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HIGH-QUALITY, HIGH-VALUE HEALTH CARE:
"ARE WE THERE YET?"

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We are on a journey, but what's our destination, you might ask? Our destination is a place where everyone–not just those of us in the room–works towards high-quality, high-value health care. It's a place, somewhere in the future, where many more Americans get the care they need, delivered in smart and effective ways, at a price tag that all of us can live with. It's a place, simply put, where we raise the bar on the quality and value of health care… and then continue raising the bar over and over again.

Now, if that's our common destination, where are we on the journey? How far have we come? How much further do we have to go?

Well, here's the thing. There are days when it feels like we've made a lot of progress, and then there are days when it feels like changes in health care are taking a really, really long time.

My children are grown-up now, and out of the house, but I still remember those days when my husband and I took them on long road trips–to see family, to see the sights. And like all kids, before there were video monitors and games mounted in the back seat, they used to ask one question, again and again, from the back seat.

What's the question? Are we there yet!

But you can certainly understand why kids ask that age-old question from the backseat. Sometimes long journeys can seem, well, really long. Some days, you cover a lot of ground, and it seems like the destination is getting closer, but some days, it feels like everything and anything is conspiring to get in your way. And those days, you just want to *be* there, already.

The same is true of this journey we're on, to high-quality, high-value health care. Many of us in this room have been working for better health care for a long, long time. We may all have different reasons and motivations for caring about this issue. Some of us may be alarmed at how much we're paying for health care and how little we're getting in return. Some of us–or our loved ones–might have gone through care experiences that were frustrating, less than ideal, or downright scary.

Some of us, like me, may have talked to hundreds of doctors and nurses and heard stories about how the system isn't working for them, either. They are working to care for more and more patients, in less time. They don't get paid for making their patients better; they get paid for doing a certain number of things. Health care is the only business where we think more is better. Let me explain what I mean by that. This jacket I'm wearing: I bought it for a number of reasons that have to do with quality and value. Like, how well does it fit? How much it cost? How long it will last? Will it keep me warm?

But what if the price tag for this jacket was based on kinds of things that we pay for in health care, like the number of buttons, or sleeves there are on the jacket? If another jacket had more buttons, and more sleeves, it might be considered more valuable. Maybe a jacket with five sleeves would be considered best

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even though it is hard to imagine how it would fit me very well.

We reward doctors and other providers for whether procedures happen or pills are provided, but we don't reward them in a way that leads to overall good outcomes for patients. To make matters worse, **businesses**, small and large, are in danger of collapsing under the pressure of rising health care costs; increasingly health care is becoming unaffordable for larger numbers of people.

So for many of us in this room, I'm guessing that you already know the answer to the question, "Are we there yet?"

The answer is, no. We're not there yet. We've got a long way to go. How long a ways do we have to go? Well, you've heard this before, but it bears repeating.

We spend nearly half of what the whole world spends on health care, to care for only 4.5 percent of the world's population. Whether you look at quality, access, efficiency, infant mortality, or life span–you name it–we rank poorly in almost every international comparison.

True enough, a recent paper released with the Urban Institute found that while we do better than other countries in a few areas, like cancer care, overall, we are not getting what we pay for. There is much room for improvement when it comes to our health care.

I don't want to ruin your lunch, but in 2001, the Institute of Medicine's landmark report, "Crossing the Quality Chasm," said this: "Good value does not lie in spending over $1 trillion on health care that leaves some people receiving care they do not need and others not receiving the care they do need." And here we are, eight years later questioning the value we're getting for the $2.4 trillion we now spend. Remember my jacket; it's like paying over twice as much for a jacket that still doesn't keep you warm.

Now: since 2001, we have come to understand some of the reasons why our care is high volume, but not high value. Let me give you one example.

For a long time, the Robert Wood Johnson Foundation has been funding a research effort known as the Dartmouth Atlas Project. Led by Jack Wennberg and now Elliott Fisher, the research was based on an observation Jack made decades ago… that some of the regional differences in the types of health care that people received just *didn't* make sense. In one county, kids were getting tonsillectomies like they were going out of style. In other counties, the kids were managing to hold on to their tonsils. So Jack and others looked at these numbers and scratched their heads and said, Huh. What's going on here? That was the beginning of the Dartmouth Atlas Project.

For decades, the Wennberg & Colley Dartmouth Atlas Project has used Medicare claims data to look at health care spending and quality region by region. And what they found care be boiled down to this: there are pretty major differences from region to region, city to city, but these differences were not based on how sick people are, and how much care they need. The differences are based on supply. Meaning, if there was a doctor or hospital around who could perform a certain type of procedure and bill it to Medicare, chances are, they would do it.

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Today, you can go to our Web site and you can scroll over a really cool interactive map that depicts the Dartmouth Atlas data region by region. You can look at this map and see where you live and how it fares against other regions in terms of Medicare spending. Go look at your region, you might be surprised.

This past year, an article appeared in the New Yorker magazine called "The Cost Conundrum," by Dr. Atul Gawande, one of my favorite health care commentators. In that article, Atul described going to visit places across the country that represented the highest and the lowest value according to the Dartmouth Atlas. In some places, he found health care systems like the Mayo Clinic that had figured out ways to provide high-quality care at lower cost. In other places, like McAllen, Texas, he found that expensive health care services were being delivered at the highest volume, and no one in these places–not the doctors, not the health plans, not anyone–had the wherewithal to change the situation.

This article became a must-read for those working on national health reform. I know it was passed around Senate Finance. It was read by the president himself. I am certain that the main messages that the ways we are delivering and paying for health care make absolutely no sense, for anyone–have been heard at the highest policy levels and did influence their thinking.

With the House vote on Saturday night, we are closer than ever to achieving national health reform legislation but that alone will not get us to our destination. It will help, but it is not sufficient to get every American high-quality, high-value health care.

So. What *is* going to get us there? We believe that the answers will come not only from our national leaders, but from local ones as well… through sustained and ambitious collaboration across public and private sectors. I know that our destination of high quality, high value health care is a lot more complicated than a long road trip with your kids, but maybe some of the same tips for perseverance might apply to both journeys.

For example: You need to keep on reminding people about what they're going to get when they actually reach the destination– in other words, what's in it for them.

I love to hike in the mountains, but sometimes, when the ascent is steep, and I'm panting and feeling exhausted, I start thinking to myself, why am I doing this again? Why am I climbing up this mountain instead of sipping wine and reading a book? And then I reach a place that's breathtakingly beautiful, that gives me a vista unreachable by any means other than my own two legs, and I think to myself: oh. *This* is why I did this. In much the same way, we might try to hold out the promise of the destination to our restless back seat travelers . . . saying things like, "we're going to a really cool beach, and you can get ice cream!"

Admittedly, our goal of a better health care system is harder to describe than a mountain vista or a vacation destination, in part because the destination doesn't exist yet. In any one place. BUT based on all of our work I can describe where this journey should go. In fact, I do it all the time.

In our health care future, I see a place where Americans have health insurance. It is absolutely essential to have everybody "in" the system we are trying to improve. I also see a place where all stakeholders in a community understand what good health care is and what *their* role is in achieving it. Through shared

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commitment and getting better information about the quality and value of health care services in those places, I see more concerted actions by doctors, nurses, plans, businesses, and consumers on how to demand, deliver, and achieve good health care.

Now, I know what you're all thinking.

You're thinking that, along with your lunches, I've decided to serve you some pie-in-the-sky. Because maybe everything I've just described, about our future destination, sounds impossibly utopian. But there is evidence that this future is already a reality. The trick is to stay on track . . . local collaboration with the goal of improving health care quality might be one of the most *important* ways to keep people engaged while on this really long journey.

Just like when on a road trip with my kids, I might point out interesting sights and milestones along the way–like, hey, look at those mountains over there!, or, we're leaving New Jersey, we'll be in Seattle in no time! I think you've got to point out the interesting sights that help spur us along on the road to high-quality care and tell us that we ARE on the right road.

What are these sights? You can probably share stories about the encouraging milestones you've glimpsed and that keep you traveling down this road. Three years ago, we launched an initiative called Aligning Forces for Quality, which is now supporting 15 very different regions ranging from metropolitan areas to entire states–the purpose is to dramatically lift health care quality in these places and provide models for national health reform. Nearly a dozen of your member organizations are working with these alliances. And in some cases, your members don't just work with the local Aligning Forces groups, they're leading them.

The health reform legislation looming on the horizon in Washington, D.C., won't work without the on-the-groundwork that's taking place in these communities. Because in these communities, we will find out what works, and what doesn't. In these communities, we will find out if we're really making progress towards our destination, or whether we need to alter the course a bit on our journey.

Now, the Aligning Forces initiative represented an important course correction for RWJF, in and of itself. Here's why. For decades, we had developed new strategies and tools to improve specific aspects of health care. We invested in the development of:

- quality measures,
- early pay-for-performance experiments,
- improvements in patient safety and outcomes in hospitals, and
- improvements in providing chronic care across a range of common diseases like asthma, diabetes, and depression.

The nation learned a lot from these hundreds of projects and the smart people who led them. We saw terrific results from many programs. Hospitals DID improve care, quantifiably. Health plans DID figure out how to reward better quality. Physicians DID learn how to improve quality, by moving from the acute care model to approaches that were better suited to chronic illnesses.

But after years of investing in this work, it felt like the nation was stuck. The work stayed in silos. We

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would fund one collaborative, and see heartening results–but the good work remained confined within individual organizations. Meanwhile, the Dartmouth Atlas kept telling us that variations in quality of care were not getting smaller. Entire communities and systems of care were not being transformed for the better.

So with a treasure trove of good work in hand, done by the best people in America, we decided to find a new route to our destination. We decided to move beyond working with one clinic, or one disease, at a time, and take a community-based approach that built alliances among stakeholders.

And we envisioned Aligning Forces with the belief that no single person, group, or profession can improve health or health care throughout a community without the support of the other stakeholders. Every alliance in an Aligning Forces must engage people representing those who give care, get care, and pay for care.

In these alliances, you will find the major businesses at the table, health insurance plans representing the majority of covered lives in the region, the physician groups, and consumer groups. And for many of these stakeholders, the Aligning Forces initiative provided the first opportunity for them to actually talk to each other about how to improve health care in the entire region.

The heart of the Aligning Forces effort is a three-pronged strategy:

- to improve the quality of care in doctors' offices and hospitals;
- to measure and publicly report on the quality of care; and
- to engage patients and consumers in making informed choices about their health and health care.

We believe that these three prongs, with a special attention paid to reducing racial and ethnic inequities, will lift the overall quality of health care in these communities and allow them to set the pace for the rest of the country.

One of the first tasks that the Aligning Forces communities took on was to involve at least half of the physicians in the region in efforts to measure and publicly report on the quality of care being provided. We do not view these types of transparency-related activities as ends in and of themselves. We don't think that measuring care alone will change the ways we deliver and pay for care, but we do think that standardized, actionable information about the quality and value of health care is the essential underpinning quality improvement and better value. You cannot improve what you don't measure.

Some alliances now involved in our Aligning Forces work were already measuring and reporting. Others were starting from scratch. To date, nine of the 15 have begun publicly reporting on quality standards, some for doctors' offices, some for hospitals, and some for both, and three have begun reporting on patient experience with doctors. The rest are well on their way to incorporating this critical measure of good care.

In community after community, there have been "ah-ha" moments when doctors see their data for the first time, see that it's accurate and conclude: Holy smokes. I thought I was doing the best I could, but

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I'm not. One doctor told the story about a notable physician in the region, known for publishing journal articles and boasting that the patients in her practice were all getting great care. Then lo and behold, the first time she was confronted with her actual results. Thirty percent of her patients with diabetes had hemoglobin A1C levels that were way out of line. She realized that some of the gap was attributable to the fact that there was no way of keeping track of what care these patients were getting. I remember having a similar ah-ha moment when I looked at how often I was giving flu shots in my practice 20 years ago.

Aligning Forces, however, isn't just about pointing fingers at the docs. It is about bringing the right people to the table to work together on important goals related to achieving quality health care. And while it is hard to imagine sustaining that type of collaboration across stakeholder lines in D.C., it is not so hard to imagine it happening at the local level.

In fact, we don't have to imagine it at all. It's happening. Let me tell you another story.

Dr. Jerry Frankel is a family physician, and head of a large medical society in Detroit, Mich. When he tells his story about how he became involved in Aligning Forces, he titles it, "Tale of a Jerk." When Jerry heard about things like measuring the quality of health care, and publicly reporting on these results, his initial reaction was... scorn. He thought: after all his years of training in medicine, who were these green eyeshade people who were going to come and tell him how he was doing in caring for his patients?

But then Jerry got drafted into the local Aligning Forces effort, which is housed at the Greater Detroit Area Health Council, known as GDAHC for short. The leader of GDAHC is a genial powerhouse of a woman, Vern Anthony. And Vern Anthony got Jerry Frankel and other physicians to sit down with some of the major businesses and health plans in the region, as well as hospital leaders, to talk about what it would REALLY take to improve quality in the Detroit area.

As Jerry tells it, he looked around the table at his first meeting and realized that he had never before met the business leaders from Detroit. Never met the health plan representatives. And yet somehow, here he was, and everyone seemed to care about the same thing he did, providing good care. And when Detroit's measurement and reporting effort got underway, Jerry realized that, JUST like most every part of the health care system, yes, he did have room for improvement in caring for his patients with diabetes.

And so now, as he says it, he's a jerk no longer. He's a convert. And he's working shoulder to shoulder with the other stakeholders in the region to ensure that more physicians and nurses are becoming engaged in this effort, and that they might actually start using the data to deliver *better* care, *all* the *time*, to *all* of their *patients.*

With this type of collaboration, you can see how Aligning Forces communities have the collective power to take on the toughest challenges we face in health care. And their accomplishments do make me, and others in the field, feel as if we're actually getting somewhere on this journey.

If getting doctors to change their behavior is a milestone on the journey, then another landmark on the route has to be: how the communities are dealing with overuse. This is one of the most vexing problems in health care today–the delivery of unnecessary, expensive, and sometimes harmful health care services.

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And yet, it's hard to talk about overuse without raising everyone's hackles about rationing.

But undeniably, when health care services are delivered without regard to whether the evidence warrants such an intervention, it IS wasteful and inappropriate. And calling attention to the problem of overuse is not about "rationing." It's about being "rational."

Let's look at one example: diagnostic imaging for lower back pain, because it's an embarrassing case study in overuse. Lower back pain is the fifth most common reason Americans see a doctor; most of us in this room have probably had a bout. If you remember it, you probably remember wanting it to go away and wanting to DO something to make that happen. So you think–get an MRI.

But for more than a decade, guidelines for treating lower back pain recommend waiting a few weeks to see if the pain will subside before doing a diagnostic imaging like a MRI. For the vast majority of patients the imaging doesn't show anything fixable *and* their pain subsides, within a month. Why make someone take time off from work and sit around, and pay good money for a test that doesn't give you actionable information?

Some say it's pushy patients but maybe it's the incentives in the system. A recent study in Health Affairs took a look at the relationship between the supply of MRI machines, and their use for lower-back pain. The researchers found "a clear relationship between MRI availability and MRI use for lower-back pain patients." The areas with the largest growth in MRI availability also had the fastest growing Medicare bills for imaging. Little wonder: at $2 million a pop, if you buy one, you either use it maximally, or take a bath on the investment.

Remember what I said about that suit jacket with five sleeves?

So why do I say things are getting better? The Puget Sound Health Alliance in Seattle, another Aligning Forces site, is showing us how to align doctors and patients on these sorts of issues. They put out a report called the Community Checkup, which scores practices on how often imaging is deployed for patients with new onset low back pain. It's a simple thing–the fewer the scans, the higher the score.

And the Web site explains to potentially antsy patients, that unless they have a red flag like leg weakness they should wait at least six weeks before having an X-Ray, MRI, or CT scan, much less injections or surgery. And it urges doctors to use a patient education tool, to help explain whether these costly scans are needed. The Puget Sound Health Alliance is not trying to say that NO patients should get scans. It is trying to strike a balance between what doctors and patients think is best, but in a way that is based on science and doesn't break the bank.

And I heard stories from Foundation staff about Puget Sound's astonishing advances. But I was taken by surprise when at a gathering I attended this past summer, to discuss health reform with national policymakers and other stakeholders, Sally Jewell, president and CEO of the Seattle-based, outdoor gear company REI, stood up and waved a report. The conversation was about quality and value, and the report Sally was waving was the Community Checkup report from the Puget Sound Health Alliance. She said that as the CEO of REI, she uses the report to purchase better care for her employees.

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And I said to myself, these alliances are working.

- They're staying together, they're changing expectations.
- They're issuing public reports–some of them are on their third or fourth generation.
- They're getting doctors and hospitals to improve.
- They're targeting different groups of patients and consumers to get them to understand what quality health care means, and what actions they can take to become more active in their own health care.
- And they're getting businesses to be better purchasers of care.

Now, I am hearing story after story about how these Aligning Forces initiatives, which keep people velcroed together across stakeholder lines, are showing us that we're on the right road to our final destination. We are not there yet, not by a long shot–and that's why the Foundation is investing in this initiative over the long term.

We've got to. We've got to stick it out.

But while it is still too early to see dramatic improvements in the quality and value of health care across the board in the Aligning Forces communities, I find the early achievements in these places enormously encouraging. Here's why.

One: I think that for the type of change we need in health care, we will need to go beyond individual organizations. I think that we need to create integrated, functioning systems of care where none now exist. It is all very well for people to hold up the Mayos and the Geisingers and Inter-Mountain Health as shining examples of high-quality, high-value health care. Those outstanding organizations deserve the accolades–but we need to show that more places can get the job done, across entire communities. It can't just be one hospital that does great work, or a handful of primary care practices that are outstanding. If I'm a patient, I want to be able to walk into any hospital or practice and know that I'm going to get decent care.

And so far, the Aligning Forces communities have provided the necessary infrastructure to keep stakeholders at the table and moving towards this essential yet elusive goal.

Let me end by saluting you, members of the National Business Coalition on Health and people like you across the country because most of the Aligning Forces communities, businesses have stepped up and taken on a leadership role in the local alliances' work. Proctor & Gamble in Cincinnati–Harley Davidson in South Central, Pa.–FedEx in Memphis–each of these businesses has contributed in meaningful and important ways.

Here's the final point I want to make to you. If businesses like the ones represented in the coalition are already at the table, and are working to improve health care, then that tells me that we're on the right journey and that we will get to our destination of high quality, high value health care for all.

Whatever the policies will be from D.C. on national health reform legislation, I still believe that people like you, working with providers, plans, and patients, will help get us to our ultimate destination.

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I love the wisdom of African proverbs. There is one that says, "A single hand can't cover the sky; it takes many hands to cover the sky." You are the many hands that are required to cover the sky and achieve high quality and value in our health care system.

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