mangione-Smith R, DeCristofaro AH, Setodji CM, et al. "The Quality of Ambulatory Care Delivered to Children in the United States." *The New England Journal of Medicine,* 357(15): 1515–1523, 2007.

[11] McGlynn EA, Asch SM, Adams J, et al. "The Quality of Health Care Delivered to Adults in the United States." *The New England Journal of Medicine*, 348(19): 2635–2645, 2003.

[12] Kohn LT, Corrigan JM, Donaldson, MS (eds). "To Err Is Human: Building a Safer Health Care System." Washington, DC: National Academies Press, 2000.

[13] Klevens RM, Edwards JR, Richards CL, Jr., et al. "Estimating Health Care-Associated Infections and Deaths in U.S. Hospitals, 2002." Public Health Reports, 122: 160–166, 2002.

[14] Aspden P, Wolcott J, Bootman JL, et al. (eds). "Preventing Medication Errors: Quality Chasm Series." Washington, DC: National Academies Press, 2007.

[15] Kohn LT, Corrigan JM, Donaldson, MS (eds). "To Err Is Human: Building a Safer Health Care System." Washington, DC: National Academies Press, 2000.

[16] Midwest Business Group on Health. "Reducing the Costs of Poor-Quality Health Care Through Responsible Purchasing Leadership." Chicago, IL: Midwest Business Group on Health, 2003. (No authors given.)

[17] Subcommittee on Management of Acute Otitis Media. "Diagnosis and Management of Acute Otitis Media." *Pediatrics*, 113(5): 1451–1465, 2004.

[18] Weinstein JN, Lurie JD, Olson PR, et al. "United States' trends and regional variations in lumbar spine surgery: 1992–2003." *Spine*, 31(23): 2707–2714, 2006.

[19] Fisher ES, Goodman DC, Chandra A. "Disparities in Health and Health Care among Medicare Beneficiaries: A Brief Report of the Dartmouth Atlas Project." Princeton, NJ: Robert Wood Johnson Foundation, 2008.

[20] Orszag P. "Increasing the Value of Federal Spending on Health Care." Washington, DC: Congressional Budget Office, 2008.

[21] Jha A et al. "Use of Electronic Health Records in U.S. Hospitals." *New England Journal of Medicine,* 360(16): 1628–38, 16 April 2009.

[22] Blumenthal D, et al. “Health Information Technology in the United States: Where We Stand, 2008.” Princeton, NJ: Robert Wood Johnson Foundation, 2008.

[23] American Heart Association news release. “One in four hospitalized heart failure patients with Medicare back in hospital within a month.” December 11, 2009. *http://americanheart.mediaroom.com/index.php?s=43&item=867* (Accessed December 11, 2009.)

[24] Jencks SF, Williams MV and Coleman EA. “Rehospitalizations among Patients in the Medicare Fee-for-Service Program.” *The New England Journal of Medicine,* 360(14): 1418–1428, April 2009.

[25] Centers for Disease Control and Prevention. “National Diabetes Fact Sheet: General Information and National Estimates on Diabetes in the United States, 2007.” Atlanta: U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, 2008.

[26] Urbina, I. “In the Treatment of Diabetes, Success Often Does Not Pay.” *The New York Times.* January 11, 2006, News section, National edition.

[27] Smedley BD, Stith AY, Nelson AR. “Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care.” Washington, DC: Institute of Medicine, 2003.

[28] Smedley BD, Stith AY, Nelson AR. “Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care.” Washington, DC: Institute of Medicine, 2003.

[29] Smedley BD, Stith AY, Nelson AR. “Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care.” Washington, DC: Institute of Medicine, 2003.

[30] Smedley BD, Stith AY, Nelson AR. “Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care.” Washington, DC: Institute of Medicine, 2003.

[31] Fisher ES, Goodman DC, Chandra A. “Disparities in Health and Health Care among Medicare Beneficiaries: A Brief Report of the Dartmouth Atlas Project.” Princeton, NJ: Robert Wood Johnson Foundation, 2008.

[32] Jha AK, Orav EJ, Zhonghe L, et al. “Concentration and Quality of Hospitals That Care for Elderly Black Patients.” Chicago: American Medical Association, 2007.

[33] Jha AK, Orav EJ, Zhonghe L, et al. “Concentration and Quality of Hospitals That Care for Elderly Black Patients.” Chicago: American Medical Association, 2007.

[34] Wennberg J. “Tracking the Care of Patients with Severe Chronic Illness.” Lebanon, NH: The Dartmouth Institute for Health Policy and Clinical Practice Center for Health Policy Research, 2008.

[35] Wennberg JE. “Tracking the Care of Patients with Severe Chronic Illness: The Dartmouth Atlas of Health Care 2008.” Lebanon, NH: The Dartmouth Institute for Health Policy and Clinical Practice, 2008.

[36] Wennberg JE. “Tracking the Care of Patients with Severe Chronic Illness: The Dartmouth Atlas of Health Care 2008.” Lebanon, NH: The Dartmouth Institute for Health Policy and Clinical Practice, 2008.

[37] Fisher ES, Goodman EC and Chandra A. “Disparities in Health and Health Care among Medicare Beneficiaries.” Lebanon, NH: Trustees of Dartmouth College, 2008.

[38] Fisher ES, Goodman DC, Chandra A. “Disparities in Health and Health Care among Medicare Beneficiaries: A Brief Report of the Dartmouth Atlas Project.” Princeton, NJ: Robert Wood Johnson Foundation, 2008.

[39] Fisher ES, Goodman DC, Chandra A. “Disparities in Health and Health Care among Medicare Beneficiaries: A Brief Report of the Dartmouth Atlas Project.” Princeton, NJ: Robert Wood Johnson Foundation, 2008.

[40] Fisher ES, Goodman DC, Chandra A. “Disparities in Health and Health Care among Medicare Beneficiaries: A Brief Report of the Dartmouth Atlas Project.” Princeton, NJ: Robert Wood Johnson Foundation, 2008.

[41] The Dartmouth Institute for Health Policy and Clinical Practice. “Cardiac Surgery Report.” Lebanon, NH: The Dartmouth Institute for Health Policy and Clinical Practice, 2005. (No authors given.)

[42] The Dartmouth Institute for Health Policy and Clinical Practice. “Spine Surgery Report.” Lebanon, NH: The Dartmouth Institute for Health Policy and Clinical Practice, 2006. (No authors given.)

[43] Fisher ES, Bell J, Tomek I, Esty A, Goodman DC, Bronner, K. “Trends and Regional Variation in Hip, Knee, and Shoulder Replacement.” Lebanon, NH: The Dartmouth Institute for Health Policy and Clinical Practice, 2010.

[44] Orszag P. “Increasing the Value of Federal Spending on Health Care.” Washington, DC: Congressional Budget Office, 2008.

[45] Fisher ES, Wennberg DE, Stukel TA, et al. “The Implications of Regional Variations in Medicare Spending. Part 1 and Part 2.” *Annals of Internal Medicine,* 138(4): 273–298, 2003.

[46] Fisher ES, Wennberg DE, Stukel TA, et al. “The Implications of Regional Variations in Medicare Spending. Part 1 and Part 2.” *Annals of Internal Medicine,* 138(4): 273–298, 2003.

[47] The Dartmouth Institute for Health Policy and Clinical Practice. “Chronically Ill Patients Get More Care, Less Quality, Says Latest Dartmouth Atlas.” Lebanon, NH: The Dartmouth Institute for Health Policy and Clinical Practice, 2008. (No authors given.)

[48] Kaiser Family Foundation and Agency for Healthcare Research and Quality. “2008 Update on Consumers' Views of Patient Safety and Quality Information.” Washington, DC: Kaiser Family Foundation and Agency for Healthcare Research and Quality, 2008. (No authors given.)

[49] BlueCross BlueShield Association. “Consumer Preferences and Usage of Healthcare Information: Summary Report.” Chicago: BlueCross BlueShield Association, 2006. (No authors given.)

[50] Fronstin P and Helman R. “The 2009 Health Confidence Survey: Public Opinion on Health Reform Varies; Strong Support for Insurance Market Reform, Mixed Response to Tax Cap.” Washington, DC: Employee Benefit Research Institute, 2009.

[51] Deloitte Center for Health Solutions. “2009 Survey of Health Care consumers: Key Findings, Strategic Implications.” Washington, DC: Deloitte Center for Health Solutions, 2009.

[52] Audet AJ, Doyt MM, Shamasdin J, et al. “Physicians’ Views on Quality of Care: Findings from the Commonwealth Fund National Survey of Physicians and Quality of Care.” New York: The Commonwealth Fund, 2005.

[53] Hibbard JH and Cunnningham PJ. “Research Brief No. 8: How Engaged Are Consumers in Their Health and Health Care, and Why Does It Matter?” Washington, DC: Center for Studying Health System Change, 2008.

[54] Committee on Quality of Health Care in America, Institute of Medicine. “Crossing the Quality Chasm: A New Health System for the 21st Century.” Washington, DC: National Academies Press, 2001.

[55] Zhan C, Friedman B, Mosso A, et al. “Medicare Payment for Selected Adverse Events: The Business Case for Investing in Patient Safety.” *Health Affairs,* 25(5): 1386–1393, 2006.

[56] Balas EA. “Information technology and physician decision support. Program and abstracts of Accelerating Quality Improvement in Health Care: Strategies to Speed the Diffusion of Evidence-based Innovations,” sponsored by National Committee for Quality Health Care; January 27–28, 2003; Washington, DC.

[57] Shojania KG and Grimshaw JM. “Evidence-Based Quality Improvement: The State of the Science.” *Health Affairs,* 24(1): 138–150, 2005.

[58] Draper DA, Felland LE, Liebhaber A, et al. “Research Brief No. 3: The Role of Nurses in Hospital Quality Improvement.” Washington, DC: Center for Studying Health System Change, 2008.

[59] Prometheus Payment, Inc. “What is Prometheus Payment®? An Evidence-Informed Model for Payment Reform.” Princeton, NJ: Robert Wood Johnson Foundation, 2009.

[60] Fisher ES et al. “Fostering Accountable Health Care: Moving Forward In Medicare.” *Health Affairs,* 28(2): w219–w231, January 2009.

[61] Keehan S, Sisko A, Truffer C, et al. “Health Spending Projections Through 2017: The Baby-Boom Generation Is Coming To Medicare.” *Health Affairs,* 27(3): w145–w155, 2008.

[62] The Kaiser Family Foundation and Health Research & Educational Trust. “Employer Health Benefits: 2009 Summary of Findings.” Menlo Park, CA: The Henry J. Kaiser Family Foundation, September 2009.

[63] Orszag P. “Increasing the Value of Federal Spending on Health Care.” Washington, DC: Congressional Budget Office, 2008.

[64] Anderson G. “Chronic conditions: Making the Case for Ongoing Care.” Baltimore, MD: Johns Hopkins Bloomberg School of Public Health, November 2007.

[65] McGlynn EA, Asch SM, Adams J, et al. "The Quality of Health Care Delivered to Adults in the United States." *The New England Journal of Medicine,* 348(19): 2635–2645, 2003.

[66] Jiang H, Russo C and Barrett M. "Nationwide Frequency and Costs of Potentially Preventable Hospitalizations." Rockville, MD: Agency for Healthcare Research and Quality, 2009.

[67] Bodenheimer T and Berry-Millett R. "Follow the Money—Controlling Expenditures by Improving Care for Patients Needing Costly Services." *The New England Journal of Medicine,* (10.1056/NEJMp0907185). Posted on NEJM.org, September 30, 2009.

[68] Institute of Medicine of the National Academies. "Report Brief: America's Uninsured Crisis: Consequences for Health and Health Care." Washington, DC: Institute of Medicine of the National Academies, 2009. (No authors given.)

[69] Keehan S, Sisko A, Truffer C, et al. "Health Spending Projections Through 2017: The Baby-Boom Generation Is Coming To Medicare." *Health Affairs,* 27(3): w145–w155, 2008.

[70] Institute of Medicine. "America's Uninsured Crisis: Consequences for Health and Health Care." Report brief. February 2009. (No authors given.)

[71] Orszag P. "Increasing the Value of Federal Spending on Health Care." Washington, DC: Congressional Budget Office, 2008.

[72] Keehan S, Sisko A, Truffer C, et al. "Health Spending Projections Through 2017: The Baby-Boom Generation Is Coming To Medicare." *Health Affairs,* 27(3): w145–w155, 2008.

[73] The Kaiser Family Foundation and Health Research & Educational Trust. "Employer Health Benefits: 2009 Summary of Findings." Menlo Park, CA: The Henry J. Kaiser Family Foundation, September 2009.

[74] Orszag P. "Increasing the Value of Federal Spending on Health Care." Washington, DC: Congressional Budget Office, 2008.

[75] Shea K, Davis K and Schor E. "U.S. Variations in Child Health System Performance: A State Scorecard." The Commonwealth Fund, 2008.

[76] National Committee for Quality Assurance Web site. "The Basics: Public Reporting," National Committee for Quality Assurance, *www.ncqa.org/tabid/442/default.aspx.* (Accessed December 14, 2009).

[77] Midwest Business Group on Health. "Reducing the Cost of Poor-Quality Health Care Through Responsible Purchasing Leadership." Chicago: Midwest Business Group on Health, 2003. (No authors given.)

[78] Orszag P. "Increasing the Value of Federal Spending on Health Care." Washington, DC: Congressional Budget Office, 2008.

[79] Kelley R. "Where Can $700 Billion in Waste Be Cut Annually from the U.S. Healthcare System?" Ann Arbor, MI: Thomson Reuters, October 2009.

[80] National Committee for Quality Assurance. "The Essential Guide to Health Care Quality." Washington, DC: National Committee for Quality Assurance, 2007. (No authors given.)