

Improving Quality in a Time of Change

Presented by John R. Lumpkin, RWJF Senior Vice President and Director, Health Care Group

March 9, 2009



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John R. Lumpkin,
M.D., M.P.H.

REMARKS TO THE AMERICAN MEDICAL ASSOCIATION'S PHYSICIAN CONSORTIUM FOR PERFORMANCE IMPROVEMENT

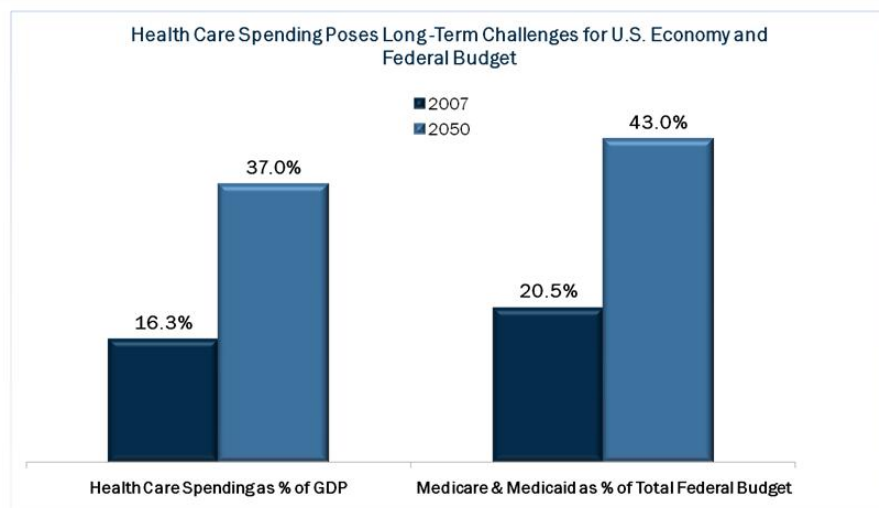
American Medical Association

We are meeting at an incredible time in our nation's history. Health care costs are rising at an alarming rate.

Rising Health Care Spending



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Keehan S, et al. "Health Spending Projections Through 2017." *Health Affairs*, 27(2): w145-w155 (published online 26 February 2008; *The Long Term Budget Outlook*. Washington: Congressional Budget Office, Dec. 2007.

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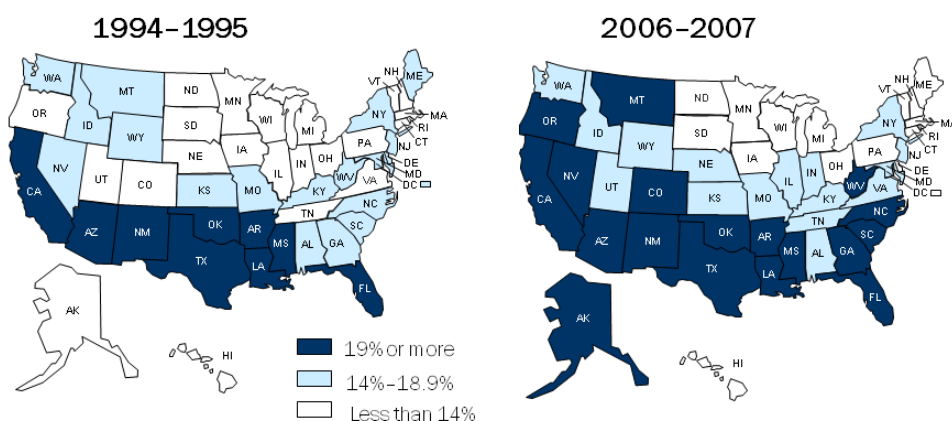
The Congressional Budget Office (CBO) projects that if health care costs continue to increase at the current rate, our nation will be spending 37 percent of GDP on health care, and Medicare and Medicaid will represent 43 percent of the total federal budget.

While spending is increasing dramatically, the number of uninsured continues to increase. You can see the marked increase of states where 20 percent or more of working people are uninsured—46 million in total.

Percent of Uninsured Workers, Ages 19-64



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State Health Access Data Assistance Center (SHADAC) analysis from U.S. Census Bureau CPS 2007-08, 1995-96.

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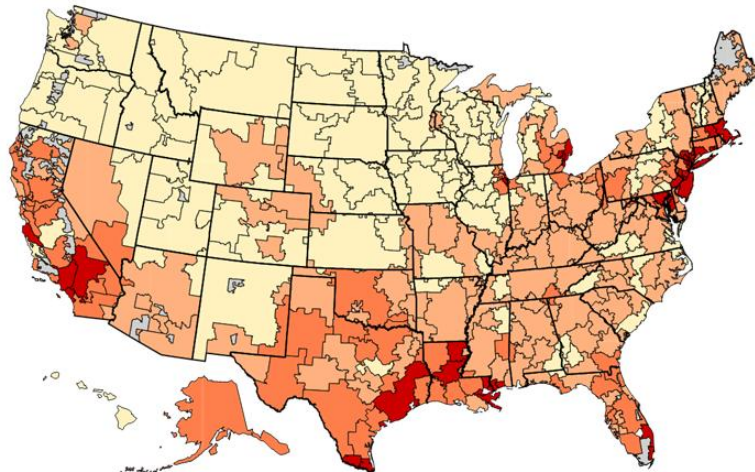
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


I am sure that all of you are familiar with the material from Jack Wennberg and Elliott Fisher's work at the Dartmouth Atlas of Health Care. Health care costs are not consistent across the country.

Medicare Reimbursements (Part A and B) in Relation to the National Average (2000)



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Dartmouth Atlas of Health Care		More than 15% Above Average	(36)
		0 - 15% Above Average	(68)
		0 - 15% Below Average	(112)
		More than 15% Below Average	(90)
		Not Populated	

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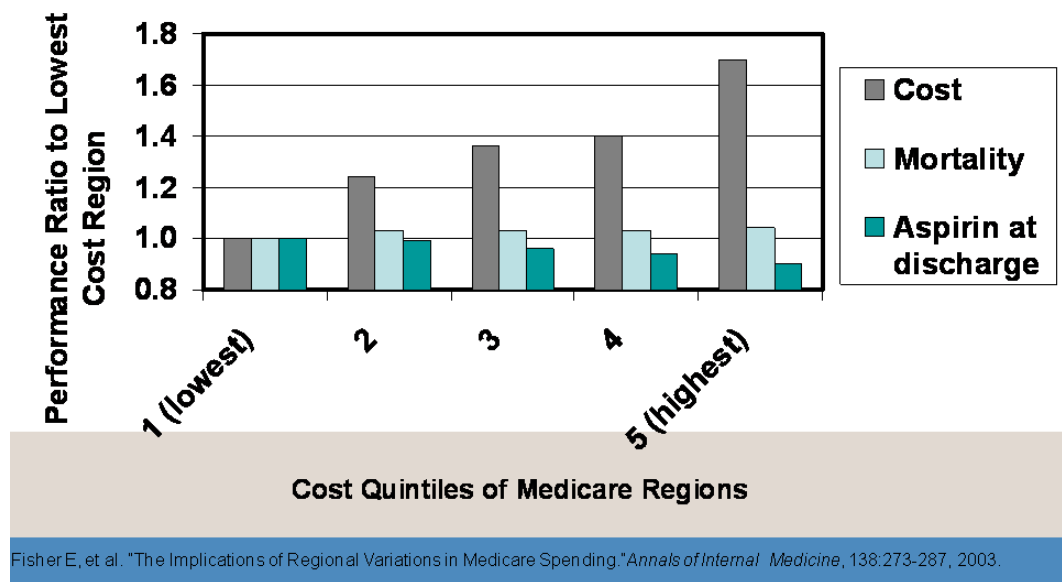
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In fact, there is great variation in costs, but the high-cost regions just provide more care, not better care.

Medicare Spending is Unrelated to Mortality, Access and Quality



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All of this is the backdrop for President Obama's comments during his first address to Congress.

Environment



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Let there be no doubt:
health care reform
cannot wait, it must not
wait, and it will not wait
another year.

President Obama, Address to Congress
February 24, 2009



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This is a call that has been echoed by legislators on both sides of the aisle.



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“We applaud you for bringing this issue of national importance to the forefront. . . Congress needs to take decisive action not only to expand access to health insurance for all Americans but also to reduce the costs of care and get better value for every dollar we spend on health care. Republicans stand ready to work with you on health care reform.”

Senator McConnell, Gregg, Grassley, Enzi and Hatch
Letter to President Obama
March 4, 2009



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If we are going to have meaningful health reform, if we are going to “bend the curve” to moderate the rapid increase in costs, we must, as a nation and as practitioners, do something to improve the quality of health care.

That is why I’m pleased to be here today with physician leaders in the growing movement to improve the quality of health care that our profession provides Americans.

Quality measuring and reporting is central to this effort. Today, I want to talk a little about why this work is critical for practitioners and their patients; how it is helping improve the health of patients in communities across the country by improving the quality of health care they receive; and the responsibility we have as leaders to spread the word about this important work.

The fact that we are here is in itself an acknowledgement that we know we can do our jobs better.



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**Medicine “wants not
dogma, but facts”**

— *Abraham Flexner*

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But the fact that we have far to go to improve the quality of care shouldn't prevent us from also taking stock of how far we have come. After all, it has only been a century since the nation coalesced around the idea that science should drive medicine, thanks to Abraham Flexner and the AMA, among others.

Flexner never attended medical school, but the former teacher and school principal visited 155 of them—every medical school in North America. The Flexner Report, issued in 1910, changed the course of American medicine by, among many other things, pressing the profession to base the education of physicians on science.

Of medicine, Flexner wrote: "It wants not dogma, but facts."

It has only been 34 years since the publication of Archie Cochrane's influential book *Effectiveness and Efficiency: Random Reflections on Health Services*, describing the importance of using randomized controlled trials. And David Eddy, the heart surgeon turned mathematician and health care economist, coined the term "evidence-based medicine" less than two decades ago, in 1990.

The last three decades have also brought a deeper understanding that the way we practice medicine isn't always the scientific enterprise the public may think it is.

- The landmark 1999 Institute of Medicine (IOM) report *To Err is Human* offering the startling comparison that more people die unnecessarily each year in American hospitals because of medical errors than they do from car crashes, breast cancer or AIDS.
- Beth McGlynn and her colleagues at RAND showing that adults get a little more than half of recommended care, and children get even less.

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The need for quality improvement that these and other studies demonstrate is clear enough—and the country is putting great stock in measurement as a strategy for progress. As the IOM noted in its *Pathways to Quality Health Care* series in 2006, the full potential of quality improvement initiatives “cannot be realized without a coherent, robust, integrated performance measurement system that is purposeful, comprehensive, efficient and transparent.”



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“Quality Improvement cannot be realized without a coherent, robust, integrated performance measurement system that is purposeful, comprehensive, efficient and transparent.”



Performance Measurement: Accelerating Improvement. Washington, DC: National Academies Press, 2005.

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This emerging consensus that we must have better information about the actual performance of doctors and hospitals if we are to improve quality can become controversial, of course, when the discussion turns to what we do with this information beyond the walls of a clinic, hospital or office. But we know that even inside those walls, there is a paucity of information.

Doctors Lack Information About Quality



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- Only one doctor in three gets any data about performance
- Only one in four gets patient survey data
- Only one in five gets process-of-care data
- Fewer than one in five get clinical outcomes data
- Only one in seven solo practitioners has access to any quality data

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.

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A 2005 Commonwealth Fund survey showed that most doctors lack information about the quality of care they or their colleagues provide.

- Only one doctor in three gets any data about performance.
- Only one in four gets patient survey data.
- Only one in five gets process-of-care data.
- Fewer than one in five get clinical outcomes data.
- Only one in seven solo practitioners has access to any quality data.

Doctors know better than anyone that we need better information. And with doctors' participation, the national conversation over how and to whom we report performance data has turned from antagonistic to civil and productive.

The Foundation, for its part, has been a strong proponent of both measurement and public reporting. At the same time, we have also argued that these efforts must be transparent in methodology; specific about the data used to develop the measures; clear about any limitations presented by the data; and inclusive of physicians from the beginning. One of our grantees, the Consumer-Purchaser Disclosure Project, worked closely with the AMA and others to develop an agreement called the Patient Charter that enshrines those principles as central to any performance measurement and reporting effort.

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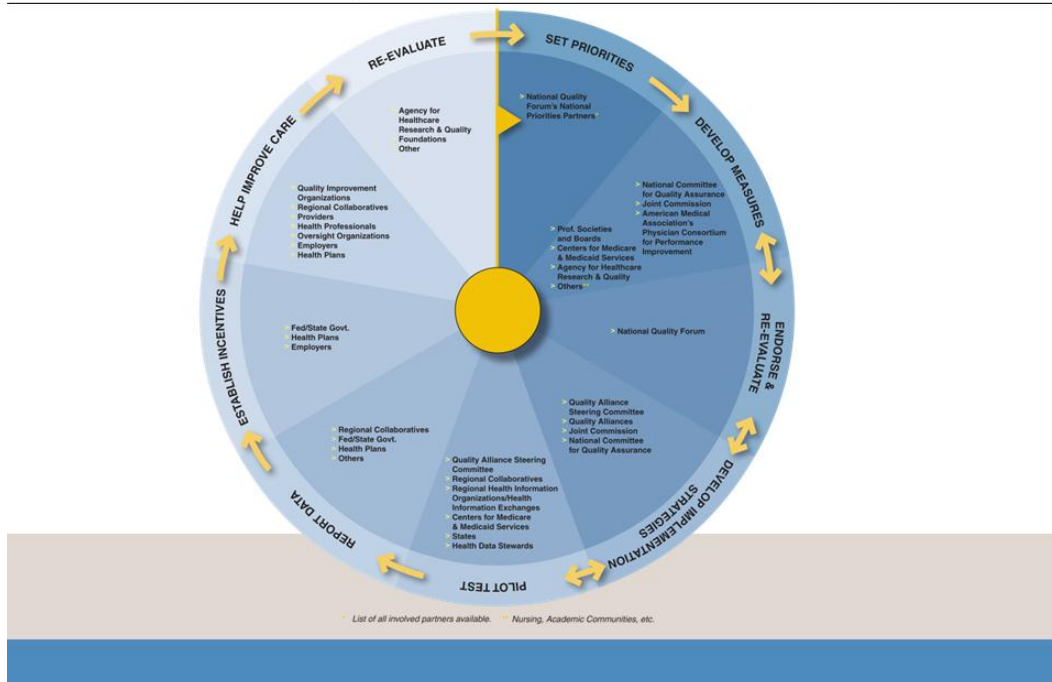
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The challenge we now confront is turning the idea of measurement into the reality of quality improvement on the ground.

The Crowded Measurement and Reporting Landscape



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One challenge has been the great goo-goobs of measures themselves—not to mention the numerous entities involved in their development, from local quality reporting initiatives to national efforts such as those of the National Committee for Quality Assurance, the AQA, Hospital Quality Alliance (HQA), the Joint Commission and others. The AMA's Physician Consortium for Performance Improvement has itself developed 266 performance measures for 42 clinical topics or conditions. There are more than 70 state and regional performance measurement and reporting efforts underway nationwide, and no two are alike.

As I survey this landscape, I see the contours of an emerging national consensus. We need to standardize measures, we need to collect and report the data publicly, and we need to engage doctors and other practitioners to use this information to improve the quality of the care for their patients—the outcome that matters most.

Slowly but surely, this consensus view is becoming a reality in living laboratories of quality improvement. I want to take you on a tour of that work, starting with what some of our grantees have done to improve care for chronically ill people, turn second to some of our programs aimed at lifting quality in hospitals, and then talk about our signature effort to take what we have learned from all of our quality efforts and apply them to entire communities.

The Foundation's approach to quality improvement (QI) may be best exemplified by a holistic approach to delivering care known as the Chronic Care Model. There is a lot of discussion these days about what patient-centered care means. If you want to know what patient-centered care looks like, look at the Chronic Care Model in action. It draws on a variety of providers and stakeholders to deliver care.

This pioneering effort is spearheaded by Dr. Edward Wagner of the Group Health Cooperative in Seattle and is supported by a Foundation program called Improving Chronic Illness Care.

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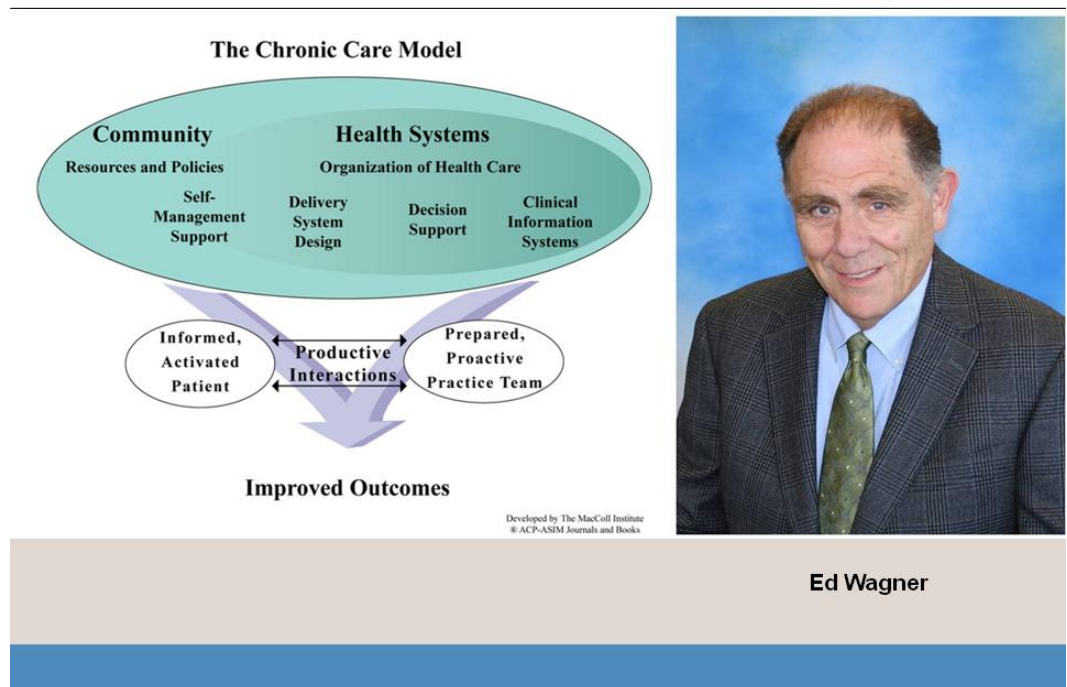
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The program's goal—indeed, the goal of the Chronic Care Model—is to provide care for chronically ill people no matter their condition. As such, it represented an important step forward for the Foundation, from attacking specific illnesses such as asthma, diabetes or depression to advancing a system of care that helps primary care practices meet the complex needs of patients with a chronic illness.

The Chronic Care Model



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In the Chronic Care Model, the practice isn't about the doctor or the care team—it is about the patient, and it embraces a wide range of resources beyond the doctor and even the practice. A clinical team—doctors, nurses, case managers, dietitians, patient educators—supports and collaborates with the patient. The team identifies resources in the community—maybe a YMCA program for exercise or a market to buy wholesome food. The team uses information technology to organize data about their patients and keeps them abreast of patients' needs, and perhaps integrating with the patient's personal health record.

The Chronic Care Model is now in use at more than 1,000 sites across America. And it is working, and not just in large practices like Group Health.

The model was the foundation for an experiment to improve care for predominantly minority patients with diabetes in rural northeastern North Carolina. A case manager—an advanced-practice nurse trained in the quality improvement and the Chronic Care Model—was hired to work with five solo and small-group primary care practices serving 3,700 patients with diabetes.

The case manager visited each practice weekly for 12 months, becoming known as the "circuit rider case manager." She reviewed the cases against American Diabetes Association standards of care. She conducted group education programs to engage patients in managing their own care. The practices were plugged into a registry system.

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What happened? The percentage of patients achieving their diabetes management goals improved, and so did the productivity of the practices.

RAND Evaluation of CCM



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- **Congestive heart failure patients were more knowledgeable and more often on recommended therapy, with 35 percent fewer hospital days**
- **Asthma and diabetes patients were more likely to receive appropriate therapy**
- **Asthma pilot patients had better quality of life**
- **Diabetes patients had significantly better blood sugar control**

Note: The evaluation was conducted by RAND and the University of California at Berkeley in cooperation with the IHI, ICIC, and the sponsors of the Washington State Diabetes Collaborative.

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Nationally, a rigorous RAND evaluation of 51 sites using the Chronic Care Model found the following:

- Congestive heart failure patients were more knowledgeable and more often on recommended therapy, with 35 percent fewer hospital days.
- Asthma and diabetes patients were more likely to receive appropriate therapy.
- Asthma pilot patients had better quality of life.
- Diabetes patients had significantly better blood sugar control.

A second initiative to improve care for patients with chronic illness is being implemented in partnership with the American Board of Medical Specialties (ABMS)—called Improving Performance in Practice (IPIP)—is now at work in seven states after a promising start in North Carolina and Colorado. IPIP focuses on diabetes and asthma and works mostly with small family practices. Quality improvement coaches, typically RNs (interestingly, in Michigan they are exploring the use of former auto industry QI workers), work with practices to install patient registries, electronic medical records, templates to plan a care visit, protocols for who does what and in what order to prepare for and manage a patient visit, and locate support, such as diabetes educators for patient self-management efforts.

The concept of “team care” underpins the entire approach. Coaches help practices relentlessly ask the question: “Is this physician or non-physician work?” If a doctor doesn’t have to do it, someone else can, and the physician can focus on those things that only a physician can do.

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Measurement, of course, is at the heart of these quality improvement efforts. As one Colorado doctor told IPIP staff, "Until I saw my data, I thought I was providing excellent care. Now I see we have a lot of work to do."



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**"Until I saw my data, I
thought I was providing
excellent care. Now I see I
have a lot of work to do."**

— Colorado doctor



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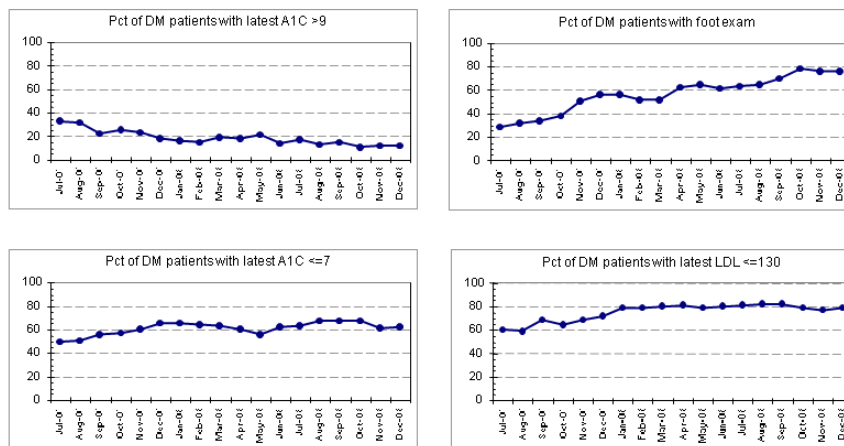
The results you see here are from the Lone Tree Family Practice in Lone Tree, Colorado. The long-term changes in blood sugar control are impressive. The practice has a solid process in place for foot exams that has now been sustained for 18 months. The practice looked at their data and realized they needed to put a process in place to reach out to patients to call them back in.

Improving Performance in Practice



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Lone Tree Family Practice, Colorado



IPIP has helped the clinic make steady improvements in both outcomes and processes of care for patients with diabetes.

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The work flow improvements have had an important side effect. Not only do practices get more done, they are finding important benefits: quality of life.

What we have learned is that aiming high raises the bar on health care performance and leads to clinical and operational results once considered out of reach. We have seen major improvements on diverse fronts: preventing patients from falling and reducing infectious diseases.

Surprisingly, in too many hospitals, nurses are not directly involved in QI. In Transforming Care at the Bedside (TCAB), frontline nurses and other frontline staff are empowered to make and test changes to improve care. Some examples are:

To reduce patient falls and injuries from falls, the Seton Family of Hospitals in Austin, Texas, solicited the best ideas from nurses. Here's what they decided to do. They train staff on how to properly assess which patients are at risk for falls. Patients deemed at risk are given orange identification bracelets and red socks, and orange flags are posted outside their doors. Higher-risk patients receive a visit from a staff member every two hours during rounds. Clinical assistants help with feeding and bathroom visits. Patients at very high risk receive a visit every hour.

Orange Flags and Red Socks to Reduce Falls



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Patients deemed at risk for falls are given orange identification bracelets and red socks, and orange flags are posted outside their doors.



Seton Family Hospital, Texas

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Falls and injuries from falls have decreased, and staff is consistently meeting its goal of just two falls per 1,000 patient days. From November 2007 to January 2008, staff maintained an injury rate of 0.1 per 1,000 patient days. Patients, caregivers and families have all become part of a team to prevent falls.

St. Luke's Hospital in Cedar Rapids, Iowa, set out to reduce infections acquired in the transitional care unit. Here's what they did:

- They standardized times to restock gowns, masks, medical waste bags, cleaners and other supplies.
- They posted reminder signs for hand hygiene and used humor to make the point.
- They initiated "Secret Shopper" audits to see if guidelines were being followed. The results were posted at the end of the shift and aggregated monthly.
- They produced a hand hygiene video featuring the CEO as a strain of bacteria.
- They developed and used a checklist to audit cleaning.
- They displayed a large poster on the unit listing the physicians in compliance with hand hygiene.

Compliance with hand hygiene improved from 66 percent to 94 percent in one year. The transitional care unit met its goal of 30 days between *Clostridium difficile* infections. It had no Methicillin-resistant *Staphylococcus aureus* (MRSA) bloodstream infections or hospital-acquired pneumonias for 193 days, and no vancomycin-resistant enterococci (VRE) bloodstream infections and urinary tract infections for 11 months.

Yet with all of this work, we have found that the adoption of quality improvement tools have been spotty. What we realized is that we do not have a national quality problem; rather, we have quality problems in every community in America. Quality is a local issue and has to be resolved where the care is delivered.

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That is the genesis of our program *Aligning Forces for Quality*. It is a real laboratory now operating in 14 communities* across America. To give you an idea of the scope of this work, the 14 regions* represent approximately 33 million people and 489 hospitals. This represents 11 percent of the population and number of hospitals in the country.

*[*Since the delivery of the speech, the AF4Q program has expanded to 15 communities, with the addition of Albuquerque, announced on April 28, 2009.]*

Aligning Forces for Quality Communities



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The first step in Aligning Forces was to develop multi-stakeholder coalitions of businesses, consumers, purchasers, payers and providers—those who get the care, provide the care and pay for the care—to increase transparency about the quality and cost of care in their regions. This public reporting of quality and price information is at the heart of our strategy, and we believe that it will be transformational. The goal is to generate provider demand for the adoption of quality improvement methods. The public reporting of quality and price information by providers will help to correct the health care market by helping consumers make better decisions. Perhaps more powerfully, public reporting is, for the first time, confronting providers with the quality of care that they are delivering. Most of the providers that I know want to do a good job; they just think that the quality problem in their community, hospital or clinic is because of the other guy, not them.

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The goals of Aligning Forces are to:

1. Help clinicians improve the quality of care for patients.
2. Engage people to become better partners with their doctors and make informed choices about their care.
 - a. Self-management
3. Improve care across different settings.
 - a. Outpatient
 - b. Inpatient
 - c. Special focus on the role that nursing plays
4. Reduce racial and ethnic disparities in care for patients through measurement and reduction of gaps.

Goals of AF4Q



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- ***Helping physicians improve the quality of care for patients***
- ***Engaging people to become better partners with their doctors and make informed choices about their care***
- ***Improving care across different settings, with a special focus on the central role that nursing plays***
- ***Reducing inequality in care for patients of different races and ethnicities by measuring gaps in care and targeting strategies for improvement***



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In short, we're using everything we've learned from two decades of work in both acute and outpatient settings and putting it to work in Aligning Forces' communities. No two communities are alike. They go from tiny Humboldt County, California, to entire states like Minnesota and Maine, from communities that had never tried our strategies to some of the country's most experienced regions at measuring and reporting on care.

We are learning a lot and already seeing some promising results, as some of our communities had a legacy of improvement that pre-existed Aligning Forces. And as you will see, physician leadership has been integral to these communities' efforts. Physicians are at the table, helping to decide the measures, examining the data sets, talking about how it is presented to the public and leading quality improvement efforts for practices.

I want to start the Aligning Forces tour in Maine, because in Maine, you can see the interplay of the strategies to improve quality coming together, with the added element of a reimbursement strategy.

In Maine, Aligning Forces works with several organizations, including Quality Counts, which is devoted to improving chronic care, and the Maine Health Management Coalition (MHMC), which runs the measurement and public reporting effort. The 50-member coalition describes itself as "public and private employers, hospitals, health plans and doctors working together to measure and report health care value. MHMC helps employers and their employees use this information to make informed decisions." This is an important descriptor, because in Maine, the ratings have consequences.

They began the quality reporting effort in 2002, asking primary care providers for information about their use of office systems to manage care and claims data to measure care. Of note, Maine shifted to clinical outcomes measures in 2004. This came about because the doctors objected to claims data; so, the coalition challenged them to come up with better data, and they did.

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Practices supply the data on a voluntary basis, and participation has grown steadily to more than 70 percent of primary care practices in 2008 on the office systems survey and more than 50 percent on clinical data.

Maine Health Management Coalition



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Maine Doctor Ratings			
Optional: Search within 10 miles of zip code View Results			
Primary Care Physicians Sort by: Highest Rated Name City			
view Pediatric Practices »			
Doctor Ratings Explained page last updated Jan 2009	Uses Clinical Office Systems	Measures Results of Diabetes Care	Measures Results of Heart Disease Care
Acadia Family Health Center 460 Main Street, Madawaska 04756 · view map			
Arnold Memorial Medical Center 70 Snare Creek Lane, Jonesport 04649 · view map			
Augusta Family Physicians 77 Sewall Street, Suite 1, Augusta 04330 · view map			
B Street Health Center 57 Birch Street, Community Clinical Services, Inc, Lewiston 04240 · view map			
Baker Family Health 331 Maine Street #3, Dr. Stacia Baker, Brunswick			

As you can see here, the Maine effort involves assigning an overall rating to doctors in three categories. The categories for adults are: use of clinical office systems, diabetes care and cardiovascular care. Practices can achieve one, two or three ribbons based on criteria set by a doctor-led committee. The pediatric measures look at asthma care and immunizations in addition to office systems.

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There are consequences for not participating or poor scores. The state waives co-pays and deductibles only for employees that use two- and three-ribbon practices.

Maine Health Management Coalition (cont.)



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49 Pineland Drive, Suite 302A, New Gloucester 04062 · view map			NOT REPORT
Family Medicine of Fryeburg 581 Main Street, Fryburg 04937 · view map			
Fish River Rural Health Systems - Eagle Lake 10 Carter Street, P.O. Box 309, Eagle Lake 04739 · view map			
Fore River Family Medicine, PA 51 Sewall St, Second Floor, Portland 04102 · view map			NOT ENOUGH DATA
Goodall Health Partners - East Waterboro Rte 202, P.O. Box 176, East Waterboro 04958 · view map			
Goodall Health Partners - Sanford 272 Cottage Street, Sanford 04073 · view map			
Goodall Health Partners Family Medicine Medical Office Building, 25A June Street, Sanford 04073 · view map			
Gray Family Health Center 116 Shaker Rd, PO Box 1139, Gray 04039 · view map			

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The story of how Maine arrived at its blue ribbon rating system holds important lessons for physicians. The defining moment came in 2005, when a major employer in the state, Hannaford Brothers, told the coalition it needed an overall ranking system instead of a collection of individual measures, and if the coalition did not do it, the grocery chain would do it on its own, because it wanted to create a preferred tier of physicians based on the rankings. The doctors didn't like it, but within two weeks, they developed a star system that was the precursor to the blue ribbon system Maine uses now.

The number of practices earning ribbons has increased steadily each year.

But that's not the end of the story. Performance measurement and public reporting was necessary, but not sufficient by itself, to achieve these results. As Don Berwick says quoting a Chinese—or is it an African—proverb, "You don't fatten a pig by weighing repeatedly." Measurement is a tool, not a goal or outcome.

Working with Quality Counts, several physician-hospital organizations and networks saw the Pathways to Excellence initiative as a catalyst for quality improvement work that would be needed to move physicians along. The Maine Medical Center Physician-Hospital Organization (PHO) was especially proactive, offering low-cost, Internet-based registries, care managers and other support to help practices manage patients with chronic diseases.

So while the MHMC focused on why doctors should improve quality, Quality Counts and the PHOs focused on the how to do it.

And as Ted Rooney, the project director for *Aligning Forces for Quality* in Maine, put it, "When the state of Maine started to tier primary care practices in 2007 based on quality, it put the whole system on steroids."

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Another veteran community is Minnesota, where the initiative is run by Minnesota Community Measurement. Through its Web site, Minnesota Community Measurement reports quality comparisons among provider groups and clinics. Consumers are encouraged to use the comparisons to make choices and inform conversations with their doctors. Provider groups and clinics are using the results to improve care. Just how they are is illustrated by the story Anne Snowden, the director of quality reporting, likes to tell about how measurement and reporting are making a difference.



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“You don’t get to hear these stories every day. You don’t hear that public reporting actually saved somebody’s life.”

– Anne Snowden

*Director of Quality Reporting,
Minnesota Community Measurement*



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March 9, 2009



Robert Wood Johnson Foundation

While attending a reception for medical groups that were top performers on the measures, Anne met a nurse practitioner who expressed appreciation for the addition of a cancer screening composite measure. It measures the percentage of patients ages 50 to 80 who received all appropriate cancer screenings (breast, cervical and colorectal). She told Anne that she knew the results would be reported publicly and that their medical group would be compared to their peers. She said that this motivated her clinic leadership to add this measure to their internal goals. They put systems in place to remind physicians, patients and clinic staff to make sure their patients got all of the cancer screenings.

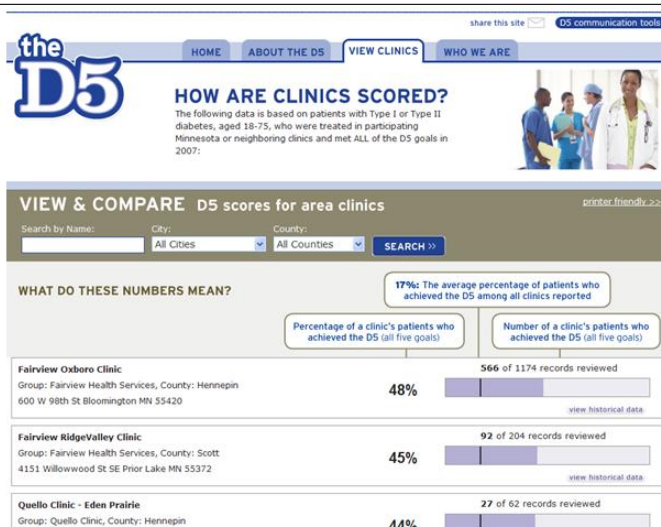
One of her patients came in for a mammogram and they found an early stage breast cancer. This nurse practitioner was convinced that this patient would not have come in for a mammogram had the reminders not been sent. Her breast cancer was caught early enough that it made a difference.

As Anne told our team at RWJF, "You don't get to hear these stories every day. You don't hear that public reporting actually saved somebody's life."

Minnesota Community Measurement



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Like many communities, Minnesota has made diabetes a priority. To put an exclamation point on this emphasis, it even launched a separate campaign and Web site called the D5:

- Blood pressure under 130/80.
- LDL less than 100.
- Blood sugar less than 7 percent.
- Tobacco free.
- Daily aspirin for ages 40 and older.

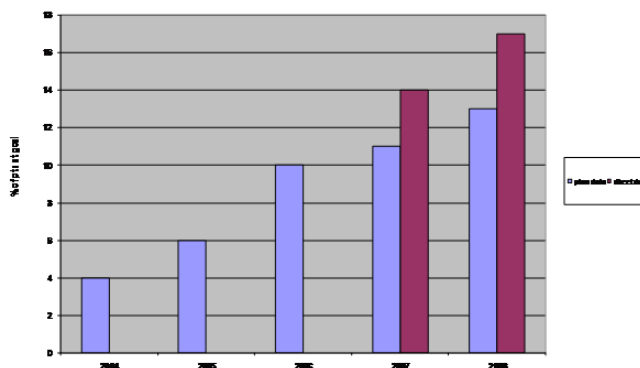
As you can see, over the last four years, providers in Minnesota have more than doubled the number of people with diabetes who are receiving optimal care. That translates, of course, into thousands of fewer complications: fewer vision problems, fewer myocardial infarctions, fewer strokes and fewer amputations. The slide shows data both from health plans and data submitted directly by medical groups.

Steady Progress on its D5 Measures



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MNCDM Optimal Diabetes Care Measure



- Blood pressure under 130/80
- LDL less than 100
- Blood sugar less than 7 percent
- Tobacco free
- Daily aspirin for 40+

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One last thing about the D5. Doctors are not only NOT running from the data, they are part and parcel of a marketing campaign to draw attention to the public reports. The Minnesota team rolled out a suite of tools that are used to talk about the measures with patients. They use exam room posters, notebooks and score cards, and they all refer patients back to the Web site, where they can check how their doctors' clinic rates. This campaign rolls consumer engagement, quality improvement and measurement, and reporting into a single package.

I want to end the Aligning Forces tour in Seattle, an area of the country that has been on the front lines of some of the antagonism that greeted early measurement and reporting efforts. The state medical society sued a health plan to stop its reporting efforts and eventually won.

Puget Sound Health Alliance



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In this environment, our Aligning Forces partner, the Puget Sound Health Alliance, has taken deliberate steps to present its measurement and reporting initiative not as a gotcha game with doctors, but as a tool to improve population health. Hence, as you can see on the slide, its Web site is called Community Checkup. Doctors were deeply involved in the measurement effort and in the creation of the reports. Rather than make it a finger-pointing exercise, their messaging to the community has instead placed the emphasis on how well the community is doing and the role everyone must play in improving care.

In the year since the measurement and reporting initiative began, clinics have begun making changes. Let me give you a few examples.

- The PolyClinic, a large multispecialty group in Seattle, changed its internal metrics regarding diabetes care to only give “credit” to physicians who provide ALL of the elements of recommended care to patients with diabetes. Prior to that, PolyClinic leaders gave partial credit to physicians who provided some of the elements of care. They raised the internal evaluation standards for one reason: to focus physician attention on making improvements.
- Providence Physician Group built templates into their electronic medical records to reflect each specific measure in the Community Checkup report. This helps to ensure that physicians and other clinicians in that medical group are reminded on a daily basis—during their patient care encounter—about the elements of health care quality that are being measured and reported in the community.

In one community after another, Aligning Forces for Quality is sparking new conversations about the quality of care being delivered to patients—none more so than with doctors.

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“When we first began Aligning Forces and the whole concept of physician reporting and physician engagement, there was a lot of pushback, a lot of positioning. But now they have come to the table as leaders of their own physician groups willing to share information and speak on behalf of public reporting for purposes of improving quality.”

*— Vernice Anthony Davis,
President and CEO, Greater Detroit Area Health Council*



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Vernice Anthony, the CEO of the Detroit Area Health Council and director of our Detroit Aligning Forces initiative called Save Lives, Save Dollars, told us that the concept of physician reporting and engagement was initially greeted with “pushback” and “positioning.” That has changed. Physicians have “come to the table as leaders of their own physician groups willing to share information and speak on behalf of public reporting for purposes of improving quality.” The key to “getting physicians from opponents to partners,” she said, was physician leadership. A few physician champions stepped up to understand and speak on behalf of other physicians.

Aligning Forces for Quality provides genuine opportunities for the house of medicine to get engaged and work with consumers, purchasers and payers in an environment that is collaborative and not adversarial. These same coalitions can serve as resources for committed non-physician advisors to the house of medicine.

The AMA, in its charge to this body, states, “It is imperative that physicians be leaders in defining quality.”

Charge to PCPI



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- **It is imperative that physicians be leaders in defining quality**



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The folks in this room get that—you wouldn't be here if you didn't. But we have to persuade the vast rank and file of American medicine that measurement and reporting is not only inevitable, it is the right thing to do. We have to make sure that all of our organizations are engaged, from the county medical society to ABMS.

My wife is a recovering OB-GYN. She left her practice almost 10 years ago out of frustration with the way care was delivered in the hospital where she practiced. At one point, she told me that she had not had a patient admitted to the hospital in the last six months that did not have a health care-related error committed. She felt overwhelmed by the economics that forced her to see more patients in less time. When the offer came to work for Attorney General Jim Ryan, she leapt at the offer. It was the conversations in the doctor's lounge that spoke to me. No one tried to talk her out of it. Rather, they all lamented that they did not have an exit strategy. For my wife, and too many more, the joy of medicine has been replaced with the grind. Too many have moved from the thrill of private practice to the isolation and sense of oppression.

We in this room have the ability to do something about that. Quality improvement has the potential to get doctors back to doctoring. In each of our regions, we are working to build a supporting infrastructure for quality improvement—an organization that works with the doctors in small practices, not against them, an organization that helps them acquire the skills and resources to do what they got into medicine to do: better care for their patients. I believe that the AMA and state and local medical societies can play a role. Could not a state medical society create the infrastructure to create a virtual large group where resources are pooled to provide assistance in implementing quality improvement and HIT? The same kind of assistance that large groups can afford?

Dr. Tracy Hofeditz, a Lakewood, Colorado, doctor, marveled to IPIP staff, "I was considering leaving the profession; now I have rediscovered the joy of practicing medicine."

Working in an environment where help is available and the practice is refocused on caring for the patient is one way to bring the joy back into medicine. And wouldn't that be a wonderful thing?

The past century saw us more fully embrace the science of medicine. And the science of medicine has given us information about what works that is helping us fulfill our most basic obligation: to care for people. And as I hope I have shown today, the science of measurement is being deployed in countless ways to improve the health and health care of Americans every day in hospitals and clinics across the country.

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It is our obligation to make sure our colleagues in every corner of America understand that measurement and reporting is not about putting doctors on the spot; it is about taking better care of our patients.

We cannot leave this task to the politicians or insurance companies. It is not enough to have physician leadership. It must become central to medicine itself.

We must move from the day where knowing the outcomes of our care for patients is the exception to the day where it is the rule. Nothing less is acceptable.