

Aligning Our Efforts to Transform America's Healthcare

National Priorities & Goals

November 2008



**National
Priorities
Partnership**

*Convened by the
National Quality Forum*



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Executive Summary

NATIONAL PRIORITIES AND GOALS: ALIGNING OUR EFFORTS TO TRANSFORM AMERICA'S HEALTHCARE

The promise of our healthcare system is to provide all Americans with access to healthcare that is safe, effective, and affordable. But our system as it is today is not delivering on that promise.

In recent years, we have seen remarkable efforts that demonstrate how well healthcare organizations can do in delivering on this promise, but these examples stand out because they are the exception, not the norm.

To improve our results, we must fundamentally change the ways in which we deliver care, and this will require focused and combined efforts by patients, healthcare organizations, healthcare professionals, community members, payers, suppliers, government organizations, and other stakeholders.

we must fundamentally
change the ways in
which we deliver care.

The National Priorities Partnership—a collaborative effort of 28 major national organizations that collectively influence every part of the health care system—is doing just that. The Partners, convened by the National Quality Forum to address the challenges of our healthcare system, represent multiple stakeholders drawn from the public and private sectors. These organizations believe that it will require the work of many to achieve the transformational change that is needed for the United States to have a high-performing, high-value healthcare system.

Recent economic events, including instability of the U.S. economy and what appears to be a wide and deep recession, make addressing our healthcare problems even more urgent. Many Americans have seen their retirement savings decline markedly, and millions of others have lost their homes and jobs. It is clear that the health care status quo is unsustainable. Health care spending accounts for 16 percent of the GDP (gross domestic product) and is increasing at an average annual rate of around 7 percent.ⁱ Americans spend more per capita on healthcare than any other industrialized country, yet our results on many important indicators of quality fall significantly below those of similar nations.ⁱⁱ

The time for serious and transformational change is now.

As a first step, the Partners have identified a set of National Priorities and Goals to help focus performance improvement efforts on high-leverage areas—those with the most potential to result in substantial improvements in health and healthcare—and thus accelerate fundamental change in our healthcare delivery system.

THE NATIONAL PRIORITIES AND GOALS

The National Priorities and Goals were selected because they collectively and individually address four major challenges—eliminating harm, eradicating disparities, reducing disease burden, and removing waste—that are important to every American.

Six Priority areas have been identified in which the Partners believe our combined and collective efforts can have the most impact. While the Goals are aspirational, the success of many small scale improvement projects offer direction on how we might proceed to bring this to scale nationally.

Engage patients and families in managing their health and making decisions about their care.

We envision healthcare that honors each individual patient and family, offering voice, control, choice, skills in self-care, and total transparency, and that can and does adapt readily to individual and family circumstances, and differing cultures, languages and social backgrounds.

The Partners will work together to ensure that:

- ✔ All patients will be asked for feedback on their experience of care, which healthcare organizations and their staff will then use to improve care.
- ✔ All patients will have access to tools and support systems that enable them to effectively navigate and manage their care.
- ✔ All patients will have access to information and assistance that enables them to make informed decisions about their treatment options.

Improve the health of the population.

We envision communities that foster health and wellness as well as national, state, and local systems of care fully invested in the prevention of disease, injury, and disability—reliable, effective, and proactive in helping all people reduce the risk and burden of disease.

The Partners will work together to ensure that:

- ✔ All Americans will receive the most effective preventive services recommended by the U.S. Preventive Services Task Force.
- ✔ All Americans will adopt the most important healthy lifestyle behaviors known to promote health.
- ✔ The health of American communities will be improved according to a national index of health.

Improve the safety and reliability of America's healthcare system.

We envision a healthcare system that is relentless in continually reducing the risks of injury from care, aiming for “zero” harm wherever and whenever possible—a system that can promise absolutely reliable care, guaranteeing that every patient, every time, receives the benefits of care based solidly in science. We envision healthcare leaders and healthcare professionals intolerant of defects or errors in care, and who constantly seek to improve, regardless of their current levels of safety and reliability.

The Partners will work together to ensure that:

- ✔ All healthcare organizations and their staff will strive to ensure a culture of safety while driving to lower the incidence of healthcare-induced harm, disability, or death toward zero. They will focus relentlessly on continually reducing and seeking to eliminate all healthcare-associated infections (HAI) and serious adverse events.

Healthcare-associated infections include, but are not limited to:

- Catheter-associated blood stream infections
 - Catheter-associated urinary tract infections
 - Surgical site infections
 - Ventilator-associated pneumonia
- (See the Centers for Disease Control and Prevention’s *Infectious Diseases in Healthcare Settings* for a more inclusive list.)ⁱⁱⁱ

Serious adverse events include, but are not limited to:

- Pressure ulcers
 - Wrong site surgeries
 - Falls
 - Air embolisms
 - Blood product injuries
 - Foreign objects retained after surgery
 - Adverse drug events associated with high alert medications
- (See the National Quality Forum’s *Serious Reportable Events* for a more inclusive list.)^{iv}

- ✔ All hospitals will reduce preventable and premature hospital-level mortality rates to best-in-class.^v

- ✔ All hospitals and their community partners will improve 30-day mortality rates following hospitalization for select conditions (acute myocardial infarction, heart failure, pneumonia) to best-in-class.

Ensure patients receive well-coordinated care within and across all healthcare organizations, settings, and levels of care.

We envision a healthcare system that guides patients and families through their healthcare experience, while respecting patient choice, offering physical and psychological supports, and encouraging strong relationships between patients and the healthcare professionals accountable for their care.

The Partners will work together to ensure that:

- ✔ Healthcare organizations and their staff will continually strive to improve care by soliciting and carefully considering feedback from all patients (and their families when appropriate) regarding coordination of their care during transitions.
- ✔ Medication information will be clearly communicated to patients, family members, and the next healthcare professional and/or organization of care, and medications will be reconfirmed each time a patient experiences a transition in care.
- ✔ All healthcare organizations and their staff will work collaboratively with patients to reduce 30-day readmission rates.
- ✔ All healthcare organizations and their staff will work collaboratively with patients to reduce preventable emergency department visits.

Guarantee appropriate and compassionate care for patients with life-limiting illnesses.

We envision healthcare capable of promising dignity, comfort, companionship, and spiritual support to patients and families facing advanced illness or dying, fully in synchrony with all of the resources that community, friends, and family can bring to bear at the end of life.

The Partners will work together to ensure that:

- ✦ All patients with life-limiting illnesses will have access to effective treatment for relief of suffering from symptoms such as pain, shortness of breath, weight loss, weakness, nausea, serious bowel problems, delirium, and depression.
- ✦ All patients with life-limiting illnesses and their families will have access to help with psychological, social, and spiritual needs.
- ✦ All patients with life-limiting illnesses will receive effective communication from healthcare professionals about their options for treatment; realistic information about their prognosis; timely, clear, and honest answers to their questions; advance directives; and a commitment not to abandon them regardless of their choices over the course of their illness.
- ✦ All patients with life-limiting illnesses will receive high-quality palliative care and hospice services.

Eliminate overuse while ensuring the delivery of appropriate care.

We envision healthcare that promotes better health and more affordable care by continually and safely reducing the burden of unscientific, inappropriate, and excessive care, including tests, drugs, procedures, visits, and hospital stays.

The Partners will work together to ensure that:

- ✦ All healthcare organizations will continually strive to improve the delivery of appropriate patient care, and substantially and measurably reduce extraneous service(s) and/or treatment(s).

The recommended areas of concentration are as follows:

- ✦ Inappropriate medication use, targeting:
 - *Antibiotic use*
 - *Polypharmacy (for multiple chronic conditions; of antipsychotics)*
- ✦ Unnecessary laboratory tests, targeting:
 - *Panels (e.g., thyroid, SMA 20)*
 - *Special testing (e.g., Lyme Disease with regional considerations)*
- ✦ Unwarranted maternity care interventions, targeting:
 - *Cesarean section*
- ✦ Unwarranted diagnostic procedures, targeting:
 - *Cardiac computed tomography (noninvasive coronary angiography and coronary calcium scoring)*
 - *Lumbar spine magnetic resonance imaging prior to conservative therapy, without red flags*
 - *Uncomplicated chest/thorax computed tomography screening*
 - *Bone or joint x-ray prior to conservative therapy, without red flags*
 - *Chest x-ray, preoperative, on admission, or routine monitoring*
 - *Endoscopy*
- ✦ Inappropriate non-palliative services at end of life, targeting:
 - *Chemotherapy in the last 14 days of life*
 - *Aggressive interventional procedures*
 - *More than one emergency department visit in the last 30 days of life*

- ✦ Unwarranted procedures, targeting:
 - Spine surgery
 - Knee/hip replacement
 - Hysterectomy
 - Percutaneous transluminal coronary angioplasty (PTCA)/Stent
 - Coronary artery bypass graft (CABG)
 - Prostatectomy
- ✦ Unnecessary consultations
- ✦ Preventable emergency department visits and hospitalizations, targeting:
 - Potentially preventable emergency department visits
 - Hospital admissions lasting less than 24 hours
 - Ambulatory care sensitive conditions
- ✦ Potentially harmful preventive services with no benefit, targeting:
 - BRCA mutation testing for breast and ovarian cancer – female, low risk
 - Coronary heart disease (CHD): Screening using electrocardiography, exercise treadmill test, electron beam computed tomography – adults, low risk
 - Carotid artery stenosis screening – general adult population
 - Cervical cancer screening – female over 65, average risk and female, post-hysterectomy
 - Prostate cancer screening – male over 75

(From the U.S. Preventive Services Task Force D Recommendations List)^{vi}

THE PATH FORWARD

Identifying a starter set of National Priorities and Goals is a major accomplishment, but it is only the first step in what must be a more expansive and ongoing implementation aimed at achieving the performance goals. Over the next year and beyond, we hope the National Priorities and Goals will spur action and innovation, because without coordinated actions, these goals will not be reached. The Partners have agreed to work with each other and with policymakers, healthcare leaders, and the community at large, to build on the framework provided in this report, and to develop actions in each of the major areas that will drive improvements needed: performance measurement, public reporting, payment systems, research and knowledge dissemination, professional development, and system capacity.

Health care reform is well underway and the current economic crisis makes solving the puzzles of quality, equity, and value not just an ideal, but an imperative. The National Priorities Partnership is encouraging everyone to join not in *calling* for

reform, but in *enacting* it nationally and in local communities across the country. The mere existence of a shared sense of responsibility to meet specific goals can transform healthcare quality. Acting to meet them can revolutionize it.

ⁱ Catlin A, Cowan C, Heffler S, et.al., National health spending in 2005: The slowdown continues. *Health Aff*, 2007;26(1):142-153.

ⁱⁱ The Commonwealth Fund, “Why Not the Best? Results from the National Scorecard on U.S. Health System Performance, 2008”.

ⁱⁱⁱ Centers for Disease Control and Prevention, *Infectious Disease in Healthcare Settings*. Available at www.cdc.gov/ncidod/dhqp/id.htm

^{iv} National Quality Forum, Serious Reportable Events. Available at www.qualityforum.org/projects/completed/srz/fact-sheet.asp.

^v “Best-in-class” may be determined by using an accepted methodology, such as *Achievable Benchmarks in Care (ABC)*TM.

^{vi} Agency for Healthcare Research and Quality, *U.S. Preventive Services Task Force (USPSTF)*. Available at www.aahrq.gov/clinic/prevenix.htm.



*Delivering
on the
Promise*

DELIVERING ON THE PROMISE

The promise of our healthcare system is to provide all Americans with access to healthcare that is safe, effective, and affordable. In recent years, we have seen remarkable efforts that demonstrate how well healthcare organizations can do in delivering on this promise, but these examples stand out because they are the exception, not the norm.

All Americans should be receiving the very best of care, because we spend more per capita on healthcare than any other industrialized country. Yet our results on many important indicators of quality, such as preventable deaths and timely access to primary care, fall significantly below those of similar nations.¹ To improve our results, we must fundamentally improve the ways in which we deliver care, which will require joint efforts by patients, healthcare organizations, healthcare professionals, community members, payers, suppliers, government organizations, and all other stakeholders in healthcare.

Over the past decade, numerous expert panels and a growing body of evidence have documented serious gaps in safety and quality.² These gaps affect all Americans, including children³ and the elderly,⁴ and they take the greatest toll on low-income individuals and racial and ethnic minorities.⁵

At the same time, a confluence of events, including the recent instability of the U.S. economy, has produced an environment that makes addressing our healthcare problems not only timely, but imperative. On the cost front in particular, the status quo is unsustainable. Healthcare spending accounts for 16 percent of the GDP and is increasing at an average annual rate of around 7 percent.⁶ In short, the time for serious and transformational change is *now*.

The good news is that many promising, evidence-based improvements have begun to take hold, representing progress that is saving not only money, but lives. Across the country, new models of care are emerging, built on expanding knowledge about how to deliver effective and efficient care. They include innovations for rapid reduction in blood-

stream infections, seamless transitional care for patients with congestive heart failure and other chronic conditions, exemplary palliative care for the reduction of pain and depression among cancer patients, and new models to reduce cardiac risks and other complications for persons with diabetes.⁷

Still, despite a growing evidence base, most Americans are not yet benefiting from what has been learned through research and tens of thousands of small-scale improvement projects, because “best practices” all too often fail to spread. Of particular concern, the healthcare workforce, already under pressure from recruitment and retention challenges,

is showing signs of stress and fatigue—there are simply too many quality and performance improvement initiatives and too little time and too few resources to devote to them.⁸

Our performance improvement initiatives to date have been beneficial, but not transformative; well intended, but disconnected. We have yet to see the kind of fundamental change in the delivery system that was called for in the Institute of Medicine’s (IOM’s) *Crossing the Quality Chasm* report in 2001.⁹ Most of our improvement efforts have been narrowly focused on a single setting, such as an intensive care unit or an ambulatory practice. Yet the root of so many of our concerns about safety, quality, and waste in the current delivery system stem from the lack of coordination across settings and healthcare organizations. As a whole, the delivery system still lacks the critical organizational supports necessary to achieve higher levels of performance.

It is this sense of great promise, tempered by realism, that led to the National Priorities Partnership.

The time for serious and transformational change is now.

JOINING FORCES

The National Priorities Partnership is a collaborative effort of 28 major national organizations that collectively influence every part of the healthcare system. Convened by the National Quality Forum (NQF) to address the challenges of our healthcare system, the Partners represent multiple stakeholders, including consumer groups, employers, government, health plans, healthcare organizations, healthcare professionals, scientists, accrediting and certifying bodies, and quality alliances.

As a first step, the Partners have identified a set of National Priorities and Goals to help focus performance improvement efforts on *high-leverage areas*—those with the most potential in the near term to result in substantial improvements in health and healthcare—and thus accelerate fundamental change in our healthcare delivery system.

As a second step, the Partners have agreed to work together over the next year to align the drivers of change, such as payment reform, accreditation and certification, and performance measurement, around common goals for improvement. We are aware that the scaffolding we are constructing is built on decades of effort and research, countless major reports and commissions, and the thoughtful work of thousands of healthcare leaders and front-line workers. These examples of excellence and success are what make our path clear. As demonstrations of our ability to make progress, samples of these efforts can be found throughout this report as “Examples of Actions.” The Partners recognize, however, that these good works have not been enough to foster the systemwide improvements we need. In 2009 and beyond, the Partners will work with each other and with others to develop specific actions to achieve the National Priorities and Goals.

We recognize, too, that all of us share responsibility for our nation’s health and healthcare system. Although it is both necessary and appropriate that we focus a great deal of attention on improving the healthcare delivery system, we recognize with humility that there are limits on our ability to affect patient outcomes. The World Health Organization has pointed out that health is affected also by lifestyle, genetics, and public health efforts to provide clean water and safe food.¹⁰ Although the focus of the National Priorities Partnership is on

maximizing the contribution of healthcare, we encourage a broad array of efforts in all of these areas to improve the health of the American population. The National Priorities and Goals discussed in this document are areas in which we can make the most impact through concerted joint efforts and by actively working together over time in new and innovative ways to improve access to high-quality, affordable healthcare and to reduce the burden of disease.

The Partners share a sense of urgency and believe that repairing our broken healthcare system should and will soon be a top national priority. The Partners believe that solving this complex and costly crisis will require leadership from both the public and private sectors that crosses political boundaries, and we have committed to work together to translate this agenda into action to achieve these goals that have the power to vastly improve our healthcare delivery system.

Additionally, in order to achieve the measures of success called for by the Partners, investments must be made in the healthcare system’s capacity to improve and measure its performance. This includes developing within healthcare organizations the capacity for achieving continuous improvements in quality and safety, such as creating a culture of safety and sharing of best practices. Building a workable and efficient healthcare information infrastructure to collect, analyze, aggregate, and report accurate and credible performance information is critical to supporting these efforts.

The Partners urge all stakeholders to reevaluate their investment priorities to ensure resources are dedicated to improving safety and quality and are not spent wastefully.

IDENTIFYING CHALLENGES

The National Priorities and Goals collectively and individually address four major challenges: eliminating harm, eradicating disparities, reducing disease burden, and removing waste. The Partners also considered the collective impact of the Priorities—if taken together as a set, would they be effective in achieving these results?

Eliminating Harm

Patient safety is improving at a very slow pace, with leading indicators showing gains of only 1 percent per year on average.¹¹ Every year in U.S. hospitals, there are 1.7 million healthcare-associated infections (HAIs);¹² other serious adverse events, such as pressure ulcers, falls, adverse drug events, and blood product injuries, affect hundreds of thousands of patients.¹³

We believe the healthcare system should be relentless in continually reducing the risks of injury from care, while aiming for “zero” harm wherever and whenever possible.

Eradicating Disparities

Racial and ethnic minorities, as well as those in low-income groups, face disproportionately higher rates of disease, disability, and mortality.¹⁴ African Americans have higher death rates from heart disease, diabetes, AIDS, and cancer.¹⁵ American Indians and Alaskan Natives have a lower life expectancy and higher rates of infant mortality.¹⁶ There are significant variations in the rates of potentially preventable hospitalizations for nonwhite patients and patients in lower-income areas.¹⁷ Much of the conversation about healthcare centers on improving access to care for these groups.

We believe this is not enough and that every American should have access not just to care, but to quality care.

Reducing Disease Burden

The adverse impact of poor health and disease is extraordinary. More than 72 million Americans are

obese, putting them at risk for serious healthcare problems, such as high blood pressure, heart disease, and diabetes,¹⁸ at a cost of nearly \$120 billion in 2000.¹⁹ Tobacco use remains the leading preventable cause of death and results in nearly 440,000 U.S. deaths annually. Between 1997 and 2001, tobacco use was estimated to have cost the United States \$167 billion annually in health-related economic losses.²⁰ According to the Centers for Disease Control and Prevention (CDC), almost half of all Americans live with a chronic disease—for 1 in 10 it is disabling.²¹ Yet adult Americans receive recommended preventive, acute, and chronic care only about 55 percent of the time, dramatically reducing healthcare’s effectiveness.²²

To reduce disease burden, we believe the healthcare system must not only provide effective services, but must work in partnership with consumers and other stakeholders to achieve dramatic improvements in health behaviors.

Removing Waste

Excessive, unnecessary, and often risky treatments and tests jeopardize safety, increase already exorbitant healthcare costs, and neglect the needs of patients and their families. An estimated 30 to 40 cents of every dollar we spend on healthcare (more than \$500 billion dollars) is spent on unnecessary and even unsafe care.²³

At a time when one in seven Americans lacks health insurance,²⁴ and an estimated 57 million American families are struggling to pay their medical bills (43 million of whom have insurance),²⁵ we believe steps must be taken to ensure that healthcare resources are focused on providing high-quality care that is appropriate and timely.

ESTABLISHING GUIDEPOSTS

There are a number of key elements that can serve as guideposts for the transformation needed to achieve the National Priorities and Goals.

Listening to Patients and Families

Standardized information on patient experience of care should be routinely captured in all healthcare settings and should be analyzed and acted upon for purposes of continuous improvement. Healthcare professionals should support patients in setting realistic goals for maintaining and improving their health, and shared decisionmaking between patients and healthcare professionals should be the norm for most diagnostic and treatment processes. Patient representatives should participate in governance, quality oversight, and other institutional processes throughout the system.

Organizing Around the Patient's Journey

The healthcare delivery system of the future must accept responsibility for the patient's lifelong healthcare experience. This includes providing health promotion and disease prevention resources to minimize the need for acute and chronic care, ensuring timely access to safe and effective diagnostic and therapeutic services, ensuring well-coordinated transitional care, providing ongoing care management, supporting patient and family efforts to manage care, and ensuring compassionate care for those with life-limiting illnesses. Healthcare organizations and insurers must capture and integrate relevant data from all members of the care team, including the patient and family caregivers. Attention should be focused on measuring and improving value at every step along the way.

Engaging All Stakeholders

All stakeholders must commit to advancing the National Priorities and Goals, which must be relevant at the national, regional, and local levels. Although this is a national agenda, we all must invest in the solutions. Patients and their advocates, corporate purchasers of health benefits,

insurers and their administrators, and healthcare organizations, including providers and suppliers, must contribute. Patients need to adopt behaviors that promote good health and become partners in managing their health and making healthcare decisions. Purchasers need to demand the best outcomes for the money spent. Payers need to bring simplification and accountability. Healthcare organizations need to achieve higher levels of quality and efficiency. The entire healthcare workforce, including administrators; medical, nursing, pharmacy, and allied health professionals; paraprofessionals; and service employees, need to be engaged in advancing quality and efficiency. Community-wide leadership is needed to advance population health. We must work together to jointly define and deliver solutions.

SUCCESS WILL REQUIRE...

Listening to Patients and Families

- Provide for direct, standardized measures of "patient voice" regarding the experience of care.

Organizing Around the Patient's Journey

- Focus on the continuum of care, not just individual provider performance.
- Emphasize desired patient outcomes in addition to desired care processes.
- Incorporate measures of efficiency, as well as of outcomes and experience of care.

Engaging All Stakeholders

- Emphasize local improvement as well as external assessment.
- Engage all providers of care, no matter what their current level of achievement.

THE VISION

The challenges are daunting, but the prognosis is promising—if we act swiftly, thoughtfully, and collectively. There are six National Priorities that address areas in which the Partners believe our combined and collective efforts can have the most impact.

Engaging patients and families in managing their health and making decisions about their care. We envision healthcare that honors each individual patient and family, offering voice, control, choice, skills in self-care, and total transparency, and that can and does adapt readily to individual and family circumstances, and to differing cultures, languages, and social backgrounds.

Improving the health of the population. We envision communities that foster health and wellness as well as national, state, and local systems of care fully invested in the prevention of disease, injury, and disability—reliable, effective, and proactive in helping all people reduce the risk and burden of disease.

Improving the safety and reliability of America’s healthcare system. We envision a healthcare system that is relentless in continually reducing the risks of injury from care, aiming for “zero” harm wherever and whenever possible—a system that can promise absolutely reliable care, guaranteeing that every patient, every time, receives the benefits of care based solidly in science. We envision healthcare leaders and healthcare professionals intolerant of defects or errors in care and who constantly seek to improve, regardless of their current levels of safety and reliability.

Ensuring patients receive well-coordinated care within and across all healthcare organizations, settings, and levels of care. We envision a healthcare system that guides patients and families through their healthcare experience, while respecting patient choice, offering physical and psychological supports, and encouraging strong relationships between patients and the healthcare professionals accountable for their care.

Guaranteeing appropriate and compassionate care for patients with life-limiting illnesses. We envision healthcare capable of promising dignity, comfort, companionship, and spiritual support to patients and families facing advanced illness or dying, fully in synchrony with all of the resources that community, friends, and family can bring to bear at the end of life.

Eliminating overuse while ensuring the delivery of appropriate care. We envision healthcare that promotes better health and more affordable care by continually and safely reducing the burden of unscientific, inappropriate, and excessive care, including tests, drugs, procedures, visits, and hospital stays.

The Partners will continually evaluate and assess progress toward achieving these National Priorities and Goals. We believe that significant, measurable progress can be made toward most of the National Goals in the next three to five years, if we work together. The shift toward a focus on the health of the population, rather than only on the healthcare delivery system, will require a significant change in strategy; the Partners therefore recognize that the goals of the Priority related to population health may take longer to achieve.

*The National
Priorities
& Goals*

NATIONAL PRIORITY: PATIENT AND FAMILY ENGAGEMENT

Engage patients and families in managing their health and making decisions about their care

OUR VISION: We envision healthcare that honors each individual patient and family, offering voice, control, choice, skills in self-care, and total transparency, and that can and does adapt readily to individual and family circumstances, and to differing cultures, languages, and social backgrounds.

Why is Patient and Family Engagement a National Priority?

Too many of us move through the healthcare system as passive recipients of care, rather than as central members of our healthcare team. Many patients are not asked how they want to be treated or what their experiences are like; they may not feel adequately informed or involved in decisions about their care; they frequently do not understand important information healthcare professionals discuss with them; and they often do not have the knowledge or support to maintain and improve their health.

Although most of our national healthcare expenditures are for the treatment of chronic conditions, patients and families bear most of the burden for the day-to-day management of chronic care. Patients and their families need access to appropriate tools and support that equip them with the knowledge, skills, and abilities to effectively manage their health. An understanding of self-management strategies can help patients avoid exacerbations or setbacks, which can lead to burdensome and preventable treatments and hospitalizations. Engaged patients—those who seek out information about their condition and work collaboratively with their providers—are more likely to demonstrate healthy self-management behaviors (such as diet, exercise, and weight management) as well as disease-specific health management behaviors (such as keeping a diary of glucose levels when you have diabetes).²⁶ Patients who are engaged as active partners in their healthcare team, and who

Patients who are engaged as active partners in their healthcare team are vital to achieving better health outcomes, lower service utilization, and lower costs.

participate in the management of their personal health, are vital to achieving better health outcomes, lower service utilization, and lower costs.²⁷

Patients can become more actively engaged in their care with the help of their professional caregivers. By seeking feedback on patients' and families' experiences of care, healthcare professionals can make improvements in quality and deliver care that is more patient centered and responsive to their patients' needs. By providing the right kind of information and decision support, patients can be empowered to assume a more active role in determining their course of treatment and can make choices concordant with the evidence-based recommendations of their healthcare professional and their own personal values and preferences.

Healthcare decisionmaking can be complex. Many times there is not one best treatment option; rather, there are several that have varying risks and benefits that require thoughtful consideration by the patient, with the help of his or her healthcare provider. Options for low back pain, for example, can range from very conservative treatment, such as physical therapy, to more aggressive interventions, such as spinal surgery.

The choice a patient makes should be based on a clear understanding of the options and their trade-offs and should be consistent with his or her values, preferences, and life situation. When fully aware of the risks and benefits, patients may opt for care that is less invasive in nature; this is particularly true for

those patients with conditions that have multiple treatment alternatives and tradeoffs to consider.²⁸

Some studies have shown that shared decisionmaking can reduce the number of patients choosing more invasive surgical procedures by 21 to 44 percent without adversely impacting health outcomes.²⁹

More and more, healthcare professionals are using decision aids to help their patients make the best decision. The use of such aids has been demonstrated to improve patient decisionmaking by increasing knowledge and active participation, creating more realistic expectations, reducing uncertainty and decisional conflict, and improving the alignment of value and choice.

Making Patient and Family Engagement a National Priority Will:

REDUCE HARM. Many patients do not fully understand the instructions given to them by healthcare professionals. In the United States, health literacy—the ability to obtain, process, and understand information that is communicated regarding health status and healthcare—is poor, with only 12 percent of American adults having the skills to manage their own healthcare proficiently.³⁰ A recent study indicates that 78 percent of patients discharged from the emergency department do not adequately comprehend important information or instructions, leaving them at risk of improperly managing their condition(s) and potentially experiencing harm (e.g., adverse drug events). Perhaps more concerning, the majority of these patients do not realize that they are not understanding the information presented to them.³¹

REDUCE DISPARITIES. Health outcomes are known to vary widely among different groups based on race, ethnicity, gender, socioeconomic status, and other variables.³² Additionally, functional health literacy is worst among the elderly and low-income populations, leaving those who are the most in need of healthcare the least able to

One study of arthritis patients found that only 15 percent of those identified as possible candidates for knee surgery actually wanted the surgery—a far greater number were attracted to more conservative treatment options.

understand the information intended to help them.³³ Today, almost 50 million Americans speak a language other than English at home, and 23 million have limited English proficiency.³⁴ In order to identify opportunities to improve the care

provided to different populations, healthcare professionals need information regarding patient experience of care. This information is essential for identifying tools and strategies that are culturally and linguistically appropriate and that will ideally lead to better care.

REDUCE DISEASE BURDEN. Self-management programs, which teach problem-solving skills, have been more effective than information-only patient education in improving clinical outcomes.³⁵ One study targeting Hispanics indicates that such programs also can produce good outcomes in minority populations, including improved health status (e.g., reduced health distress, fatigue, and pain/physical discomfort), improved health behaviors (e.g., increased exercise, communication with healthcare professional, and mental stress management), and reduced healthcare utilization.³⁶ Good communication and education lead to better results: Asthma patients who receive self-management education and regular follow-up with a healthcare professional have reported a reduction in hospitalizations and emergency department visits and fewer work days lost.³⁷

REDUCE WASTE. Patients need a full understanding of their treatment options, along with the benefits, risks, and tradeoffs associated with those options, to make informed decisions about their care. There is growing evidence that patients who receive this kind of decision support tend to make more conservative (and potentially less costly and less risky) decisions. One study of arthritis patients, for example, found that only 15 percent of those identified as possible candidates for knee surgery actually wanted the surgery—a far greater number were attracted to more conservative treatment options.³⁸

Patient and Family Engagement: Examples of Actions

The concept of patient-centered care has become more mainstream in recent years, and more healthcare organizations are striving to offer care that is individualized and tailored to their patients' needs and preferences. This can be challenging, given the diversity of our population, but it is possible. Chronic disease self-management programs can be tailored to specific populations, such as those offered for Spanish-speaking Hispanics with chronic conditions in Tomando Control de su Salud (Taking Control of Your Health) programs. These programs offer workshops in community settings, such as churches, libraries, and hospitals, and they bring together Spanish-speaking individuals with similar chronic conditions. Courses are taught in Spanish (without the use of translators) and in ways that address cultural differences. Participants, when compared with other usual-care patients, have demonstrated improved health status, health behavior, and self-efficacy (the belief that one has the ability to adopt certain behaviors), as well as fewer emergency room visits.³⁹

At the Dartmouth-Hitchcock Medical Center (DHMC) in Lebanon, New Hampshire, patients with a positive breast biopsy are no longer contacted by the radiologist first and then immediately scheduled for an appointment with a surgeon. Instead, each patient completes a screening questionnaire and uses web-based decision aids to gain a better understanding of their treatment preferences. Healthcare professionals use this information to tailor their consultations to each patient to ensure that the patient's ultimate decision is consistent with her expressed preferences. The healthcare professional provides additional information, as appropriate, to assist the patient in better understanding the risks and benefits of the options as the patient makes her decision. DHMC's Center for Shared Decision Making offers additional decision aids developed by the Foundation for Informed Medical Decision Making for a host of conditions, including back pain, heart disease, and prostate disorders.⁴⁰

More and more healthcare organizations are seeing the benefits of understanding how their patients and families view their experience of care. Feedback from patients and their families is critical to understanding the value of the services provided and offers invaluable information about areas that may need improvement. Healthcare payers are also realizing the importance of this information. Beginning in July 2007, the Centers for Medicare & Medicaid Services changed its payments to hospitals to require use of the Hospital Consumer Assessment of Healthcare Provider and Services (HCAHPS) survey instrument in order to receive their full payment. This survey asks patients 27 questions pertaining to their hospital experience and produces data that hospitals can use for quality improvement and that consumers can use to compare hospital performance and get meaningful information for their own decisionmaking.⁴¹

PATIENT AND FAMILY ENGAGEMENT:

HOW WILL WE GET THERE?

The Partners will work together to ensure that:

Goal: All patients will be asked for feedback on their experience of care, which healthcare organizations and their staff will then use to improve care.

To get there, all healthcare organizations and settings, including individual and group practices, hospitals, nursing homes, assisted living facilities, community health centers, ambulatory settings, and hospice, home health, end stage renal disease, and behavioral health providers will administer and publicly report on patient experience surveys. Healthcare organizations and their staff will use this information to improve the quality of care they provide and to eliminate disparities in quality and outcomes. Benefit designs and payment methods will reward healthcare organizations that demonstrate improved patient experience of care and reduction of disparities. This information will be made available in ways that can inform the patient's choice of healthcare organization.

Goal: All patients will have access to tools and support systems that enable them to effectively navigate and manage their care.

To get there, healthcare organizations and their staff will offer or facilitate access to culturally and linguistically appropriate tools and practices that have been demonstrated to support patient engagement and self management. Benefit designs and payment methods will support the availability and use of such tools and systems; reward healthcare organizations that demonstrate improvement in outcomes and reduction of disparities; and provide incentives for patients to use such tools and support systems.

Goal: All patients will have access to information and assistance that enables them to make informed decisions about their treatment options.

To get there, healthcare organizations and their staff will use proven and culturally and linguistically appropriate strategies and tools to enable patients to understand all treatment options and to make decisions consistent with their values and preferences. Benefit designs and payment methods will support the use and availability of such strategies and tools; reward healthcare organizations that demonstrate improvement in outcomes and reduction of disparities; and provide incentives for patients to use such tools to make appropriate decisions about their care.

NATIONAL PRIORITY: POPULATION HEALTH

Improve the health of the population

OUR VISION: We envision communities that foster health and wellness as well as national, state, and local systems of care fully invested in the prevention of disease, injury, and disability—reliable, effective, and proactive in helping all people reduce the risk and burden of disease.

Why is Population Health a National Priority?

With 60 percent of American deaths attributable to behavioral factors, social circumstances, and physical environmental exposures, we must ensure the optimal use of preventive services and superior clinical preventive care, provide support for healthy lifestyle behaviors, and address social and environmental issues that lead to poorer health outcomes.⁴² The Partners strongly uphold that this work must take place at the community level, with national, state, and local involvement enabled through the development of stronger partnerships and coordination of care between the public health and healthcare delivery systems. IOM's 2002 report *The Future of the Public's Health in the 21st Century* emphasizes that government public health

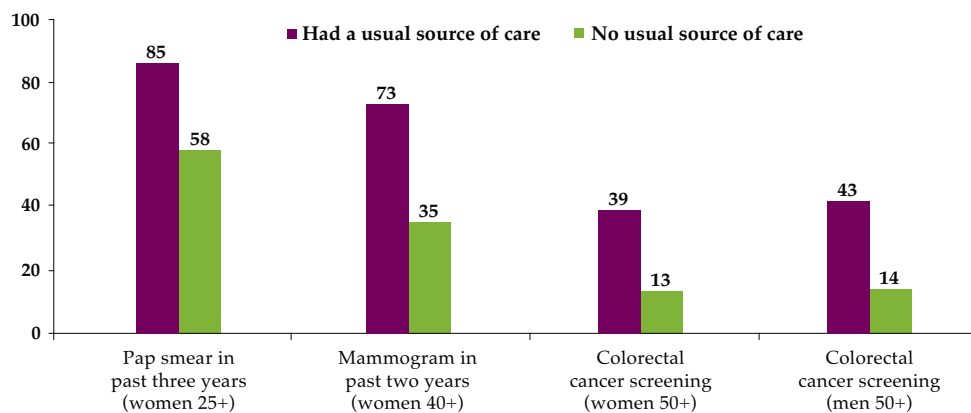
agencies are the backbone of the public health system, but they cannot work in isolation; they must partner with other organizations and sectors of society to consolidate and optimize the resources necessary to achieve better health outcomes.⁴³

Making Population Health a National Priority Will:

REDUCE HARM. More than 1,500 Americans die from cancer each day,⁴⁴ yet less than 50 percent of adults are up to date with colorectal cancer screening, and only 67 percent of women have been screened for breast cancer in the past 2 years.⁴⁵ Evidence suggests that having a regular source of care can increase the likelihood of receiving these recommended preventive services (see Chart 1).⁴⁶

Chart 1

Percentage Who Received Cancer Screening: Community-Dwelling Adults With and Without a Usual Source of Health Care, 2000



Data: National Health Interview Survey (Swan, J. et al. 2003. *Cancer* 98:1528-40). Colorectal cancer screening means a home blood stool test in the past year or a colonoscopy, sigmoidoscopy, or proctoscopy in the past five years.

Source: McCarthy and Leatherman, *Performance Snapshots*, 2006. www.cmf.org/snapshots.

An additional 36,000 people die and 200,000 are hospitalized annually due to complications from influenza, yet only 37 percent of adults over 50 get an annual flu vaccination. By immunizing 90 percent of adults over age 50 against influenza annually, approximately 12,000 additional lives could be saved each year.⁴⁷

REDUCE DISPARITIES. Health status is known to vary widely between communities and regions. In 2007, approximately 68 percent of Hispanic and 56 percent of African American adults over the age of 65 were identified as never having received a pneumococcal vaccination, compared with only 38 percent of white adults in the same age group.⁴⁸ African Americans are more likely to develop and die from cancer than any other group, and death rates are 17 to 37 percent higher than those of whites.⁴⁹

REDUCE DISEASE BURDEN. Tobacco use remains the leading preventable cause of death and contributes to the development of many serious diseases, including coronary heart disease, stroke, and peripheral vascular disease.⁵⁰ Likewise, being overweight or obese leads to many other diseases, such as diabetes, hypertension, and stroke.⁵¹

Research shows, however, that certain services and behaviors may help patients to improve their health status and reduce the risk of disease. Smoking cessation counseling for adult smokers lowers the risk for lung and other types of cancer and reduces respiratory symptoms, such as coughing, wheezing, and shortness of breath.⁵² Good nutrition and regular physical activity may also lower the risks for many chronic diseases, including heart disease, stroke, osteoporosis, diabetes, and some cancers, and may be associated with fewer hospitalizations, physician visits, and medications.⁵³

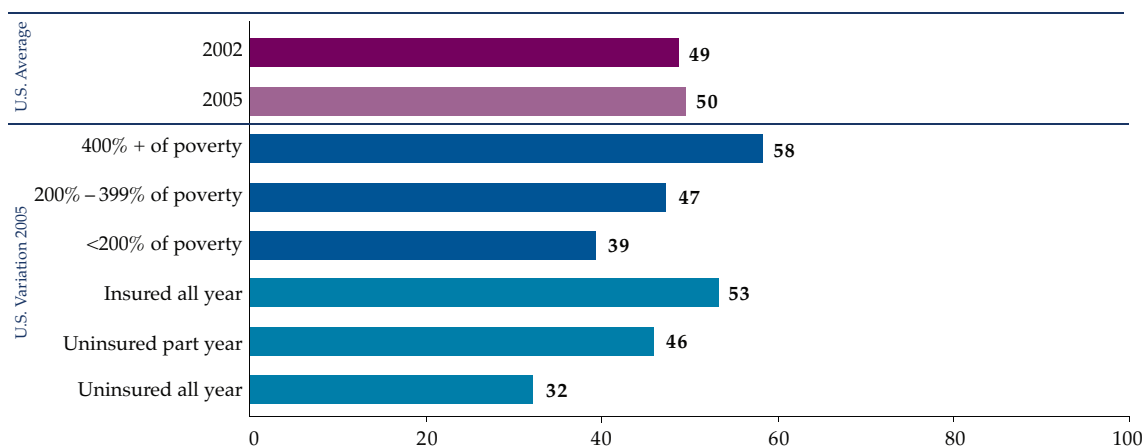
REDUCE WASTE. The ultimate goal is to ensure that all patients consistently receive the most effective recommended preventive services. In achieving this goal, it is hoped that patients will no longer be subjected to tests for which there is poorly documented evidence of benefit. Unwarranted tests, based on U.S. Preventive Services Task Force recommendations, have been estimated to be ordered more than 40 percent of the time during annual health exams.⁵⁴

Chart 2

QUALITY: EFFECTIVE CARE

Receipt of Recommended Screening and Preventive Care for Adults

Percent of adults (ages 18+) who received all recommended screening and preventive care within a specific time frame given their age and sex*



* Recommended care includes seven key screening and preventive services: blood pressure, cholesterol, Pap, mammogram, fecal occult blood test or sigmoidoscopy/colonoscopy, and flu shot. See report Appendix B (from chart source) for complete description.

Data: B. Mahato, Columbia University analysis of Medical Expenditure Panel Survey.

Source: Commonwealth Fund National Scorecard on U.S. Health System Performance, 2008.

Population Health: Examples of Actions

HealthPartners, a consumer-governed nonprofit healthcare organization in Minnesota, has been improving the health of its communities by working to ensure that all of its members receive evidence-based preventive screenings based on age and gender. In 2006, 72 percent of its adult members were up to date on *all* appropriate screenings in their composite measure.⁵⁵ This achievement is significant: On average, Americans only receive 50 percent of recommended preventive care based on a similar composite measure (see Chart 2).⁵⁶

The University of Wisconsin Population Health Institute has been publishing county health rankings for the past five years. The Wisconsin County Health Rankings are designed to summarize the overall health of its counties, as well as the factors that are key in determining health status, such as health behaviors, socioeconomic factors, and healthcare. This information is intended to stimulate all community stakeholders to partner with health departments and healthcare organizations to improve the population's health.⁵⁷

The Eleventh Street Family Health Services of Drexel University is a nurse-managed, transdisciplinary health center founded in 1998 that serves residents of four public housing developments and the surrounding urban community, where 57 percent of patients are covered by the state Medicaid plan and 33 percent are uninsured. The program provides a full range of primary care, dental services, behavioral health services, and health promotion and disease prevention care. It provides one-stop shopping for both health and life concerns, offering not only health services but a fitness center, a teaching kitchen serving persons with diabetes and other clients, and weekly distribution of fresh fruits and vegetables. Eleventh Street Family Health Services has led to significant improvements in basic care and health outcomes for the population it serves by improving access to care for the underserved and uninsured in the community. During 2006, there were 7,837 primary care visits—a 19 percent increase from 2005—which resulted in improved diabetes management, improved control of hypertension, increased adult immunization rates, and increased rates of breast cancer screening.⁵⁸

Healthy lifestyle education has been widely recognized as one key to a healthier society and decreased healthcare costs. Most large employers are adding health and wellness promotion programs to support their employees and their families as they strive to get and stay healthy. Beyond the 83 percent of employers nationally that now offer health risk assessments, best performers are increasingly providing direct financial incentives to their employees to participate in health risk reduction activities.⁵⁹ The San Antonio-based financial services corporation USAA, winner of the 2006 C. Everett Coop National Health Award, offers its 22,000 U.S. employees a “Take Care of Your Health” program, which includes onsite health clinics, fitness centers and personal trainers, healthy options in vending machines, and smoking cessation and weight loss programs. In 2005, nearly 70 percent of USAA's employees participated in at least one of these programs. Together, these programs have reduced workplace absences and are estimated to have saved the organization more than \$105 million over a three-year period.⁶⁰

POPULATION HEALTH:

HOW WILL WE GET THERE?

The Partners will work together to ensure that:

Goal: All Americans will receive the most effective preventive services recommended by the U.S. Preventive Services Task Force.

To get there, we will develop a composite measure of preventive services that can assess the extent to which each individual in the population and the population as a whole receive all of the most effective preventive services based on a prioritized list of recommendations of the U.S. Preventive Services Task Force.⁶¹ We will develop an educational campaign for the general public and for healthcare professionals, and tools to collect data and improve the measure in clinical practices and populations across the country. We will develop support for individuals and clinical practices to improve the use of these important clinical preventive services. We will develop and implement benefit designs, payment methods for healthcare organizations, and incentives for consumers that encourage the use of these effective preventive services.

Goal: All Americans will adopt the most important healthy lifestyle behaviors known to promote health.

To get there, we will develop a composite measure of interventions known to be effective in helping individuals adopt healthy behaviors and a composite measure that can assess the extent to which each individual in the population and the population as a whole adopt all of the most important healthy behaviors. We will develop a method for determining the most important healthy behaviors and the interventions known to be effective in improving them. We will develop an educational campaign for the general public and for healthcare professionals, tools to collect and improve the measures in clinical practices and populations across the country, and support for individuals and clinical practices to improve the use of these important interventions known to improve healthy behaviors. We will develop and implement benefit designs, payment methods for healthcare organizations, and incentives for consumers that encourage the adoption of these healthy behaviors.

Goal: The health of American communities will be improved according to a national index of health.

To get there, we will develop a national health index that addresses not only the contribution of healthcare to good health, but also the health behaviors of individuals and the socioeconomic and physical environment factors that affect health. We will calculate and report the index for all counties in the United States, and will provide training in and knowledge of the interventions that are known to be effective in improving health to all stakeholders. We will support the efforts of stakeholders to demonstrate annual improvement in health in their communities and in particular for disadvantaged populations. We will promote coordination and cooperation between public and private health entities in working toward the achievement of this significant and challenging improvement in the health of the population.

NATIONAL PRIORITY: SAFETY

Improve the safety and reliability of America's healthcare system

OUR VISION: We envision a healthcare system that is relentless in continually reducing the risks of injury from care, aiming for “zero” harm wherever and whenever possible—a system that can promise absolutely reliable care, guaranteeing that every patient, every time, receives the benefits of care based solidly in science. We envision healthcare leaders and healthcare professionals intolerant of defects or errors in care and who constantly seek to improve, regardless of their current levels of safety and reliability.

Why is Safety a National Priority?

Patients should have the utmost confidence they will not be harmed in the places where they go for care. Still, each year more people die as a result of avoidable medical errors than they do from car accidents, breast cancer, or AIDS.⁶² Although the odds of dying in a hospital certainly hinge on the severity of a patient's condition, they also simply depend on the hospital in which that patient receives care.⁶³ Quality and safety vary from healthcare organization to organization, yet few of us have performance information we can use to

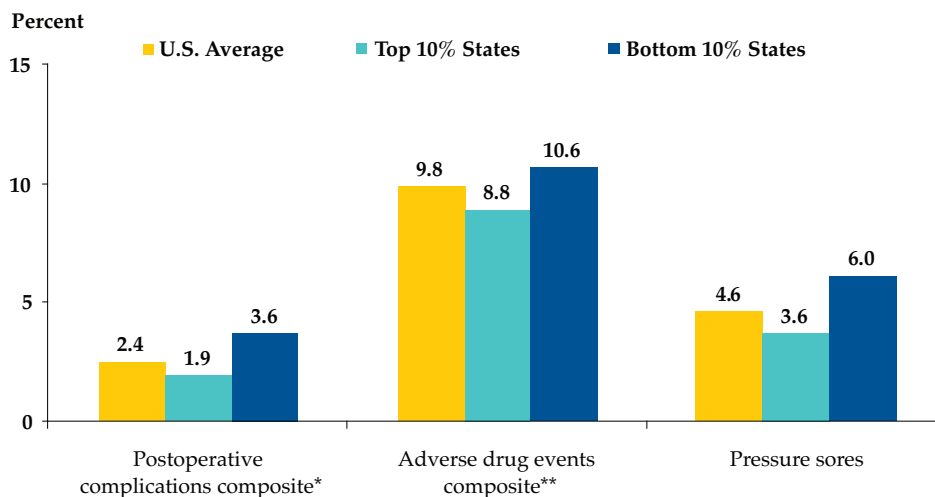
choose a healthcare organization; others have limited choices due to place of residence, health plan provider networks, and ability to pay.

The good news is that there is evidence that certain practices can help prevent many of these errors—some hospitals have reduced the incidence of harms, such as wrong-site surgeries and bloodstream infections to “zero” for sustained periods of time⁶⁴—the bad news is that there is still a significant performance gap between what the vast majority of healthcare organizations are doing and the demonstrated good works of high

Chart 3

QUALITY: SAFE CARE

Potentially Preventable Adverse Events and Complications of Care in Hospitals Among Medicare Beneficiaries, 2004–2005



* Surgical patients with postoperative pneumonia, urinary tract infection (2005 only), or venous thromboembolic event.

** Patients with serious bleeding associated with intravenous heparin, low molecular weight heparin, or warfarin, or hypoglycemia associated with insulin or oral hypoglycemics.

Data: M. Pineau, Qualidigm analysis of Medicare Patient Safety Monitoring System.

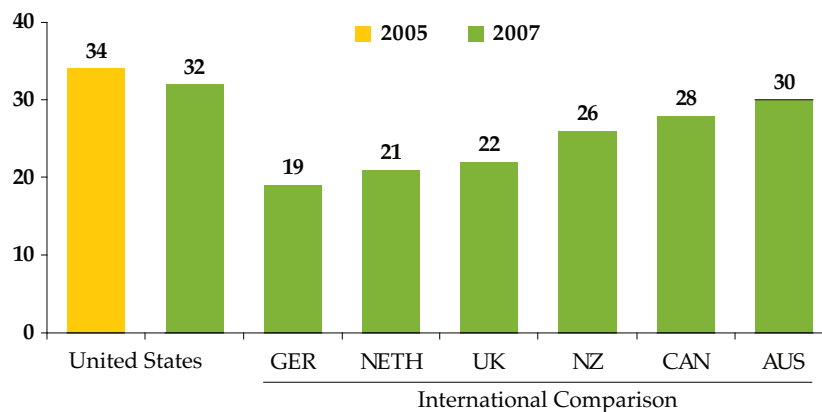
Source: Commonwealth Fund National Scorecard on U.S. Health System Performance, 2008.

Chart 4

QUALITY: SAFE CARE

Medical, Medication, and Lab Errors, Among Sicker Adults

Percent reporting medical mistake, medication error, or lab error in past two years



AUS=Australia; CAN=Canada; GER=Germany; NETH=Netherlands; NZ=New Zealand; UK=United Kingdom.
Data: 2005 and 2007 Commonwealth Fund International Health Policy Survey.

Source: Commonwealth Fund National Scorecard on U.S. Health System Performance, 2008.

performers.⁶⁵ This performance gap is evident when comparing preventable adverse event rates in top-performing states to those in low-performing states (see Chart 3).⁶⁶ Safety has long been a focus of quality improvement in the United States, and many initiatives have been successful in improving the safety of our healthcare system. Still, we have not seen the degree of success that is possible, in large part because the routine use of evidence-based practices that can improve safety has not been as widespread as it should be. For example, studies have long shown that shaving surgical sites prior to surgery actually increases the risk of infection,⁶⁷ but many surgeons still have not adopted clipping as a preferred method of hair removal; the percentage of patients receiving appropriate hair removal continues to increase steadily, but it is still less than 100 percent.⁶⁸ National data suggest that although our healthcare expenditures are growing at more than 7 percent per year, patient safety is improving at only 1 percent per year.⁶⁹

Critical to improving safety is the establishment of a culture that supports the reporting of situations

that threaten, or potentially threaten, the safety of patients or caregivers and that views the occurrence of errors and adverse events as opportunities to make the healthcare system better. Although the primary concern of this Priority relates to safety events resulting in harm, all learning organizations must also focus on opportunities to learn from experiences that have the potential to cause harm, even though they may not directly result in harm (e.g., “near misses”). Although we may never be able to claim that no patient ever suffers a preventable infection or harm, or a preventable or premature death, to aim for anything short of this is unacceptable.

Making Safety a National Priority Will:

REDUCE HARM. Approximately 1.7 million healthcare-associated infections (HAIs) occur annually in U.S. hospitals and are responsible for nearly 99,000 deaths;⁷⁰ patients who survive them frequently have longer and more expensive hospital stays and longer recovery times.⁷¹ Beyond HAIs, an estimated 44,000 to 98,000 Americans die each year as a result of preventable medical errors.⁷² Compared

to other developed countries, American patients experience more medical mistakes, medication errors, and laboratory errors (see Chart 4).⁷³ But known interventions can make a difference.

Evidence suggests that use of computerized physician order entry and perioperative antibiotic protocols may result in up to an 81 percent reduction in medication errors and a 93 percent reduction in surgical site infections, respectively.⁷⁴

REDUCE DISPARITIES.

Racial, ethnic, and socioeconomic minorities still do not receive equal care, and they face higher rates of disease, disability, and mortality resulting in part from a greater likelihood of suffering from avoidable errors that occur in the delivery of healthcare.⁷⁵ For example, African Americans have higher rates for postoperative surgical and central venous catheter complications and are more likely to have adverse drug events associated with insulin or oral hypoglycemics; Hispanics and Asians have lower rates of appropriately timed antibiotics.⁷⁶ It has also been demonstrated that the hospitals that care for the vast majority of elderly African American and Hispanic patients often provide a lower quality of care.⁷⁷ Additional quality issues may arise because

of bias, racism, or intercultural communication difficulties, which may be reflected in greater disparities more in communication-sensitive areas, such as patient counseling.⁷⁸

More than 70 percent of adverse events may result in disability lasting up to six months, and more than 15 percent of serious adverse events may lead to permanent disability or death.

REDUCE DISEASE

BURDEN. More than 70 percent of adverse events may result in disability lasting up to six months, and more than 15 percent of serious adverse events may lead to permanent disability or death.⁷⁹ Ventilator-associated pneumonias (VAPs), which in many cases are preventable, result in an estimated additional length of stay of nearly 2 weeks and

an additional cost of \$40,000 to a hospital admission.⁸⁰ The use of a VAP bundle protocol may decrease VAP by 62 percent.⁸¹

REDUCE WASTE. Beyond the toll of human life, preventable errors have been estimated to cost the United States \$17 billion to \$29 billion per year in healthcare expenses, lost worker productivity, lost income, and disability.⁸² Preventable errors have opportunity costs as well—healthcare dollars spent to counter adverse drug events or to treat complications is money that is not available for other interventions.

For certain heart attack patients, rapid treatment with angioplasty can be lifesaving, but timing is essential. Studies indicate that faster door-to-balloon (D2B) times (the time between a patient's arrival at the hospital to the deployment of the balloon or device) are associated with meaningful differences in survival. Each 15-minute decrease in D2B time from 150 minutes to less than 90 minutes, results in approximately six fewer deaths per 1,000 patients treated. Strategies to reduce D2B times are not only available, but have been successfully implemented by hospitals across the country and are one example of how preventable mortality can be reduced in hospitals.⁸³

Since October 2008, the Centers for Medicare & Medicaid Services will no longer pay for the costs associated with several preventable serious adverse events, such as falls and trauma and foreign objects retained after surgery.⁸⁴ Many other payers have been quick to follow suit, including state Medicaid agencies and private payers. Hospital groups in nearly half of U.S. states have now developed policies to discourage hospitals from billing for such events, indicating a decreasing tolerance for preventable harms.⁸⁵

The World Health Organization has identified safe surgery as its second global patient safety challenge, intended to improve the safety of surgical care worldwide. Working groups of international experts reached consensus on four areas in which dramatic improvements could be made in the safety of surgical care: surgical site infection prevention, safe anesthesia, safe surgical teams, and measurement of surgical services. Resources, including a surgical safety checklist, are available to the public. To date, 284 worldwide organizations have endorsed this campaign.⁸⁶

Consumers Union has launched a nationwide campaign, *Stop Hospital Infections*, that encourages consumers to lobby their congressional representatives to mandate the public reporting of infection rates, reflecting the widely held perception that there is a correlation between public awareness and overall health and performance.⁸⁷

A project conducted over 2 years in more than 100 hospitals in Michigan demonstrates that implementing evidence-based practices can lead to impressive results. Participating hospitals implemented a bundle of five practices aimed at decreasing catheter-related bloodstream infections, including hand washing; full barrier protection; skin cleansing with chlorhexidine; placement of catheters in the chest or neck rather than in the groin; and the removal of unnecessary catheters as soon as possible. The results: The average infection rate fell from 7.7 per 1,000 catheter days to 1.4 per 1,000 catheter days after 18 months, and more than half of the hospitals reported that they had no infections after implementing the program.⁸⁸ This project is estimated to have saved the state of Michigan more than \$100 million and 1,500 lives over an 18-month period by simply teaching doctors and nurses to use checklists. Importantly, no new staff was added to perform the interventions, and the work can be generalized to other hospitals regardless of size or type.⁸⁹

SAFETY:

HOW WILL WE GET THERE?

The Partners will work together to ensure that:

Goal: All healthcare organizations and their staff will strive to ensure a culture of safety while driving to lower the incidence of healthcare-induced harm, disability, or death toward zero. They will focus relentlessly on continually reducing and seeking to eliminate all healthcare-associated infections and serious adverse events.

HAI include but are not limited to:

- ↑ Catheter-associated bloodstream infections
- ↑ Catheter-associated urinary tract infections
- ↑ Surgical site infections
- ↑ Ventilator-associated pneumonia

(See CDC's *Infectious Diseases in Healthcare Settings* at www.cdc.gov/ncidod/dhqp/id.htm for a more inclusive list.)

Serious adverse events include but are not limited to:

- ↑ Pressure ulcers
- ↑ Wrong-site surgeries
- ↑ Falls
- ↑ Air embolisms
- ↑ Blood product injuries
- ↑ Foreign objects retained after surgery
- ↑ Adverse drug events associated with high alert medications

(See NQF's *Serious Reportable Events* at www.qualityforum.org/projects/completed/sre/fact-sheet.asp for a more inclusive list.)

To get there, we will develop and endorse standardized individual and composite measures for HAIs and serious adverse events that build on current datasets. We will develop effective reporting mechanisms and broadly disseminate information to increase consumer understanding of the importance of these measures and how they can be used to choose healthcare organizations. We will increase support for training about interventions known to be effective in reducing harm. We will change private and public payment policies and contracting to support healthcare systems with better performance in safety and reliability.

Goal: All hospitals will reduce preventable and premature hospital-level mortality rates to best-in-class.*

To get there, we will promote consistency and transparency in performance by first encouraging hospitals to choose a standardized, risk-adjusted mortality measure for the purposes of internal quality improvement; based on this experience, we will endorse and universally adopt a single standardized measure that will be used for public reporting. We will provide training and knowledge of interventions known to be effective in reducing mortality. We will develop payment mechanisms that reward substantial improvement and outstanding performance.

Goal: All hospitals and their community partners will improve 30-day mortality rates following hospitalization for select conditions (acute myocardial infarction, heart failure, pneumonia) to best-in-class.

To get there, all hospitals and their community partners will collect standardized, risk-adjusted mortality rates and 30-day mortality rates. Mortality rates will be used for the purposes of internal quality improvement and for public reporting. We will provide training in and knowledge of interventions known to be effective in reducing mortality. We will develop payment mechanisms that reward substantial improvement and outstanding performance.

* "Best-in-class" may be determined by using an accepted methodology, such as *Achievable Benchmarks in Care (ABC)*TM, available at <http://main.uab.edu/show.asp?durki=14527>.

NATIONAL PRIORITY: CARE COORDINATION

Ensure patients receive well-coordinated care within and across all healthcare organizations, settings, and levels of care

OUR VISION: We envision a healthcare system that guides patients and families through their healthcare experience, while respecting patient choice, offering physical and psychological supports, and encouraging strong relationships between patients and the healthcare professionals accountable for their care.

Why is Care Coordination a National Priority?

In 2000, 125 million people in the United States were living with at least one chronic illness, a number that is expected to grow to 157 million by 2020; the number of individuals with multiple chronic conditions is expected to reach 81 million by 2020.⁹⁰ Patients with multiple chronic conditions often receive care from numerous healthcare organizations in multiple care settings, and may see up to 16 physicians annually.⁹¹ As these patients attempt to navigate our complex healthcare system and transition from one care setting to another, they are often unprepared or unable to manage their care. Incomplete or inaccurate transfer of information, poor communication, and a lack of appropriate follow-up care lead to confusion and poor outcomes, including medication errors and preventable hospital readmissions and emergency department visits.

Care coordination is an important aspect of healthcare that helps ensure that patients'

needs and preferences for services are understood and that they are shared as patients move from one healthcare setting to another or to home, as care is transferred from one healthcare organization to another or as care is shared between a primary care professional and specialists. Care must be well coordinated to avoid waste, conflicting plans of care, and over-, under-, or misuse of prescribed medications, tests, and therapies.⁹²

The coordination of care involves making fundamental changes to the current healthcare delivery and payment systems. To address the challenges involved, tools and practices are available to help healthcare professionals improve care coordination for their patients. Medication reconciliation practices, for example, can have a positive impact on outcomes by reducing medication errors and adverse drug events; some have demonstrated reductions in medication errors by 70 percent and reductions in adverse drug events by more than 15 percent.⁹³ Still, compared with other industrialized countries, the United States ranks last in simply reviewing medications with patients prior to discharge (see Chart 5).⁹⁴

Having consistent access to the same healthcare professional over time is an essential element for

care coordination and may be the most important factor in obtaining optimal preventive care.⁹⁵ Having a regular source of care is also associated with better health outcomes and lower total costs.⁹⁶ Both the cost of care and the

Patients with multiple chronic conditions often receive care from numerous healthcare organizations in multiple care settings, and may see up to 16 physicians annually.

potential for medical errors are greater when patients receive care from many healthcare professionals and do not have an identified and accountable primary source of care.⁹⁷ Primary care practices that offer easy access to care, a long-term, personal relationship with the primary care professional, integrated and comprehensive team care, and the coordination of specialty care and referrals may have the greatest potential to provide the level of care coordination that all Americans

deserve, but that patients with multiple complex health issues so desperately need.⁹⁸

Transition programs geared toward patients with chronic illness that include ongoing plans directed by advance practice registered nurses to address discharge planning and home follow-up can decrease hospital readmissions, increase the length of time between discharge and readmission,

increase patient and family satisfaction, decrease caregiver burden, and decrease healthcare costs.⁹⁹

Hospitals can use tools such as the Care Transition Measure (CTM-3), a survey that includes three simple questions to assess the hospital's performance

in honoring patient preferences, helping patients to understand how to manage their health, and helping patients to understand the purpose of taking their medications.¹⁰⁰

Nearly 18 percent of Medicare patients are readmitted to the hospital within 30 days, and 75 percent of those 30-day readmissions were identified as potentially preventable.

Making Care Coordination a National Priority Will:

REDUCE HARM. Nearly one in five patients discharged from the hospital to home experience an adverse event within three weeks, and two-thirds of them are due to adverse drug events.¹⁰¹ Annually, more than 700,000 patients were treated for adverse drug events in U.S. emergency departments in 2004

and 2005, and 1 of every 6 required admission, transfer to another facility, or an emergency department observation admission.¹⁰²

REDUCE DISPARITIES.

There are significant variations in the rates of hospitalizations by ethnicity and patient

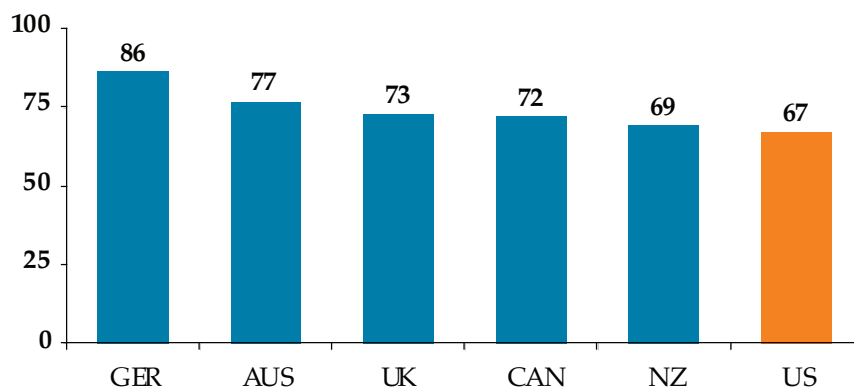
income, with nonwhite patients and patients in lower-income areas admitted much more frequently.¹⁰³ Improvement in primary healthcare services is considered one of the most promising ways to reduce avoidable hospitalizations and

Chart 5

QUALITY: COORDINATED CARE

Medications Reviewed When Discharged from the Hospital, Among Sicker Adults, 2005

Percent of hospitalized patients with new prescription who reported prior medications were reviewed at discharge



AUS = Australia; CAN = Canada; GER = Germany; NZ = New Zealand; UK = United Kingdom; US = United States.

Data: 2005 Commonwealth Fund International Health Policy Survey.

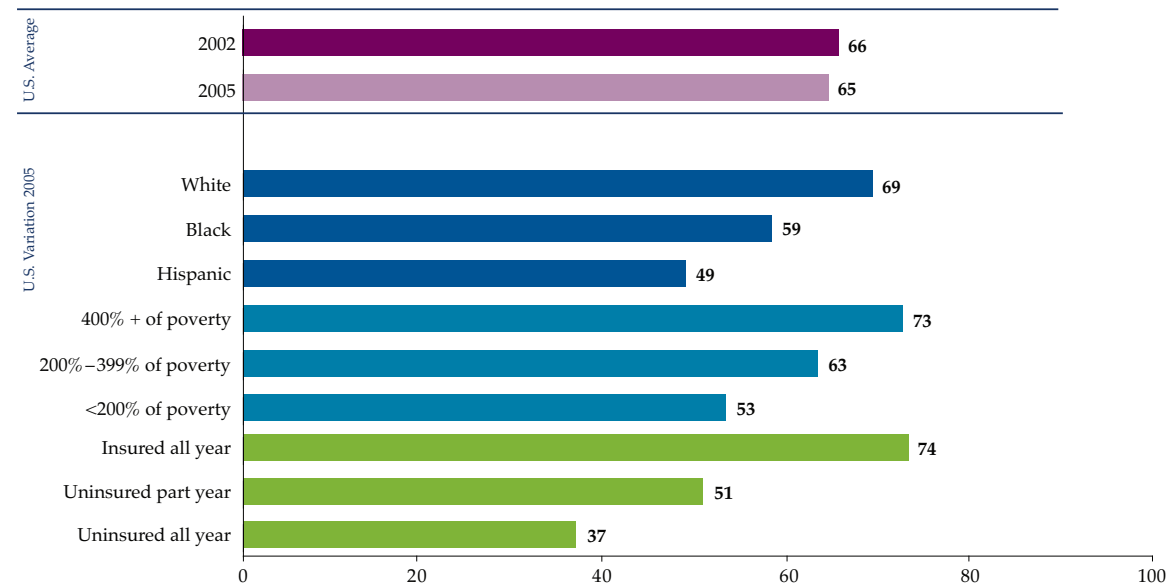
Source: Commonwealth Fund National Scorecard on U.S. Health System Performance, 2008.

Chart 6

QUALITY: COORDINATED CARE

Adults with an Accessible Primary Care Provider

Percent of adults ages 19–64 with an accessible primary care provider*



* An accessible primary care provider is defined as a usual source of care who provides preventive care, care for new and ongoing health problems, referrals, and who is easy to get to.

Data: B. Mahato, Columbia University analysis of Medical Expenditure Panel Survey.

Source: Commonwealth Fund National Scorecard on U.S. Health System Performance, 2008.

emergency department visits; however, access to primary care organizations also remains variable depending on race, income, and insurance (see Chart 6).¹⁰⁴

REDUCE DISEASE BURDEN. Nearly 18 percent of Medicare patients are readmitted to the hospital within 30 days, and 75 percent of those 30-day readmissions were identified as potentially preventable.¹⁰⁵ Nearly 20 percent of patients admitted to the hospital with a preventable admission had at least one preventable readmission within six months,¹⁰⁶ and emerging evidence suggests that many patients are not receiving timely follow-up with their primary

source of care after being discharged from the hospital.¹⁰⁷ Despite the high cost of healthcare, the United States consistently ranks behind other industrialized countries in the frequency of emergency department use for conditions that could have been treated with appropriate primary care.¹⁰⁸

REDUCE WASTE. The cost to Medicare of preventable hospital readmissions that occur within 30 days of discharge is estimated to be upwards of \$15 billion.¹⁰⁹ For those 20 percent that have another preventable admission within six months, the costs skyrocket to \$729 million, or \$7,400 per readmission.¹¹⁰

The Transitional Care Model (TCM), led by master's-prepared advanced practice nurses (APNs) in conjunction with the patient's entire healthcare team, targets patients at increased risk for poor postdischarge outcomes and focuses on transitional care. TCM assures that APNs establish a relationship with patients and their families soon after hospital admission; design the discharge plan in collaboration with the patient, the patient's physician, and family members; and implement the plan in the patient's home following discharge, substituting for traditional skilled nursing follow-up. TCM reduces the incidence of poor communication among healthcare professionals and healthcare agencies, inadequate patient and caregiver education, and poor quality of care, and enhances access to quality care. Findings from three clinical trials consistently demonstrate that the APN TCM improves quality of care and substantially decreases healthcare costs. Compared to standard care there are longer intervals before initial rehospitalizations, fewer rehospitalizations overall, shorter hospital stays, and better patient satisfaction. Following a four-year trial with a group of elderly patients hospitalized with heart failure, the APN TCM cut hospitalization costs by more than \$500,000, compared with a group receiving standard care, of an average savings of approximately \$5,000 per Medicare patient.¹¹¹ Ongoing National Institutes of Health (NIH)-funded studies are examining the impact of TCM among older adults with cognitive impairment and setting the stage for its application between the acute and long-term care.

Changes in emergency department utilization patterns prompted researchers from the NYU Center for Health and Public Service Research and the United Hospital Fund of New York to develop an algorithm to analyze administrative data. Using the algorithm, patients are assigned into one of four categories:

- ✦ nonemergent;
- ✦ emergent/primary care treatable;
- ✦ emergent/emergency department care required but preventable/avoidable; and
- ✦ emergent/emergency department care required, not preventable/avoidable.

The implementation of this classification system showed extremely high rates of emergency department use for nonemergent care and for care that could otherwise be provided in a primary care setting. Such information can be helpful in predicting patients at greatest risk of hospitalization and tailoring interventions to meet the needs of particularly vulnerable populations.¹¹²

Two community hospitals in Southern California, Sharp Chula Vista Medical Center and Sharp Mary Birch Hospital for Women, implemented a culturally sensitive medication reconciliation program for residents of their community. Under the supervision of a staff pharmacist, pharmacy technicians bilingual in English and Spanish were trained to obtain comprehensive medication histories within 24 hours of a patient's admission into the hospital using a specially designed medication history form for this population. As a result of this intervention, medication errors on admission, mostly involving drugs that were omitted, were reduced.¹¹³

Care Coordination: Examples of Actions

The Santa Cruz County Health Services Agency's *Project Connect* was developed to specifically target frequent users of the county's two emergency departments. Enrolled patients receive community-based health and related services via case management along with chronic disease management, preventive care, and access to social services. In early 2006, *Project Connect* tracked changes in emergency department utilization of 78 adults who were referred by one or both of the hospitals and who in the year prior to enrollment were responsible for a total of 785 emergency department visits. In the 12 months following enrollment in the project, they recorded a 51 percent reduction in emergency department visits for the group, along with a decrease in the number of hospital inpatient days and ambulance transports by 50 percent and 47 percent, respectively. They also estimated a cost avoidance of \$803,946 as a result of the reductions in emergency department visits, hospital inpatient days, and ambulance transports.¹¹⁴

An evaluation of one care coordination model utilizing a disease management program (DMP) for patients receiving mechanical ventilation was conducted at University Hospitals of Cleveland. The objective of the DMP was to reduce hospital readmissions of chronically critically ill patients requiring mechanical ventilation. Prior to patient discharge, an advanced practice nurse met with the patient and family to engage them in the development of the discharge plan. The discharge summary included the plan of care, the patient's goals, the existence of advance directives, and the assessment of family support and coping skills. At discharge, the summary was provided to all relevant out-of-hospital healthcare organizations and professionals (e.g., extended care facility or home care staff, family physician, or consulting specialist). Patients who received the services had significantly fewer days of rehospitalization (11.4 days compared to 16.7 days for the control group). Total costs savings were approximately \$480,000.¹¹⁵

CARE COORDINATION:

HOW WILL WE GET THERE?

The Partners will work together to ensure that:

Goal: Healthcare organizations and their staff will continually strive to improve care by soliciting and carefully considering feedback from all patients (and their families, when appropriate) regarding coordination of their care during transitions.

To get there, all healthcare organizations and their staff will gather input regarding coordination of care using a valid and reliable tool (e.g., the CTM-3) for all discharged patients.

Goal: Medication information will be clearly communicated to patients, family members, and the next healthcare professional and/or organization of care, and medications will be reconfirmed each time a patient experiences a transition in care.

To get there, an active process that fully engages the patient will be implemented by all healthcare organizations and their staff. This will include documentation by the healthcare professional(s) of analysis of the medication list; resolution of any discrepancies; and a monitoring component of high-risk drugs and relevant laboratory tests.

Goal: All healthcare organizations and their staff will work collaboratively with patients to reduce 30-day readmission rates.

To get there, all healthcare organizations and their staff will implement evidence-based models, such as the TCM,¹¹⁶ beginning with patients diagnosed with heart failure, acute myocardial infarction, and pneumonia. This will include a process for discharge planning, a focus on self-care, and plans for a postdischarge visit with the healthcare professional.

Goal: All healthcare organizations and their staff will work collaboratively with patients to reduce preventable emergency department visits.

To get there, the patient's plan of care will be jointly created and managed by the patient/family and the healthcare professional(s) and coordinated by the patient's primary source of care. Both the patient's current and longstanding needs will be assessed; goals will reflect those needs in a culturally appropriate manner, consistent with the abilities and desires of the patient; medications will be actively reconciled; and patients will be educated as to appropriate rationales for emergency department visits.

NATIONAL PRIORITY: PALLIATIVE AND END-OF-LIFE CARE

Guarantee appropriate and compassionate care for patients with life-limiting illnesses

OUR VISION: We envision healthcare capable of promising dignity, comfort, companionship, and spiritual support to patients and families facing advanced illness or dying, fully in synchrony with all of the resources that community, friends, and family can bring to bear at the end of life.

Why is Palliative and End-of-Life Care a National Priority?

Patients who are diagnosed with life-limiting illnesses and those facing the end of their lives deserve high-quality and compassionate care that addresses all of their needs. During this time, patients need support and assistance to prevent and treat pain, ensure continuity of care, make informed decisions, and meet their own spiritual needs.¹¹⁷ Instead, many patients and families struggle to manage pain and other symptoms, coordinate care among many different healthcare organizations in many different settings, and ensure that treatments reflect the patient's personal preferences. Far too often, patients at the end of their lives spend their final days in hospitals full of unfamiliar faces instead of in their homes surrounded by loved ones. Caregivers and family members face many hardships and need specialized support to overcome emotional and financial challenges.¹¹⁸

Currently, more than 1 million Americans die each year of chronic and debilitating illnesses without receiving hospice services.

Palliative and hospice care programs give patients and family members the opportunity to help develop and guide care programs in a manner that is most comfortable for them and that meets their physical, social, and spiritual needs. Hospital-based palliative care teams can have a major impact on how end-of-life care is managed in hospital systems by clearly identifying transitions

from aggressive and curative plans of care to palliative plans, by clarifying resuscitation status, by discussing benefits and harms of treatment options, and by ensuring that their patients' informed choices are well articulated.¹¹⁹ Multidisciplinary palliative teams in the inpatient setting also frequently recognize problems that otherwise can go unmet by other inpatient staff. Such team consultations have been associated with lower utilization of expensive intensive care units, lower likelihood of dying in an intensive care unit, and overall lower costs of care. Evidence suggests

that patients enrolled in palliative care programs are more satisfied with their care and have fewer emergency room visits, fewer hospital and nursing facility days, and fewer physician visits than those in a comparison group.

Enrolled patients in one study averaged a 45 percent decrease in costs as compared to usual care patients.¹²⁰

Making Palliative and End-of-Life Care a National Priority Will:

REDUCE HARM. Pain is one of the most debilitating and feared symptoms that patients with life-limiting illness face, and many cancer patients have reported under-treatment and inequitable access to pain treatment. Suffering at the end of life can be prevented or alleviated for many patients through palliative care and an emphasis on effective pain management.¹²¹ Other symptoms, such as shortness of breath and

depression, can also be managed through effective clinical support to prevent unnecessary distress. Regular assessment of symptoms combined with skilled clinical care and supportive resources can reduce these types of suffering.

Although the use of hospice and palliative care services has increased in recent years, these services are still underutilized, and many patients who could benefit from these services are never referred at all, or are referred too late for the services to truly help. Currently, more than 1 million Americans die each year of chronic and debilitating illnesses without receiving hospice services.¹²²

REDUCE DISPARITIES. In a 2008 study, less than 50 percent of U.S. hospitals had palliative consultation teams, limiting access to care for many who could greatly benefit.¹²³ In 2000, the vast majority of patients receiving hospice services were white (82 percent), 8 percent were identified as African American, and 8 percent were Hispanic, indicating a clear disparity in the provision of end-of-life care. Cultural, language, and religious differences may present barriers to appropriate referrals to palliative or hospice care, and difficult subjects regarding death and dying may not be adequately discussed.¹²⁴

REDUCE DISEASE BURDEN. On top of the losses experienced by their loved ones facing life-limiting illnesses or death, families and caregivers

are confronted with emotional, physical, and economic challenges and need support to cope with added responsibilities. Caregivers can experience significant physical and psychological stress, contributing to a decline in their own health and in some cases even death. Palliative care, with its holistic focus, has the potential to reduce this burden on family members and caregivers.¹²⁵

REDUCE WASTE. Approximately 25 percent of Medicare's expenses are paid for patients in their last year of life, and these expenses will continue to rise as we face an aging population.¹²⁶ Some of these expenses are for procedures that will ultimately have only marginal if any benefit to the patient in terms of increased quality of life or productivity. These costs have fueled studies to determine how to improve the efficiency and effectiveness of end of life care.

Approximately 25 percent of Medicare's expenses are paid for patients in their last year of life, and these expenses will continue to rise as we face an aging population.

Palliative care consultation teams have been associated with significant hospital savings. Patients receiving palliative care in the hospital who were discharged alive saw a net savings of nearly \$1,700 in direct costs per admission and nearly \$300 in direct costs per day. They also

recognized significant reductions in laboratory and intensive care costs compared with patients receiving usual care. When palliative care patients die in the hospital, the savings are nearly \$5,000 in direct costs per admission, and nearly \$400 in direct costs per day including significant reductions in pharmacy, laboratory, and intensive care unit costs.¹²⁷

Palliative and End-of-Life Care: Examples of Actions

The American Board of Internal Medicine recently launched a certification program in Hospice and Palliative Medicine through collaboration with 10 specialty areas and is incorporating palliative care into core competencies for Maintenance of Certification for specialists. Core competencies include issues such as clinical care, interpersonal and communication skills, and practice-based learning.¹²⁸ The American College of Physicians has developed guidelines specifically aimed at improving care at the end of life, which include regular assessment of and the use of proven therapies to manage pain, shortness of breath, and depression. These actions will supply an increased number of healthcare professionals trained and qualified to provide hospice and palliative care services to patients.¹²⁹

After realizing that 50 percent of Kaiser Permanente TriCentral patients with heart failure, chronic obstructive pulmonary disease, and cancer were dying in hospital care units, Kaiser created a palliative care program to address the needs of those patients and to facilitate the patient's choice to die at home instead of in an inpatient setting. The program emphasizes evidence-based medicine and has developed protocols and guidelines to ensure consistent care for all of their patients, including home visits by all team members, ongoing care management, telephone support, and advance care planning that empowers patients and their families to make informed decisions. Their model has been shared with more than 200 healthcare teams and agencies throughout the United States.¹³⁰

The National Hospice and Palliative Care Organization has created a consumer-focused website—*Caring Connections*—that offers extensive resources for patients and caregivers coping with end-of-life issues. Resources include free information on healthcare decisionmaking, living with an illness, caring for the caregiver, finding local services, and more.¹³¹

Delaware Hospice's nationally recognized *New Hope* program provides counselors to assist children and adolescents in coping with the emotions associated with the loss of a loved one. Counselors listen, empathize, acknowledge feelings, and provide comforting support through one-on-one counseling, group support, workshops, therapeutic activities, ongoing communications, and a four-day summer camp where the children get to know peers who are facing similar hardships. *Camp New Hope* was created to provide an environment for children and adolescents to come together with others who have experienced a similar loss so that they know they are not alone.¹³²

The American Association of Colleges of Nursing, the national voice for America's baccalaureate- and higher-degree nursing education programs, administers an end-of-life care educational project in concert with the City of Hope, Los Angeles, California. The End-of-Life Nursing Education Consortium project provides undergraduate and graduate nursing faculty, continuing education providers, staff development educators, specialty nurses in pediatrics, oncology, critical care, and geriatrics, and other nurses with training in end-of-life care so they can teach this essential information to nursing students and practicing nurses.¹³³

PALLIATIVE AND END-OF-LIFE CARE

HOW WILL WE GET THERE?

The Partners will work together to ensure that:

Goal: All patients with life-limiting illnesses will have access to effective treatment for relief of suffering from symptoms such as pain, shortness of breath, weight loss, weakness, nausea, serious bowel problems, delirium, and depression.

To get there, we will need a workforce with the skills, knowledge, and demonstrated performance to provide palliative care and hospice expertise across a broad range of specialties of medicine and other healthcare disciplines, especially nursing, social work, and chaplaincy. Specialty board certification beginning in 2008 will allow the recognition of medical experts in hospice and palliative care for 10 different physician specialties. Funding support will be needed for fellowship training in these areas, as well as for comparable programs in other disciplines. Adequate funding for clinical services will be needed to attract trainees to this discipline.

Goal: All patients with life-limiting illnesses and their families will have access to help with psychological, social, and spiritual needs.

To get there, we will need healthcare professionals able to recognize and respond to the psychological and spiritual needs of patients. We will provide ways to make accurate information available to patients and families and ways to enlist community support around families in need. Payment will need to be available beyond the current Medicare Hospice Benefit for patients who need this broader range of care, especially at home, but who do not qualify for the Medicare Benefit because of the stage of their illness, the unpredictability of their clinical trajectory, or the requirement for the use of selected treatment modalities not accepted in the Medicare Hospice Benefit.

Goal: All patients with life-limiting illnesses will receive effective communication from healthcare professionals about their options for treatment; realistic information about their prognosis; timely, clear, and honest answers to their questions; advance directives; and a commitment not to abandon them regardless of their choices over the course of their illness.

To get there, healthcare professionals will need to have the communication skills to elicit values and advance directives. Information will need to be meaningfully recorded and accessible to and respected by every clinical contact the patient might make (including emergency medical teams and emergency departments). Communities and healthcare organizations and their staff will need to be accepting of different cultural and religious choices.

Goal: All patients with life-limiting illnesses will receive high-quality palliative care and hospice services.

To get there, all communities and/or institutions will ensure that high-quality palliative and/or hospice care programs are available and that all patients eligible for such care and with access to such services will receive a timely referral. All healthcare professionals will need to understand the value of palliative and hospice care and the advantages of such care throughout many stages of illness, and communities will need to have an adequate number of certified hospice and palliative care specialists available.

NATIONAL PRIORITY: OVERUSE

Eliminate overuse while ensuring the delivery of appropriate care

OUR VISION: We envision healthcare that promotes better health and more affordable care by continually and safely reducing the burden of unscientific, inappropriate, and excessive care, including tests, drugs, procedures, visits, and hospital stays.

Why is Overuse a National Priority?

A significant amount of attention on healthcare focuses on the care that Americans do *not* receive, but there is growing evidence that a significant portion of the care we receive is actually redundant and unwarranted—and beyond that, in some cases, even harmful.

Since the problem of overuse was defined more than 10 years ago—as when “the potential for harm exceeds the possible benefits of care”—a growing body of evidence has emerged documenting its pervasiveness and consequences.¹³⁴ Perhaps the most compelling evidence of this problem lies in the work of researchers at Dartmouth Medical School, who for many years have studied variation in healthcare service delivery and its relation to quality and costs. Their studies have shown that there is significant variation in healthcare spending between regions of the United States, only 40 percent of which can be attributed to different rates of illness and price. The remaining variation can be explained in part by practice variations that have little or nothing to do with evidence-based medicine, but rather with the capacity to provide healthcare, such as the number of hospitals, physicians, and physician specialists. Areas with more specialists have more consultations and consequently provide more surgeries and procedures and have higher

expenditures, regardless of whether such care is warranted.¹³⁵

The Partners identified targeted areas of potential waste, building on a broad evidence base, including recent work by the New England Health Institute,¹³⁶ which compiled a comprehensive compendium of evidence of overuse, underuse, and misuse from 1998 to 2006 that emphasizes high-value opportunities for tackling this problem. The Partners solicited and received important feedback from a broad array of stakeholder groups, including specialty societies, nursing organizations, hospital associations, and health plans.¹³⁷

Areas with more specialists have more consultations and consequently provide more surgeries and procedures and have higher expenditures, regardless of whether such care is warranted.

The resulting list of nine targeted areas encompasses multiple Priorities, care settings, and target populations and builds on the momentum of growing public and media attention to the issue.

The idea that “more does not necessarily mean better” is starting to resonate outside of the quality community and is entering into broader public consciousness. In the past year, a best-selling book on the topic was read by millions,¹³⁸ and reputable news outlets and national consumer organizations, including the *New York Times*, *U.S. News & World Report*, the *Wall Street Journal*, AARP, and Consumers Union, all ran articles that have increased public awareness of this issue.¹³⁹

The time is right to tackle this area, particularly given the potential for savings amidst the dire financial situation of our healthcare system and the number of under- and uninsured. It is important to emphasize, however, that for all of the identified target areas, there are patients for whom these tests and procedures are absolutely appropriate and necessary. This goal is therefore not limited just to reducing overuse, but one that equally stresses the provision of appropriate care for each and every patient. Importantly, the other five Priorities explicitly focus on underuse and ensuring that safe, effective, and culturally sensitive care is delivered.

The idea that “more does not necessarily mean better” is starting to resonate outside of the quality community and is entering into broader public consciousness.

Americans.¹⁴⁰ Inappropriate use of antibiotics contributes to the emergence of antibiotic-resistant bacteria, making all of us more susceptible to infections and leaving us with fewer options to combat them.¹⁴¹ Such antibiotic use also puts

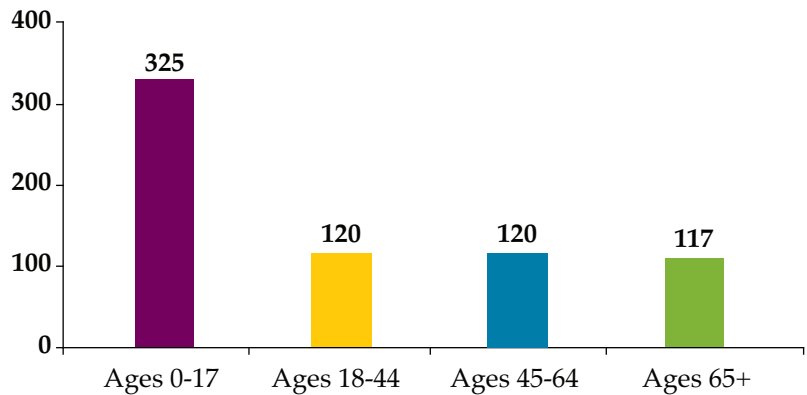
patients at unnecessary risk for adverse drug reactions, yet many patients, particularly children, are still inappropriately prescribed antibiotics for the common cold (see Chart 7).¹⁴² Unwarranted surgeries and procedures present opportunities for medical errors and serious adverse events, including surgical errors and infections, yet many women still receive unwarranted cesarean sections (c-sections)¹⁴³ and hysterectomies,¹⁴⁴ and patients with stable coronary disease receive coronary revascularization procedures when pharmacologic therapy may suffice.¹⁴⁵ Unnecessary testing exposes patients to additional risks as well—inappropriate imaging exposes patients unnecessarily to radiation, unwarranted endoscopies increase a patient’s risk of internal injuries, and unnecessary

Making Overuse a National Priority Will:

REDUCE HARM. The inappropriate use, misuse, or overuse of medical interventions poses many serious threats to our population. Beyond the negative impact of wasted resources that we can ill afford, the areas of inappropriate use identified may cause unnecessary harm to millions of

Chart 7

Rate that Antibiotics Were Prescribed at Outpatient Visits with Diagnosis of Common Cold (per 10,000 Population), by Age Group, 2001-2002



Data: National Ambulatory Medical Care Survey and National Hospital Ambulatory Medical Care Survey (Agency for Healthcare Research and Quality, 2006).

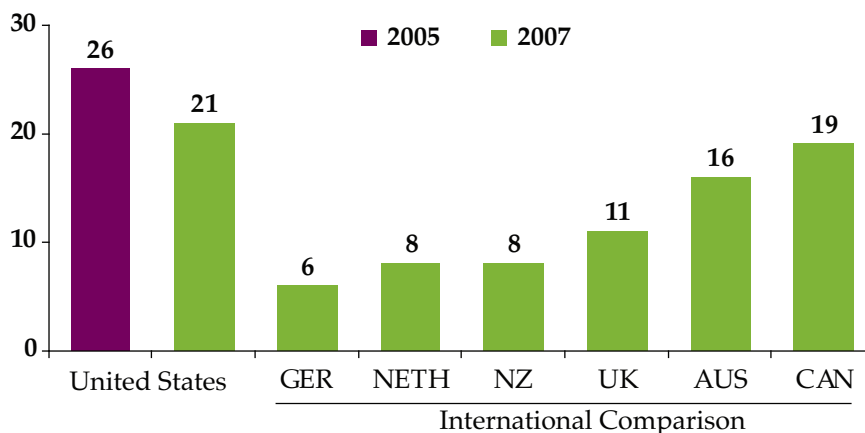
Source: McCarthy and Leatherman, *Performance Snapshots*, 2006. www.cmwf.org/snapshots.

Chart 8

EFFICIENCY

Went to Emergency Room for Condition That Could Have Been Treated by Regular Doctor, Among Sicker Adults

Percent of adults who went to emergency room in past two years for condition that could have been treated by regular doctor if available



AUS = Australia; CAN = Canada; GER = Germany; NETH = Netherlands; NZ = New Zealand; UK = United Kingdom.
Data: 2005 and 2007 Commonwealth Fund International Health Policy Survey.

Source: Commonwealth Fund National Scorecard on U.S. Health System Performance, 2008.

laboratory tests may induce more testing or exploratory procedures exposing patients to further potential harms.

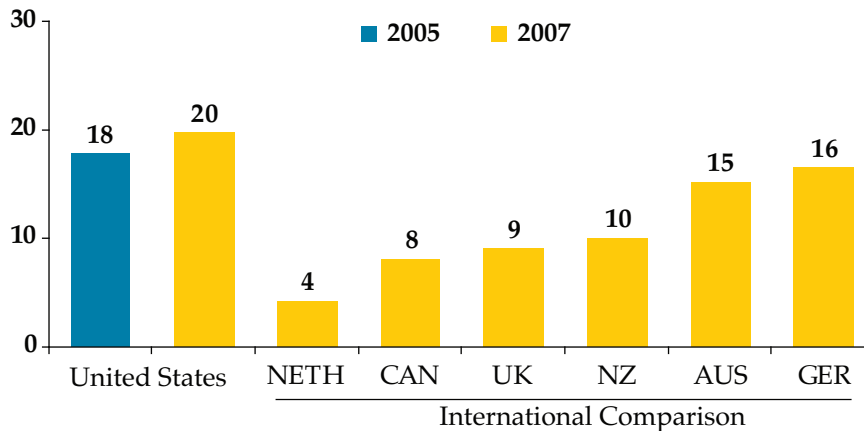
REDUCE DISPARITIES. Effectively addressing the burden of unnecessary care is one way to remedy the problem of disparities in how care is and is not provided. The discussion of healthcare disparities typically focuses around the lack of access to healthcare services and the lack of appropriate care; however, assuring access to appropriate healthcare services early on can also help to reduce more costly utilization downstream. Studies indicate that the overutilization of emergency departments and unnecessary hospitalizations, which have been associated with poor access to primary care, are more common in minority populations.¹⁴⁶ A study of neonates seen in an urban emergency room found that 60 percent of all emergency department visits were nonurgent and that patients of younger maternal age, patients with Medicaid, and patients of nonwhite race all had more frequent nonurgent emergency department use.¹⁴⁷ Separate research indicates, however, that 50 percent of hospitalizations for children who are admitted for any one of six

diagnoses, including asthma, dehydration, and skin infections, may be avoidable through better parent education and follow-up clinical care.¹⁴⁸ Minority populations may also suffer more from certain unnecessary procedures than nonminority patients. In a phone survey of women in seven different U.S. cities, the highest rates of hysterectomy were found in disadvantaged African American and Hispanic subgroups, which could not be explained by known risk factors.¹⁴⁹

REDUCE DISEASE BURDEN. The rising number of cesarean sections can have long-term unintended consequences for women and their offspring. For example, women who have c-sections are at increased risk for chronic pelvic pain or even bowel obstruction as a result of abdominal adhesions. Subsequent pregnancies following a c-section introduce dual risks for mother and child, including placenta previa, uterine rupture, low birth weight, preterm birth, stillbirth, and admissions to neonatal intensive care units. Babies that do not experience vaginal delivery may be at increased risk of respiratory problems such as allergies and asthma.¹⁵⁰

Duplicate Medical Tests, Among Sicker Adults

Percent reporting that doctor ordered test that had already been done in past two years



AUS = Australia; CAN = Canada; GER = Germany; NETH = Netherlands; NZ = New Zealand; UK = United Kingdom.
Data: 2005 and 2007 Commonwealth Fund International Health Policy Survey.

Source: Commonwealth Fund National Scorecard on U.S. Health System Performance, 2008.

On the other end of the spectrum, approximately 20 percent of patients are given chemotherapy in the last 14 days of life,¹⁵¹ at which point the disease has progressed to such an extent that the chemotherapy has essentially no chance of helping. Receiving chemotherapy at this point can be detrimental to incurable patients, who may still suffer the negative side effects of the medication and who may forego limited opportunities for spiritual growth, quality family time, and an easier transition to death.¹⁵²

REDUCE WASTE. Drawing on the Dartmouth research, individuals who live in “high-spending” areas receive approximately 60 percent more in services than those who live in “low-spending” areas, which is at least in part attributed to differences in the supply of healthcare providers in the area as well as practice variation. Furthermore,

and contrary to intuition, the low-spending regions perform as well or better on a range of quality indicators.¹⁵³ This “over spending” is substantial. In fact, one report indicates that Medicare spending would decrease by 29 percent if spending in medium- and high-spending regions reached the level of that in low-spending regions.¹⁵⁴ Evidence shows that Americans are more likely to be seen in an emergency department for a condition that is treatable by a primary care professional than in six other developed countries (see Chart 8).¹⁵⁵ Reducing preventable hospitalizations by 5 percent for ambulatory care-sensitive conditions could result in savings of more than \$1.3 billion.¹⁵⁶ The waste of healthcare resources also can be attributed to such things as duplicate testing that could be remedied by systems that allow better tracking of ordered tests and results (see Chart 9).¹⁵⁷

In collaboration with medical groups, HealthPartners, a Minnesota insurer, has developed a “decision support” tool that medical groups can embed in their electronic medical records. The tool allows physicians to enter a planned diagnostic procedure, such as a CT scan, into the computer while a patient is in the exam room and receive immediate feedback regarding whether that particular procedure makes sense; if not, alternatives are suggested. HealthPartners emphasizes that it will pay for the diagnostic procedure even if the physician does not follow its recommendation. Still, the company says its efforts have helped it avoid some 7,000 inappropriate scans.¹⁵⁸

UnitedHealth’s “advanced notification,” program requires many of its physicians to notify United before proceeding with a nonurgent scan. The company then reviews the case in advance to make sure the test makes sense. Although it sounds like prior authorization, the company says the distinction is that doctors risk not being paid only if they do not provide the notification. Once they have done that, it does not matter for payment purposes whether the doctor follows the company’s advice. United says that doctors have changed what test they have ordered 3 percent of the time, and 9 percent of the time they have canceled the order altogether.¹⁵⁹

The home health community has been targeting preventable hospitalizations and emergency department visits through the Centers for Medicare & Medicaid Services’ QIO Program. Many home health agencies have implemented interventions such as telemonitoring to better keep an eye on a high- or moderate-risk patient’s medical condition, especially when the patient is first discharged home from the hospital. Others are emphasizing better education for patients that historically have higher rehospitalization rates or emergency department visits to help them understand when a condition is a true emergency as opposed to when it is more appropriate to call the home care agency for assistance.¹⁶⁰

AARP has been informing its membership about the issue of overuse and about the potential dangers of inappropriate medical care. An article in the Health section of its magazine, “Why Does Health Care Cost So Much?,” provided an overview of the problem as well as some of the potential causes. AARP went one step further to speak to this issue by including five tips for consumers of things to do now to lessen the risk of receiving care they do not need.¹⁶¹

HOW WILL WE GET THERE?

The Partners will work together to ensure that:

Goal: All healthcare organizations will continually strive to improve the delivery of appropriate patient care and substantially and measurably reduce extraneous service(s) and/or treatment(s).

The recommended areas of concentration are as follows:

↑ Inappropriate medication use, targeting:

- Antibiotic use
- Polypharmacy (for multiple chronic conditions; of antipsychotics)

↑ Unnecessary laboratory tests, targeting:

- Panels (e.g., thyroid, SMA 20)
- Special testing (e.g., Lyme Disease with regional considerations)

↑ Unwarranted maternity care interventions, targeting:

- Cesarean section

↑ Unwarranted diagnostic procedures, targeting:

- Cardiac computed tomography (noninvasive coronary angiography and coronary calcium scoring)
- Lumbar spine magnetic resonance imaging prior to conservative therapy, without red flags
- Uncomplicated chest/thorax computed tomography screening
- Bone or joint x-ray prior to conservative therapy, without red flags
- Chest x-ray, preoperative, on admission, or routine monitoring
- Endoscopy

↑ Inappropriate nonpalliative services at end of life, targeting:

- Chemotherapy in the last 14 days of life
- Aggressive interventional procedures
- More than one emergency department visit in the last 30 days of life

↑ Unwarranted procedures, targeting:

- Spine surgery
- Percutaneous transluminal coronary angioplasty (PTCA)/Stent
- Knee/hip replacement
- Coronary artery bypass graft (CABG)
- Hysterectomy
- Prostatectomy

↑ Unnecessary consultations

↑ Preventable emergency department visits and hospitalizations, targeting:

- Potentially preventable emergency department visits
- Hospital admissions lasting less than 24 hours
- Ambulatory care-sensitive conditions

↑ Potentially harmful preventive services with no benefit, targeting:

- BRCA mutation testing for breast and ovarian cancer – female, low risk
- Coronary heart disease screening using electrocardiography (ECG), exercise treadmill test (ETT), electron-beam computed tomography (EBCT) – adults, low risk
- Carotid artery stenosis screening – general adult population
- Cervical cancer screening – female over 65, average risk and female, posthysterectomy
- Prostate cancer screening – male over 75

(See U.S. Preventive Services Task Force D Recommendations List at www.ahrq.gov/clinic/prevenix.htm)

To get there, we will continue to pursue a collaborative, multidisciplinary approach with the healthcare organizations and healthcare professionals who played a major role in the development of the targeted areas. We will work with the practicing and academic professional communities and the medical specialty societies to identify strategies to achieve this goal (e.g., embedding performance measurement in the maintenance of certification requirements). We will engage all key stakeholders, including patients, payers, employers, suppliers, and the media to promote an understanding of the nine targeted areas. We will support patient shared decisionmaking to ensure that the patient's needs are met, ensure that there are evidence-based resources for the targeted areas, and assist in the development of payment and consumer information processes to discourage inappropriate and unnecessary care. We will provide tools for successful implementation where possible and appropriate. We will develop metrics to measure successful implementation and outcomes and publicly report this data on a timely basis.

The background is a solid teal color. A large, abstract, white and light teal shape, resembling a stylized arrow or a curved path, starts from the bottom left and points towards the top right. The text is positioned in the upper left quadrant of the image.

*The Drivers of
Transformation*

THE DRIVERS OF TRANSFORMATION

The National Priorities Partnership recognizes the only way to achieve the bold goals we have set is for each of us to take bold actions.

How can we bring about a transformation of this magnitude? There are a handful of extremely effective mechanisms that can truly drive change in the healthcare system: performance measurement, public reporting, payment systems, research and knowledge dissemination, professional development, and system capacity. These will all require leadership and commitment to support change at the federal, state, and local levels, and they will require the driver that is sometimes the most difficult to achieve—partnership.

Performance Measurement

The ability to measure and track performance over time is essential to gauge progress toward our goals. The use of harmonized and consistently applied measures across settings of care linked to the National Goals can help reduce the cacophony of the current measurement environment to ultimately drive improvement.

Standardized measures that allow results to be monitored and tracked uniformly are the building blocks of performance improvement and public reporting. Four principles, which build on the work of the NQF Strategic Framework Board,¹⁶² should guide the selection of measures.

MEASURES SHOULD BE LINKED DIRECTLY TO THE NATIONAL PRIORITIES AND GOALS.

NQF endorsement is the gold standard for measures, and many NQF-endorsed[®] measures map directly to the National Priorities and Goals. Where gaps exist, measure developers should work to close them by submitting appropriate measures for endorsement.

MEASURES SHOULD HAVE A CLEAR AND COMPELLING USE. Measures can be used for multiple purposes—internal quality improvement, accountability and payment, surveillance, and public reporting. For a measure to receive NQF endorsement, it must be appropriate both for quality improvement and public reporting. At the most core level, measures should help healthcare organizations improve care delivery and help stakeholders make informed decisions.

MEASURES SHOULD BE PARSIMONIOUS AND NOT IMPOSE UNDUE COSTS OR BURDEN ON THOSE PROVIDING DATA.

To be respectful of the many competing demands on healthcare organizations' time, the set of measures collected and reported for the National Priorities and Goals must strike a balance between being comprehensive enough to capture what matters while imposing the least possible burden on busy healthcare professionals. Aggressively moving toward more electronic data sources will allow measures to be more easily collected as part of the care process.

MEASURES SHOULD BALANCE THE NEED FOR CONTINUOUS IMPROVEMENT WITH THE STABILITY NEEDED TO TRACK PROGRESS OVER TIME.

Measures should not be static but rather evaluated regularly to ensure their relevance and to monitor for unintended consequences.

Among the many challenges related to performance measurement, two are important to underscore. First, the existing measures are not typically used or adopted in an integrated fashion. In many instances, the current portfolio of measures reflect narrow silos specific to certain settings, professions, or diseases rather than a broader view of patient care. It is important that future endeavors apply the existing measures in a manner that captures the quality of care more broadly. Second, future measures need to be developed to look at patients—not as diseases but as human beings. This will involve ensuring that the patient's

perception of care is adequately assessed along with his or her preferences for care. Future measurement development efforts also would benefit from using an integrated approach from their inception.

All of the National Priorities have at least some NQF-endorsed measures that are ready for use now, but there are substantial measure gaps that will require a unified effort among measure developers, NQF, and others to close. A number of the Partners have initiatives under way to address measure gaps in areas that include care coordination; population health, including healthy lifestyle behaviors; palliative care; and areas of overuse, such as inappropriate medication use and unwarranted diagnostic procedures. In 2009, a comprehensive plan for closing measure gaps will be developed and implemented.

Public Reporting

The public reporting of performance information, if done in a way that is understandable and meaningful to consumers, will assist them in making informed choices among treatments and healthcare organizations, and it also will help them to be better equipped to get the care they need. Public reporting programs also should ensure that performance results are based on complete and accurate data and that they provide fair comparisons. To achieve our goal of eliminating disparities, we also need to encourage routine assessment of disparities in our public reporting programs.

In April 2008, the Consumer-Purchaser Disclosure Project released a national set of principles—*The Patient Charter*—to guide the measuring and reporting of physician performance data for consumers.¹⁶³ Similar principles should guide public reporting.

MEASURES SHOULD BE MEANINGFUL TO CONSUMERS AND REFLECT A DIVERSE ARRAY OF HEALTHCARE PROFESSIONALS' CLINICAL ACTIVITIES.

- Measures should reflect IOM's six aims for improving the quality of healthcare, including patient experience when feasible, and should be meaningful and useful to consumers.

- Reporting programs should not solely rely on cost-efficiency information, and they should reveal the proportionate weighting given to cost and quality elements.
- Consumers and consumer organizations should be involved in the development of programs that use these measures to provide information to consumers. Such programs should provide consumers with the appropriate context for understanding and using the information. Any such program should have a clearly defined process for receiving and addressing consumer concerns about such information.

THOSE BEING MEASURED SHOULD BE ACTIVELY INVOLVED.

- Healthcare organizations and healthcare professionals should be involved in developing reporting programs.
- Healthcare organizations and healthcare professionals should be given reasonable prior notice before information is released and should be given the opportunity to correct inaccurate results.
- Healthcare professionals should get feedback to improve their own practices.

MEASURES AND METHODOLOGY SHOULD BE TRANSPARENT AND VALID.

- Measures and related ranking methodologies should be made available to the public.
- Consumers should get clear information that allows them to compare healthcare professionals' performance.
- The public should be told of any limitations on the usefulness of the results, and the overall program should be regularly evaluated, including a review of any unintended consequences.
- Sponsors of reporting programs should be encouraged to aggregate data and to align and harmonize measures where possible to reduce redundancy and burden for healthcare organizations.

MEASURES SHOULD BE BASED ON NATIONAL STANDARDS TO THE GREATEST EXTENT POSSIBLE.

- The primary source of measures for reporting programs should be NQF.
- Supplemental measures also should be used when national standards do not yet exist or when existing measures are unduly burdensome, but these measures should follow NQF criteria to the greatest extent possible.

It is hoped that through widespread adoption of these principles, publicly reported information will be more salient and understandable to consumers and healthcare professionals and will be fair and acceptable to healthcare organizations. Health plans that adopt the Patient Charter agree to adhere to these principles and to have their “report cards” evaluated by an independent reviewer.

In 2009, the Partners will work to align public reporting with the National Priorities and Goals and to ensure that all public reporting programs adhere to these sound principles.

Payment Systems

In America, payment programs reward volume over value, so it is no surprise that volume is what we get.

Fee-for-service, the dominant method of payment, encourages increasing the volume of billable services—office visits, diagnostic tests, and procedures—rather than achieving the best patient outcomes. It is estimated that 30 to 40 percent of health services represent waste.¹⁶⁴

There is an increasing focus on taking steps to align payment with better quality, safety, and affordability. Much attention has been given to public and private purchasers linking a portion of provider payments to performance on a defined set of measures,¹⁶⁵ and to efforts by Medicare and some private purchasers to institute nonpayment policies for certain, largely preventable events (such as surgery on the wrong body part or infections acquired while hospitalized).¹⁶⁶ Attention also should be focused on payment models that reward preventive services and nonacute care, as well as on innovative and nontraditional models of care provision to encourage more efficient resource use.

Programs currently exist that could be cost-effective alternatives to more traditional care models. Yet, these programs remain largely unrecognized and they face barriers that stifle their wider adoption. The Transitional Care Model (TCM), which supports the care of elders as they transition from the hospital to their homes thereby transferring many care responsibilities from inpatient caregivers to family caregivers, is a case in point. Care transitions from hospital to home are periods when patients are particularly vulnerable to experiencing adverse events. The TCM model has demonstrated outcomes that illustrate the success of the intervention, including longer intervals between rehospitalizations, fewer rehospitalizations, and cost reductions.¹⁶⁷ Despite this evidence, barriers remain to its broad adoption, including regulatory obstacles and inadequate reimbursement for transitional care services and care coordination.¹⁶⁸

Aligning payments to foster better quality and more affordable care goes far beyond these examples. All payment systems should be examined to identify opportunities to encourage and reward the achievement of the National Priorities and Goals.

PAYMENTS SHOULD BE TIED TO RESULTS.

Payment programs should recognize and reward performance improvement and the achievement of excellence that ultimately contribute to improved patient outcomes and that reduce healthcare disparities.

SYSTEMS SHOULD FOSTER APPROPRIATE CARE AND STEWARDSHIP OF RESOURCES.

Payment systems should encourage healthcare organizations to always and only provide the right care for the right patient, based on that patient’s needs, preferences, and circumstances. Payments should support healthcare organizations that effectively use resources to meet the needs of their patients.

PAYMENTS SHOULD SUPPORT COORDINATION, INTEGRATION, AND DELIVERY CAPACITY. Payments should facilitate and reward the coordination and integrated delivery of care. Payment should support the use of technologies and systems that improve safety and quality.

PROGRAMS SHOULD BE SIMPLE AND UNDERSTANDABLE. Payment programs should be simple, transparent, and understandable to both patients and healthcare professionals.

PATIENTS SHOULD GET THE RIGHT INCENTIVES. Patients should be encouraged and rewarded to pursue behaviors that are consistent with healthy lifestyles and the safe and appropriate use of health services.

PROGRAMS SHOULD ENCOURAGE EVIDENCE-BASED CARE, WHILE FOSTERING INNOVATION. Payment programs should encourage tests, care, and interventions that are based on solid evidence, but that at the same time provide adequate flexibility to allow innovation to flourish.

It is particularly important to recognize there is no “one-size-fits-all” payment approach. However, payment programs should foster collaborative arrangements between healthcare organizations of various types, and should encourage continued organizational development.

To achieve the National Priorities and Goals the Partners have set, we need to specifically link payments between healthcare professionals and the settings in which healthcare is provided (e.g., the hospital, nursing home, ambulatory care facility, clinic, home), such as through episode payments and shared reward pools tied to reductions in preventable hospital readmissions and emergency department encounters.¹⁶⁹ Other payment options may be more relevant to integrated healthcare systems, such as payments linked to patient outcomes coupled with the efficient use of resources across the episode of care; this could include pre- and postoperative care, acute care, and rehabilitation services (e.g., for patients undergoing coronary artery bypass grafting).¹⁷⁰ In addition, mechanisms should be put in place to link provider and patient incentives.

Research and Knowledge Dissemination

For many of the Priorities and Goals, the evidence base on how to close current gaps in care is well defined; however, for others, the path is less clear. Resources must be invested to help us learn how to

translate what we have learned from basic biomedical science into clinical research—and importantly, how to apply this knowledge to different types of practice settings.

THE NATIONAL PRIORITIES AND GOALS SHOULD INFORM THE RESEARCH AGENDA—BASIC SCIENCE, CLINICAL, AND TRANSLATIONAL. SPECIFICALLY, THE RESEARCH AGENDA SHOULD:

- Build the evidence base for knowing what works and for whom, and for how to best translate this knowledge into routine practice.¹⁷¹ Once science tells us what works, we need to be sure all types of patients achieve the desired outcomes. This will require research to determine the benefits or harms of such care for different populations so we can tailor care appropriately. This is where a feedback loop between the clinical setting and the biomedical science venue is critical to ensure that problems can be rapidly conveyed and addressed.
- Build the evidence base on effectiveness of care including risks, benefits, and costs of alternative technologies and services.¹⁷² We encourage coordinated research efforts to evaluate and compare the effectiveness of treatment options—for example, a new more expensive drug versus a longstanding less costly drug—to determine which options may be most beneficial or appropriate for specific patients. This information must be made available to healthcare professionals and consumers so they can make informed decisions based on sound, unbiased evidence.

INFRASTRUCTURE SHOULD BE IN PLACE SO THAT THERE IS THE CAPACITY FOR RAPIDLY AND RELIABLY DISSEMINATING BEST PRACTICES AS WELL AS A FEEDBACK LOOP FOR ONGOING LEARNING AND MONITORING FOR UNINTENDED CONSEQUENCES.¹⁷³

- Building this infrastructure will require investment and leadership from both the public and private sectors to support and sustain this type of enterprise on a national scale.

Professional Development: Education and Certification

To achieve the National Goals, we must strengthen our professional workforce. The workforce is the backbone of any industry, but it is particularly important in healthcare, given the nature of the relationship between patients and healthcare professionals. If the quality of healthcare in the United States is to improve, there must be an adequate, appropriately prepared workforce in place, a workforce of dedicated professionals who have the knowledge and skills to provide optimal care to each and every patient.

In 2002, IOM held an interdisciplinary summit to determine how to better prepare healthcare organizations to meet both the needs of patients and the requirements of a changing health system.¹⁷⁴ This led to the identification of five core competencies that all healthcare professionals should possess, regardless of discipline.

PROVIDE PATIENT-CENTERED CARE.

- Identify, respect, and care about patients' differences, values, preferences, and expressed needs.
- Relieve pain and suffering.
- Coordinate continuous care.
- Listen to, clearly inform, communicate with, and educate patients.
- Share decisionmaking and management.
- Continuously advocate disease prevention, wellness, and the promotion of healthy lifestyles, including a focus on population health.

WORK IN INTERDISCIPLINARY TEAMS.

- Cooperate, collaborate, communicate, and integrate care in teams to ensure that care is continuous and reliable.

EMPLOY EVIDENCE-BASED PRACTICE.

- Integrate best research with clinical expertise and patient values for optimum care, and participate in learning and research activities to the extent possible.

APPLY QUALITY IMPROVEMENT.

- Identify errors and hazards in care.
- Understand and implement basic safety design principles, such as standardization and simplification.
- Continually understand and measure quality of care in terms of structure, process, and outcomes in relation to patient and community needs.
- Design and test interventions to change processes and systems of care, with the objective of improving quality.

UTILIZE INFORMATICS.

- Communicate, manage knowledge, mitigate error, and support decisionmaking using information technology.

Having a competent workforce will not be enough in itself to drive the improvement in quality that is necessary to achieve high-value healthcare. Efforts must also be made to address workforce shortages, and healthcare professions and academic institutions must ensure that there are sufficient numbers of healthcare workers in all fields, especially emphasizing the need for qualified primary care professionals. Given the growing diversity of the U.S. population, it is also critically important that we encourage a diverse healthcare workforce.

The Partners believe that the IOM core competencies are particularly relevant to achieving the National Goals. What has been lacking is a coordinated and focused effort to achieve them on the part of all organizations involved in the various phases of lifelong professional development. For practicing professionals, alignment of the education programs of professional societies and the certification programs of professional boards will be critical to achieving the National Priorities and Goals. Through reform of undergraduate and graduate education, we must ensure that the next generation of healthcare professionals is well prepared to take on the challenges confronting our healthcare system. In addition to the activities of each of the professions, including medicine, nursing, and pharmacy, it will be important to take advantage of all opportunities to engage in interdisciplinary developmental programs.

In 2009, the Partners will be initiating efforts to better align professional development with the National Priorities and Goals, and promising efforts are already under way. For example, with leadership from the American Board of Medical Specialties, all 24 specialty boards have made a commitment to incorporating a stronger “patient voice” into practice, and all are working toward adoption of CAHPS surveys that are relevant to their specialty. Board certification programs also play important roles—they provide education and assistance to healthcare organizations to improve performance, and they inform the public about healthcare professional competencies and performance. In carrying out these dual roles, certification programs shape professional education (e.g., residency programs that orient their training to prepare healthcare professionals for certification) and practice (e.g., through certification, healthcare professionals acquire and incorporate important skills and tools into their practices).

This is just the beginning of what must be a broad-based, in-depth effort to build a workforce for the twenty-first-century health system.

System Capacity

The 2001 IOM *Crossing the Quality Chasm* report noted the absence of real progress toward restructuring healthcare systems to address both quality and cost concerns and toward applying advances in information technology to improve administrative and clinical processes. The report offered strategic direction for redesigning the healthcare system in the United States and called for the development of new organizational models to support care delivery and identified six important organizational capabilities:¹⁷⁵

- investment in health information technology (HIT);
- the creation of processes for managing new clinical knowledge and skills;
- the design of care processes based on best practices;
- the capacity to assemble and deploy interdisciplinary teams to respond to the needs of patients with chronic illnesses;

- coordination of care across patient conditions, services, and settings; and
- the development of performance measurement and improvement capabilities available to healthcare organizations.

Despite the direction provided by the IOM report, problems prevail that were recently characterized as a delivery system that is fragmented and dysfunctional¹⁷⁶—words that suggest that elements of “systemness” remain lacking.

To achieve the National Priorities and Goals, we must strengthen not only our professional workforce, but the systems in which they work. All types of healthcare organizations will need to develop greater organizational capacity. For many, this will necessitate entering into partnerships to achieve greater levels of scale and clinical integration.

Achieving higher levels of performance will require organizational capabilities not present in most delivery settings. There is growing evidence that practice settings with organizational supports perform better than those without;¹⁷⁷ that certain organizational supports, such as HIT are critical;¹⁷⁸ and that the lack of organizational support leads to poor quality, unsafe conditions, and inefficient use of services.¹⁷⁹

Many of the Partners are already engaged in efforts to build system capacity. The improvement and oversight programs of accrediting bodies, such as the National Committee for Quality Assurance and The Joint Commission, impact health plans, hospitals, and other settings. Early efforts are under way to encourage and reward small practice settings that develop systems to coordinate care.¹⁸⁰ State and regional collaborations, such as the Robert Wood Johnson’s Aligning Forces for Quality Communities and health information exchanges, present opportunities to identify strategies to improve healthcare infrastructure based on regional and community needs and goals. Education and technical assistance programs have critical roles to play as the healthcare system moves through this period of transition. These and other efforts will be integral in making any strides toward significant achievement of the National Priorities and Goals.



*The Path
Forward*

THE PATH FORWARD

Every American, of every economic, social, or cultural class, deserves high-quality healthcare, and discrimination in healthcare of any kind must be eliminated.

Today, we encourage you to join us not in *calling* for reform, but in *enacting* it nationally and in local communities across the country. This reform will be reflected in performance measurement, public reporting, payment reform, sound public policy that encourages the development of a high-performing health system, support of a new robust information infrastructure, and more. We urge all those in the healthcare world to embrace transparency and public reporting and best-in-class measures of performance in their quest to achieve the National Priorities and Goals. We appeal to those working at the community level to focus on population health, coordinating care across settings, and engaging patients and their families in decisionmaking.

The bold goals we are targeting for ourselves and for the nation are nothing short of a moon shot. We believe they are achievable if our currently disparate initiatives and efforts become aligned. We recognize we are far from having all of the answers, but we believe that in areas where we do not yet have a clear path to reform, we must thoughtfully forge the way forward based on the best evidence available. We have purposefully set the bar for performance and fundamental change high. But we have confidence that all of us—and all of you—are up to the task.

Identifying this first set of National Priorities and Goals is a major accomplishment, but we all agree it is only the first step in what must be a more expansive and ongoing implementation process aimed at achieving them. Over the next year and

beyond, we hope the National Priorities and Goals will spur action and innovation, because without coordinated actions, these goals will not be reached. The Partners will work with each other and with policymakers, healthcare leaders, and the community at large to build on the framework provided in this report and to develop actions in each of the major areas that will drive the improvements needed: performance measurement, public reporting, payment systems, research and knowledge dissemination, professional development, and system capacity.

The mere existence of a shared sense of responsibility to meet specific goals can transform healthcare quality. Acting to meet them can revolutionize it.

Within three years, measures to support tracking of the National Priorities and Goals should be developed. This would permit mapping to the *National Healthcare Quality Report* and the *National Healthcare Disparities Report*, which could begin to provide a

barometer of our progress.¹⁸¹ Additionally, we urge tracking of the progress of the Priorities and Goals through regional reporting efforts, recognizing that communities across the nation will be at different starting points. The Partners plan to reassess the National Priorities every three years to ensure their ongoing relevance and to keep abreast of successes and setbacks in reaching established benchmarks.

The National Priorities Partnership is leading the way in showing us how to solve the healthcare crisis we face today. The mere existence of a shared sense of responsibility to meet specific goals can transform healthcare quality. Acting to meet them can revolutionize it.

References

- 1 The Commonwealth Fund, *Why Not the Best? Results from the National Scorecard on U.S. Health System Performance, 2008*, New York: Commonwealth Fund; 2006. Available at www.cmwf.org/usr_doc/Commission_whynotthebest_951.pdf. Last accessed October 2008.
- 2 President's Advisory Commission on Consumer Protection and Quality in the Health Care Industry, *Final Report: Quality First: Better Health Care for All Americans*; March 12, 1998. Available at www.amazon.com/Quality-First-Better-Americans-President/dp/0788177966. Last accessed October 2008.

Chassin MR, Galvin RW, The urgent need to improve health care quality. Institute of Medicine National Roundtable on Health Care Quality, *JAMA*, 1998;280(11):1000-1005.

Institute of Medicine (IOM), *Crossing the Quality Chasm: A New Health System for the 21st Century*, Washington, DC: National Academy Press; 2001.

IOM, *To Err Is Human: Building a Safer Health System*, Washington, DC: National Academy Press; 1999.

Schuster MA, McGlynn EA, Brook RH, How good is the quality of health care in the United States? *Milbank Q*, 1998;76(4):517-563.
- 3 Mangione-Smith R, DeCristofaro AH, Setodji CM, et al., The quality of ambulatory care delivered to children in the U.S., *NEJM*, 2007;357(15):1515-1523.
- 4 Chandreshwar NS, Rathore SS, Yongfei W, et al., Quality of care among elderly patients hospitalized with unstable angina, *Am Heart J*, 2001;142(2):263-270.
- 5 IOM, *Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care*, Washington, DC: The National Academies Press; 2002.
- 6 Catlin A, Cowan C, Heffler S, et al., National health spending in 2005: the slowdown continues, *Health Aff*, 2007;26(1):142-153.
- 7 Provonost P, Needham D, Berenholtz S, et al., An intervention to decrease catheter-related bloodstream infections in the ICU, *NEJM*, 2006;355(26):2725-2732.

Naylor MD, Brooten DA, Campbell RL, et al., Transitional care of older adults with heart failure: a randomized, control trial, *J Amer Geriatr Soc*, 2004;52(5):675-684.

Lorenz KA, Lynn J, Dy SM, et al., Evidence for improving palliative care at the end of life: a systematic review, *Ann Intern Med*, 2008;148(2):147-159.

Vargas R, Mangione C, Asch S, et al., Can a chronic care model collaborative reduce heart disease risk in patients with diabetes? *J Gen Intern Med*, 2007;22(2):215-222.
- 8 IOM, *Performance Measurement: Accelerating Improvement*, Washington, DC: The National Academies Press; 2006: pp. 76-77.
- 9 IOM, *Crossing the Quality Chasm: A New Health System for the 21st Century*, Washington, DC: National Academy Press; 2001.
- 10 World Health Organization (WHO), *Commission on Social Determinants of Health (CSDH)*, Geneva, Switzerland: WHO; 2008. Available at www.who.int/social_determinants/en/. Last accessed October 2008.

WHO, *Genetics and Common Diseases*, Geneva, Switzerland: WHO; 2008. Available at www.who.int/genomics/about/commondiseases/en/. Last accessed October 2008.
- 11 Agency for Healthcare Research and Quality (AHRQ), *National Healthcare Quality Report*, Rockville, MD: AHRQ; 2007. Available at www.ahrq.gov/qual/qrd07.htm#nhqr. Last accessed October 2008.
- 12 Klevens RM, Edwards JR, Richards CL Jr, et al., Estimating health care-associated infections and deaths in U.S. hospitals, 2002, *Public Health Rep*, 2007;122(2):160-166.
- 13 Rosenthal MB, Nonpayment for performance? Medicare's new reimbursement rule, *NEJM*, 2007;357(16):1573-1575.
- 14 IOM, *Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care*, Washington, DC: The National Academies Press; 2002.

- ¹⁵ Centers for Disease Control and Prevention (CDC), *Health, United States, 2007*. Available at www.cdc.gov/nchs/data/abus/abus07.pdf#042. Last accessed October 2008.
- ¹⁶ Indian Health Service (IHS), *Facts on Indian Health Disparities*. Available at <http://info.ihs.gov/files/disparitiesfacts-Jan2006.pdf>. Last accessed October 2008.
- ¹⁷ The Commonwealth Fund, *Why Not the Best? Results from the National Scorecard on U.S. Health System Performance, 2008*, New York: Commonwealth Fund; 2006.
- ¹⁸ CDC, *Obesity Among Adults in the United States – No Statistically Significant Change Since 2003-2004*. Available at www.cdc.gov/nchs/data/databriefs/db01.pdf. Last accessed October 2008.
- ¹⁹ CDC, *Overweight and Obesity*. Available at www.cdc.gov/nccdphp/dnpa/obesity/faq.htm#costs. Last accessed October 2008.
- ²⁰ CDC, *Smoking & Tobacco Use*. Available at www.cdc.gov/tobacco/data_statistics/fact_sheets/fast_facts/index.htm. Last accessed October 2008.
- ²¹ CDC, National Center for Chronic Disease Prevention and Health Promotion. *Chronic Disease Prevention and Health Promotion*. Available at www.cdc.gov/nccdphp/. Last accessed October 2008.
- ²² McGlynn EA, Asch SM, Adams J, et al., The quality of health care delivered to adults in the United States, *NEJM*, 2003;348(26):2635-2645.
- ²³ IOM, National Academy of Engineering (NAE), *Building a Better Delivery System: A New Engineering/Health Care Partnership*, Washington, DC: The National Academies Press; 2005.
- ²⁴ Cohen RA, *Health Insurance Coverage: Early Release of Estimates from the National Health Interview Survey, 2007*, Hyattsville, MD: National Center for Health Statistics; June 25, 2008. Available at www.cdc.gov/nchs/pressroom/STATCASTS/stat_cast_8.htm. Last accessed October 2008.
- ²⁵ Cunningham PJ, *Trade-offs Getting Tougher: Problems Paying Medical Bills Increase for U.S. Families, 2003-2007*, Washington, DC: Center for Studying Health System Change; September 2008. Available at www.hschange.com/content/1017/#ib5. Last accessed October 2008.
- ²⁶ Hibbard JH, Mahoney ER, Stock R, et al., Do increases in patient activation result in improved self-management behaviors? *Health Serv Res*, 2007;42(4):1443-1463.
- ²⁷ Ibid.
- ²⁸ Weinstein JN, Clay K, Morgan TS, Informed patient choice: patient-centered valuing of surgical risks and benefits, *Health Aff*, 2007;26(3):726-730.
- ²⁹ O'Connor AM, Llewellyn-Thomas HA, Flood AB, Modifying unwarranted variations in healthcare: shared decision making using patient decision aids, *Health Aff*, 2004; Suppl Web Exclusive:VAR63-72.
- ³⁰ AHRQ, *AHRQ News & Numbers*, Rockville, MD: AHRQ; 2008. Available at www.ahrq.gov/news/nn/nn051408.htm. Last accessed October 2008.
- ³¹ Engel KG, Heisler M, Smith DM, et al., Patient comprehension of emergency department care and instructions: are patients aware of when they do not understand? *Ann Emerg Med*, Epub 10 July 2008.
- ³² IOM, *Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care*, Washington, DC: The National Academies Press; 2002.
- ³³ Vernon JA, Trujillo A, Rosenbaum S, et al., *Low Health Literacy: Implications for National Health Policy*, Partnership for Clear Health Communication, National Patient Safety Foundation; 2007. Available at <http://npsf.org/pchc/downloads.php#hlpapers>. Last accessed October 2008.
- ³⁴ Flores, G, Language barriers to health care in the U.S.: Perspectives, *NEJM*, 2006;353(3):229-231.
- ³⁵ Bodenheimer T, Lorig KR, Holman H, et al., Patient self-management in chronic disease in primary care, *JAMA*, 2002;288(19):2469-2475.
- ³⁶ Lorig KR, Ritter PL, González VM, Hispanic chronic disease self-management, *Nur Res*, 2003;52(6):361-369.

- ³⁷ IOM, *Priority Areas for National Action: Transforming Health Care Quality*, Washington, DC: The National Academies Press; 2003.
- ³⁸ Hawker GA, Wright JG, Coyte PC, et al., Determining the need for hip and knee arthroplasty: the role of clinical severity and patients' preferences, *Med Care*, 2001;39(3):206-216.
- ³⁹ Lorig KR, Ritter PL, González VM, Hispanic chronic disease self-management, *Nur Res*, 2003;52(6):361-369.
- ⁴⁰ Dartmouth-Hitchcock Medical Center (DHMC), *Center for Shared Decision Making*. Available at www.dhmc.org/shared_decision_making.cfm. Last accessed October 2008.
- ⁴¹ Centers for Medicare & Medicaid Services (CMS), *HCAHPS Fact Sheet*. Available at www.cms.hhs.gov/HospitalQualityInits/Downloads/HospitalHCAHPSFactSheet200807.pdf. Last accessed October 2008.
- ⁴² Kindig DA, Asada Y, Booske B, A population health framework for setting national and state health goals, *JAMA*, 2008;299(17):2081-2083.
- ⁴³ IOM, *The Future of the Public's Health in the 21st Century*, Washington, DC: The National Academies Press; 2002.
- ⁴⁴ American Cancer Society (ACS), *Cancer Facts & Figures 2008*. Available at www.cancer.org/downloads/STT/2008CAFFfinalsecured.pdf. Last accessed October 2008.
- ⁴⁵ Partnership for Prevention, *Preventive Care: A National Profile on Use, Disparities, and Health Benefits*, Washington, DC: Partnership for Prevention; 2007. Available at www.prevent.org/content/view/full/129/72/. Last accessed October 2008.
- ⁴⁶ The Commonwealth Fund, *Usual Source of Care and Receipt of Preventive Care*, New York: The Commonwealth Fund; 2006. Available at www.commonwealthfund.org/snapshotscharts. Last accessed October 2008.
- ⁴⁷ Partnership for Prevention, *Strengthening Adult Immunization: A Call to Action*, Washington, DC: Partnership for Prevention; 2005. Available at www.prevent.org/content/view/full/26/55/. Last accessed October 2008.
- ⁴⁸ CDC, *2007 National Health Interview*, Hyattsville, MD: National Center for Health Statistics; 2008. Available at www.cdc.gov/nchs/nhis.htm. Last accessed October 2008.
- ⁴⁹ ACS, *Cancer Facts & Figures 2008*, Atlanta, GA: ACS; 2008. Available at www.cancer.org/downloads/STT/2008CAFFfinalsecured.pdf. Last accessed October 2008.
- ⁵⁰ CDC, *Smoking & Tobacco Use*. Available at www.cdc.gov/tobacco/. Last accessed October 2008.
- ⁵¹ CDC, *Overweight and Obesity*. Available at www.cdc.gov/nccdphp/dnpa/obesity/index.htm. Last accessed October 2008.
- ⁵² CDC, *Smoking & Tobacco Use*. Available at www.cdc.gov/tobacco/. Last accessed October 2008.
- ⁵³ CDC, *Overweight and Obesity*. Available at www.cdc.gov/nccdphp/dnpa/obesity/index.htm. Last accessed October 2008.
- ⁵⁴ Merenstein D, Daumit GL, Powe NR, Use and costs of nonrecommended tests during routine preventive health exams, *Am J Prev Med*, 2006;30(6):521-527.
- ⁵⁵ HealthPartners, *2007 Clinical Indicators Report 2006/2007 Results*, Minneapolis, MN: HealthPartners; 2007. Available at www.healthpartners.com/files/34613.pdf. Last accessed October 2008.
- ⁵⁶ The Commonwealth Fund, *Why Not the Best? Results from the National Scorecard on U.S. Health System Performance, 2008*, New York: Commonwealth Fund; 2006. Available at www.cmwf.org/usr_doc/Commission_whynotthebest_951.pdf. Last accessed October 2008.
- ⁵⁷ University of Wisconsin Population Health Institute, *2007 Wisconsin County Health Rankings*; 2007. Available at www.pophealth.wisc.edu/UWPHI/research/rankings_2007/rankings_2007.pdf. Last accessed October 2008.

- ⁵⁸ American Academy of Nursing (AAN), *Edge Runners: Nurse Innovator Profiles*, Washington, DC; AAN; 2008. Available at www.aannet.org/files/public/11thStreetFamilyHelthSvcs_template.pdf. Last accessed October 2008.
- ⁵⁹ *12th Annual National Business Group on Health/Watson Wyatt Survey Report*, No. 2007-US-0031, Washington, DC: Watson Wyatt Worldwide; 2007. Available at www.watsonwyatt.com/news/press.asp?ID=17172. Last accessed October 2008.
- ⁶⁰ 2006 C. Everett Koop National Health Awards, *The USAA Take Care of Your Health Program*. Available at <http://healthproject.stanford.edu/koop/2006winnerindex.htm>. Last accessed October 2008.
- ⁶¹ Maciosek MV, Coffield AB, Edwards NM, et al., Priorities among effective clinical preventive services, *Am J Prev Med*, 2006;31(1):52-61.
- ⁶² IOM, *To Err Is Human: Building a Safer Health System*, Washington, DC: National Academy Press; 1999.
- ⁶³ Hasnain-Wynia R, Baker DW, Nerenz D, et al., Disparities in health care are driven by where minority patients seek care, *Arch Intern Med*, 2007;167(12):1233-1239.
- ⁶⁴ Institute for Healthcare Improvement (IHI), *Pausing for Safety*. Available at www.ihl.org/IHI/Topics/PatientSafety/SafetyGeneral/ImprovementStories/PausingforSafety.htm. Last accessed October 2008.
- IHI, *IHI 5 Million Lives*, Cambridge, MA: IHI; 2006. Available at www.ihl.org/IHI/Programs/Campaign/Campaign.htm?TabId=1. Last accessed October 2008.
- ⁶⁵ The Commonwealth Fund, *Why Not the Best? Results from the National Scorecard on U.S. Health System Performance, 2008*, New York: Commonwealth Fund; 2006.
- ⁶⁶ Ibid.
- ⁶⁷ AHRQ, *Quality Measure Clearinghouse*. Available at www.qualitymeasures.ahrq.gov. Last accessed October 2008.
- ⁶⁸ Texas Medical Foundation, *Texas Medicine – Science Feature*. Clip, Don't Nick: Physicians Target Hair Removal to Cut Surgical Site Infections. Available at <http://www.texmed.org/Template.aspx?id=4743>. Last accessed October 2008.
- ⁶⁹ AHRQ, *2007 National Healthcare Disparities Report*, Rockville, MD: AHRQ; 2007. Available at <http://ahrq.gov>. Last accessed October 2008.
- ⁷⁰ Klevens RM, Edwards JR, Richards CL Jr, et al., Estimating health care-associated infections and deaths in U.S. hospitals, 2002, *Public Health Rep*, 2007;122(2):160-166.
- ⁷¹ Dimick J, Chen P, Taheri P, et al., Hospital costs associated with surgical complications: a report from the private sector National Surgical Quality Improvement Program, *J Am Coll Surg*, 2004;199(4):531-537.
- ⁷² IOM, *To Err Is Human: Building a Safer Health System*, Washington, DC: National Academy Press; 1999.
- ⁷³ The Commonwealth Fund, *Why Not the Best? Results from the National Scorecard on U.S. Health System Performance, 2008*. New York: Commonwealth Fund; 2006.
- ⁷⁴ Leape LL, Berwick DM, Five years after *To Err Is Human* – what have we learned? *JAMA*, 2005;293(19):2384-2390.
- ⁷⁵ AHRQ, *2007 National Healthcare Disparities Report*, Rockville, MD: AHRQ; 2007. Available at <http://ahrq.gov>. Last accessed October 2008.
- ⁷⁶ Ibid.
- ⁷⁷ Jha H, Orav E, Zheng J, et al., The Characteristics and performance of hospitals that care for elderly Hispanic Americans, *Health Aff*, 2008;27(2):528-537.
- Hasnain-Wynia R, Baker DW, Nerenz D, et al., Disparities in health care are driven by where minority patients seek care, *Arch Intern Med*, 2007;167(12):1233-1239.
- ⁷⁸ Hasnain-Wynia R, Baker DW, Nerenz D, et al., Disparities in healthcare are driven by where minority patients seek care, *Arch Intern Med*, 2007;167(12):1233-1239.

- ⁷⁹ Brennan TA, Leape LL, Laird NM, et al., Incidence of adverse events and negligence in hospitalized patients: results of the Harvard Medical Practice Study I. 1991, *Qual Saf Health Care*, 2004;13(2):145-151.
- ⁸⁰ Rello J, Ollendorf DA, Oster G, et al., Epidemiology and outcomes of ventilator-associated pneumonia in a large US database, *Chest*, 2002;122:2115-2121.
- ⁸¹ Leape, LL, Berwick, DM, Five years after To Err Is Human – what have we learned? *JAMA*, 2005;293(19):2384-2390.
- ⁸² IOM, *To Err Is Human: Building a Safer Health System*. Washington, DC: National Academy Press; 1999.
- ⁸³ Krumholz HM, Time is of the essence, *Journal Watch Cardiology*, 2007;13(12):95.
- ⁸⁴ CMS, *CMS Improves Patient Safety for Medicare and Medicaid by Addressing Never Events*, Baltimore, MD: CMS; 2008. Available at www.cms.hhs.gov/apps/media/press/factsheet.asp?Counter=3224&intNumPerPage=10. Last accessed October 2008.
- ⁸⁵ MSNBC Analysis, *Medical Mistake Billing Policies*. Available at www.msnbc.msn.com/id/26140511. Last accessed October 2008.
- ⁸⁶ WHO, *Safe Surgery Saves Lives*. Available at www.who.int/patientsafety/safesurgery/en/. Last accessed October 2008.
- ⁸⁷ Consumer's Union, *Health Care – Safety and Quality – Hospital Infections*. Available at www.consumersunion.org/pub/cathealthsafetyhosp_infections/. Last accessed October 2008.
- ⁸⁸ Provonost P, Needham D, Berenholtz S, et al., An Intervention to decrease catheter-related bloodstream infections in the ICU, *NEJM*, 2006;355(26):2725-2732.
- ⁸⁹ Gawande, A, The Checklist, *The New Yorker*, December 10, 2007.
- ⁹⁰ Anderson G, *Better Lives for People with Chronic Conditions*, Partnership for Solutions. Available at www.partnershipforsolutions.org/statistics/prevalence.html. Last accessed October 2008.
- ⁹¹ Bodenheimer T, Coordinating care – a perilous journey through the health care system, *NEJM*, 2008;358(10):1064-1071.
- ⁹² Ibid.
- ⁹³ Whittington J, Cohen H, OSF healthcare's journey in patient safety, *Qual Manag Health Care*, 2004;13(1):53-59.
- ⁹⁴ The Commonwealth Fund, *Why Not the Best? Results from the National Scorecard on U.S. Health System Performance, 2008*, New York: Commonwealth Fund; 2006.
- ⁹⁵ Starfield B, Shi L, The medical home, access to care, and insurance: a review of evidence. *Pediatrics*, 2004;113(5 suppl):1493-1498.
- ⁹⁶ Parchman ML, Culler SD, Preventable hospitalizations in primary care shortage areas: An analysis of vulnerable medicare beneficiaries, *Arch Fam Med*, 1999;8(6):487-491.
- ⁹⁷ Schoen, C, Osborn, R, Doty, MM, et al., Toward higher-performance health systems: Adults' health care experiences in seven countries, 2007, *Health Aff*, 2007;26(6):w717-w734.
- ⁹⁸ Davis K, Schoenbaum SC, Audet AM, A 2020 Vision of patient-centered primary care, *J Gen Intern Med*, 2005;20(10):953-957.
- ⁹⁹ Naylor MD, Broton DA, Campbell RL, et al., Transitional care of older adults with heart failure: a randomized, control trial, *J Am Geriatr Soc*, 2004;52(5):675-684.
- ¹⁰⁰ Coleman EA, *The Care Transitions Program*. Available at www.caretransitions.org/. Last accessed October 2008.
- ¹⁰¹ Coleman EA, Berenson RA, Lost in transition: challenges and opportunities for improving the quality of transitional care, *Ann Intern Med*, 2004;141(7):533-536.
- ¹⁰² Budnitz DS, Pollack DA, Weidenbach KN, et al., National surveillance of emergency department visits for outpatient adverse drug events, *JAMA*, 2006;296(15):1858-1866.

- ¹⁰³ Russo CA, Andrews RM, Coffey RM, *Racial and Ethnic Disparities in Potentially Preventable Hospitalizations. HCUP Statistical Brief #10*, Rockville, MD: AHRQ; 2006. Available at www.hcup-us.ahrq.gov/reports/statbriefs/sb10.pdf. Last accessed October 2008.
- ¹⁰⁴ The Commonwealth Fund, *Why Not the Best? Results from the National Scorecard on U.S. Health System Performance, 2008*, New York: Commonwealth Fund; 2006.
- ¹⁰⁵ *MedPAC Report to Congress*, Washington, DC: Medicare Payment Advisory Commission; 2007. Available at www.medpac.gov/documents/jun07_EntireReport.pdf. Last accessed October 2008.
- ¹⁰⁶ Friedman B, Basu J, The Rate and cost of hospital readmissions for preventable conditions, *Med Care Res Rev*, 2004;61(2):225-240.
- ¹⁰⁷ Minnot, J, *Reducing Hospital Readmissions. Academy Health*. Available at www.academyhealth.org/publications/Reducing_Hospital_Readmissions.pdf. Last accessed October 2008.
- ¹⁰⁸ The Commonwealth Fund, *National Scorecard on U.S. Health System Performance*, New York: Commonwealth Fund; 2006.
- ¹⁰⁹ *MedPAC Report to Congress*, Washington, DC: Medicare Payment Advisory Commission; 2007. Available at www.medpac.gov/documents/jun07_EntireReport.pdf. Last accessed October 2008.
- ¹¹⁰ The Commonwealth Fund, *Quality Matters*, March/April 2008. Available at www.commonwealthfund.org. Last accessed October 2008.
- ¹¹¹ AAN, *Edge Runners: Nurse Innovator Profiles*, Washington, DC; AAN; 2008. Available at www.aanet.org/files/public/APNtemplate.pdf. Last accessed October 2008.
- ¹¹² Billings J, Parikh N, Mijanovich T, Emergency room use: the New York story, *The Commonwealth Fund Issue Brief*, November 2000.
- Billings J, Mijanovich T, Improving the management of care for high-cost Medicaid patients, *Health Aff*, 2007;26(6):1643-1655.
- ¹¹³ American Society of Health-System Pharmacists, *Award Paper Abstracts*. Available at www.ashpadvantage.com/bestpractices/2006_papers/schwab.htm. Last accessed October 2008.
- ¹¹⁴ Choudry L, Douglass M, Lewis J, et al., *The Impact of Community Health Centers & Community-Affiliated Health Plans on Emergency Department Use*, Association for Community Affiliated Plans and National Association of Community Health Centers, Washington DC; ACAP; April 2007.
- ¹¹⁵ Daly BJ, Douglas SL, Kelley CG, et al., Trial of a disease management program to reduce hospital readmissions of the chronically critically ill, *Chest*, 2005;128(2):507-517.
- ¹¹⁶ Naylor MD, Brooten DA, Campbell RL, et al., Transitional care of older adults with heart failure: a randomized, control trial, *J Amer Geriatr Soc*, 2004;52(5):675-684.
- ¹¹⁷ Qaseem A, Snow V, Shekelle P, et al., Evidence-based interventions to improve the palliative care of pain, dyspnea, and depression at the end of life: a clinical practice guideline from the American College of Physicians, *Ann Intern Med*, 2008;148(2):141-146.
- ¹¹⁸ Lorenz K, Lynn J, Morton SC, et al., *End-of-Life Care and Outcomes*, Agency for Healthcare Research and Quality Evidence Report/Technology Assessment Number 110, Rockville, MD: AHRQ; 2004.
- ¹¹⁹ Santa-Emma PH, Roach R, Gill MA, et al., Development and implementation of an inpatient acute palliative care service, *J Palliat Med*, 2002;5(1):93-100.
- ¹²⁰ Brumley RD, Enguidanos S, Cherin DA, Effectiveness of a home-based palliative care program for end-of-life, *J Palliat Med*, 2003;6(5):715-724.
- ¹²¹ Lorenz K, Lynn J, Morton SC, et al., *End-of-Life Care and Outcomes*, Agency for Healthcare Research and Quality Evidence Report/Technology Assessment Number 110, Rockville, MD: AHRQ; 2004.
- ¹²² Jennings B, Ryndes T, D'Onofrio C, et al., Access to hospice care – expanding boundaries, overcoming barriers, *Hastings Cent Rep*, 2003; Mar-Apr Suppl: S3-7, S9-13, S15-21.

- ¹²³ Goldsmith B, Dietrich J, Qingling D, et al., Variability in access to hospital palliative care in the United States, *J Pall Med*, 2008;11(8):[Epub ahead of print].
- ¹²⁴ Jennings B, Ryndes T, D'Onofrio C, et al., Access to hospice care – expanding boundaries, overcoming barriers, *Hastings Cent Rep*, 2003; Mar-Apr Suppl: S3-7, S9-13, S15-21.
- ¹²⁵ Zimmermann C, Riechelmann R, Krzyzanowska M, et al., Effectiveness of specialized palliative care – a systematic review, *JAMA*, 2008;299(14):1698-1709.
- ¹²⁶ Hogan C, Lunney J, Gabel J, et al., Medicare beneficiaries' costs of care in the last year of life, *Health Aff*, 2001;20(4):188-195.
- ¹²⁷ Morrison RS, Penrod JD, Cassel JB, et al., Cost savings associated with United States hospital palliative care consultation programs, *Arch Intern Med*, 2008;168(16):1783-1790.
- ¹²⁸ American Board of Internal Medicine Hospice and Palliative Medicine Certification Program, Philadelphia, PA: ABIM. Available at www.abim.org. Last accessed October 2008.
- ¹²⁹ American College of Physicians (ACP), *ACP Guidelines*. Available at www.acponline.org/clinical_information/guidelines. Last accessed October 2008.
- ¹³⁰ Brumley RD, Enguidanos S, Hillary K, The palliative care program, *The Permanente Journal*, Spring 2003;7(2):7-12.
- ¹³¹ National Hospice and Palliative Care Organization Caring Connections, *Caring Connections Home Page*. Available at www.caringinfo.org. Last accessed October 2008.
- ¹³² Delaware Hospice, *Patients & Families: New Hope Program*, Delaware Hospice Center. Available at www.dehospice.org/hospice-new-hope.html. Last accessed October 2008.
- ¹³³ American Association of Colleges of Nursing, *End-of-life care*. Available at www.aacn.nche.edu/elnc. Last accessed October 2008.
- ¹³⁴ Chassin MR, Galvin RW, The Institute of Medicine National Roundtable on Health Care Quality, The urgent need to improve health care quality, *JAMA*, 1998;280(11):1000-1005.
- Schuster MA, McGlynn EA, Brook RH, How good is the quality of health care in the United States? *Milbank Q*, 1998;76(4):517-563.
- IOM, *Crossing the Quality Chasm: A New Health System for the 21st Century*, Washington, DC: National Academy Press; 2001.
- McGlynn EA, Asch SM, Adams J, et al., The quality of health care delivered to adults in the United States, *NEJM*, 2003;348(26):2635-2645.
- New England Healthcare Institute (NEHI), *How Many Studies Will it Take?* Cambridge, MA: NEHI; 2008. Available at www.nehi.net/publications/30/how_many_more_studies_will_it_take. Last accessed October 2008.
- ¹³⁵ Fisher ES, Wennberg DE, Stukel TA, et al., The implications of regional variations in Medicare spending (parts 1 & 2), *Ann Intern Med*, 2003;138(4):273-298.
- ¹³⁶ NEHI, *How Many Studies Will it Take?* Cambridge, MA: NEHI; 2008.
- ¹³⁷ Contributors included the following: American Academy of Dermatology; American Association of Clinical Endocrinologists; American College of Cardiology; American College of Physicians; American College of Radiology; American Nurses Association; American Psychiatric Association; American Society of Clinical Oncology; America's Health Insurance Plans; Childbirth Connection; Council of Accountable Physician Practices; Council of Medical Specialty Societies; Institute for Clinical Systems Improvement; North Shore Long Island Jewish Health System; Physicians Consortium for Performance Improvement; Premier; and VHA, Inc.
- ¹³⁸ Brownlee S, *Overtreated – Why Too Much Medicine Is Making Us Sicker and Poorer*, 1st ed., New York: Bloomsbury USA; 2007.

- ¹³⁹ Berenson A, Reed A, Weighing the costs of a CT scan's look inside the heart, *New York Times*, June 29, 2008. Available at www.nytimes.com/2008/06/29/business/29scan.html?_r=1&oref=slogin. Last accessed October 2008.
- HealthDay News, Increase in diagnostic imaging fueled by self-referring doctors, *U.S. News & World Report*, April 24, 2008. Available at <http://health.usnews.com/usnews/health/healthday/080424/increase-in-diagnostic-imaging-fueled-by-self-referring-doctors.htm>. Last accessed October 2008.
- Rubenstein S, Insurers lightly squeeze medical imaging costs, *The Wall Street Journal Health Blog*, July 28, 2008. Available at <http://blogs.wsj.com/health/2008/07/28/health-insurers-lightly-squeeze-medical-imaging-costs/>. Last accessed October 2008.
- Brownlee S, Why does health care cost so much? *AARP Magazine*, July/August 2008. Available at www.aarpmagazine.org/health/health_care_costs.html. Last accessed October 2008.
- Consumer Reports Health.org, Doctors & Hospitals, *Do More, Make More*; November 2007. Available at www.consumerreports.org/health/doctors-hospitals/medical-ripoffs/overspending-on-overtreatment/overspending-on-overtreatment.htm. Last accessed October 2008.
- ¹⁴⁰ NEHI, *How Many Studies Will it Take?* Cambridge, MA: NEHI; 2008.
- ¹⁴¹ Ciesla G, Leader S, Stoddard J, Antibiotic prescribing rates in the U.S. ambulatory care setting for patients diagnosed with influenza, 1997-2001, *Respir Med*, 2004;98(11):1093-1001.
- ¹⁴² The Commonwealth Fund, *Common Cold: Inappropriate Antibiotic Treatment*, New York: The Commonwealth Fund; 2006. Available at www.commonwealthfund.org/snapshotscharts. Last accessed October 2008.
- ¹⁴³ Baicker K, Buckles KS, Chandra A, Geographic variation in the appropriate use of cesarean delivery, *Health Aff*, 2006;25(5):w355-w367.
- ¹⁴⁴ Broder MS, Kanouse DE, Mittman BS, et al., The appropriateness of recommendations for hysterectomy, *Obstet Gynecol*, 2000;95(2):199-205.
- ¹⁴⁵ Boden WE, O'Rourke RA, Teo KK, et al., Optimal medical therapy with or without PCI for stable coronary disease, *NEJM*, 2007;356(15):1503-1516.
- ¹⁴⁶ Friedman B, Basu J, Health insurance, primary care, and preventable hospitalization of children in a large state, *Am J Manag Care*, 2001;7(5):473-481.
- Kozak LJ, Hall MJ, Owings MF, Trends in avoidable hospitalizations, 1980-1998, *Health Aff*, 2001;20(2):225-232.
- ¹⁴⁷ Pomerantz WJ, Schubert CJ, Atherton HD, et al., Characteristics of nonurgent emergency department use in the first 3 months of life, *Pediatr Emerg Care*, 2002;18(6):403-408.
- ¹⁴⁸ Flores G, Abreu M, Chaisson CE, et al., Keeping children out of hospitals: parents' and physicians' perspectives on how pediatric hospitalization for ambulatory care-sensitive conditions can be avoided, *Pediatrics*, 2003;112(5):1021-1030.
- ¹⁴⁹ Powell LH, Meyer P, Weiss G, et al., Ethnic differences in past hysterectomy for benign conditions, *Womens Health Issues*, 2005;15(4):179-186.
- ¹⁵⁰ Sakala C, Corry M, *Evidence based maternity care: what it is and what it can achieve*, New York: Milbank Memorial Fund; 2008. Available at www.milbank.org/reports/0809MaternityCare/0809MaternityCare.pdf. Last accessed October 2008.
- ¹⁵¹ Murillo JR, Koeller J, Chemotherapy given near the end of life by community oncologists for advanced non-small cell lung cancer, *Oncologist*, 2006;11(10):1095-1099.
- ¹⁵² Harrington SE, Smith TJ, The role of chemotherapy at the end of life: when is enough, enough? *JAMA*, 2008;299(22):2667-2678.

- ¹⁵³ Dartmouth Atlas Project, *Supply-sensitive care – a Dartmouth Atlas Project topic brief*, Lebanon, NH: Dartmouth Atlas Project; 2007. Available at www.dartmouthatlas.org/topics/supply_sensitive.pdf. Last accessed October 2008.
- ¹⁵⁴ Congressional Budget Office (CBO), *Geographic Variation in Health Care Spending*, 2008, Washington, DC: CBO; February 2008. Available at www.cbo.gov/doc.cfm?index=8972. Last accessed October 2008.
- ¹⁵⁵ The Commonwealth Fund, *Why Not the Best? Results from the National Scorecard on U.S. Health System Performance, 2008*, New York: Commonwealth Fund; 2006.
- ¹⁵⁶ AHRQ, *Preventable Hospitalizations: Window into Primary and Preventive Care*, Rockville, MD: AHRQ; 2000. HCUP Fact Book No. 5, AHRQ.
- ¹⁵⁷ The Commonwealth Fund, *Why Not the Best? Results from the National Scorecard on U.S. Health System Performance, 2008*, New York: Commonwealth Fund; 2006.
- ¹⁵⁸ Rubenstein S, Insurers lightly squeeze medical imaging costs. *The Wall Street Journal Health Blog*, 28 July 2008. Available at <http://blogs.wsj.com/health/2008/07/28/health-insurers-lightly-squeeze-medical-imaging-costs/>. Last accessed October 2008.
- ¹⁵⁹ Ibid.
- ¹⁶⁰ Home Health Quality Initiative National Campaign, *Best Practice Intervention Packages*. Available at www.homehealthquality.org/hh/hha/interventionpackages/default.aspx. Last accessed October 2008.
- ¹⁶¹ Brownlee S, Why does health care cost so much? *AARP Magazine*, July/August 2008. Available at www.aarpmagazine.org/health/health_care_costs.html. Last accessed October 2008.
- ¹⁶² McGlynn EA, Selecting common measures of quality and system performance, *Med Care*, 2003;41(1 Suppl):I39-I47.
- ¹⁶³ Consumer Purchaser Disclosure Project, *Patient Charter for Physician Performance Measurement, Reporting and Tiering Programs: Ensuring Transparency, Fairness and Independent Review*; April 1, 2008. Available at <http://healthcaaredisclosure.org/docs/files/PatientCharter.pdf>. Last accessed October 2008. Several of the Partners have endorsed the “Patient Charter,” including AARP, AFL-CIO, American Medical Association, America’s Health Insurance Plans, Leapfrog Group, National Business Coalition on Health, National Partnership for Women and Families, and Pacific Business Group on Health.
- ¹⁶⁴ IOM, NAE, *Building a Better Delivery System: A New Engineering/Health Care Partnership*, Washington, DC: The National Academies Press; 2005.
- ¹⁶⁵ Rosenthal MB, Beyond pay for performance – emerging models of provider-payment reform, *NEJM*, 2008;359(12):1197-1200.
- ¹⁶⁶ CMS, *Medicare and Medicaid Move Aggressively to Encourage Greater Patient Safety in Hospitals and Reduce Never Events*, Baltimore, MD: CMS; July 31, 2008. Available at www.cms.hhs.gov/apps/media/press/release.asp?Counter=3219&intNumPerPage=10. Last accessed October 2008.
- ¹⁶⁷ Naylor MD, Brooten DA, Campbell RL, et al., Transitional care of older adults with heart failure: a randomized, control trial, *J Am Geriatr Soc*, 2004;52(5):675-684.
- ¹⁶⁸ Jost TS, Emanuel EJ, Legal reforms necessary to promote delivery system innovation, *JAMA*, 2008;299(21):2561-2563.
- ¹⁶⁹ Trisolini M, Aggarwal J, Leung M, et al., *The Medicare Physician Group Practice Demonstration: Lessons Learned on Improving Quality and Efficiency in Health Care*, New York: The Commonwealth Fund; 2008. Available at www.commonwealthfund.org/usr_doc/1094_Trisolini_Medicare_phys_group_practice_demo_lessons_learned.pdf?section=4039. Last accessed October 2008.
- ¹⁷⁰ Casale A, Paulus R, Selna M, et al., ProvenCareSM a provider-driven pay-for-performance program for acute episodic cardiac surgical care, *Ann Surg*, 2007;246(4):613-623.
- ¹⁷¹ Dougherty D, Conway PH, The “3T’s” road map to transform US health care: the how of high quality care, *JAMA*, 2008;299(19):2319-2321.

- ¹⁷² O’Kane M, Corrigan J, Foote SM, et al., Crossroads in quality. *Health Aff*, 2008;27(3):748-758.
- ¹⁷³ Dougherty D, Conway PH, The “3T’s” road map to transform US health care: the how of high quality care. *JAMA*, 2008;299(19):2319-2321.
- ¹⁷⁴ IOM, *Health Professions Education: A Bridge to Quality*, Washington, DC: The National Academies Press; 2003.
- ¹⁷⁵ IOM, *Crossing the Quality Chasm: A New Health System for the 21st Century*, Washington, DC: National Academy Press; 2001.
- ¹⁷⁶ Jost TS, Emanuel EJ, Legal reforms necessary to promote delivery system innovation. *JAMA*, 2008;299(21):2561-2563.
- Bodenheimer T, Coordinating care: a perilous journey through the healthcare system, *NEJM*, 2008;358(10):1064-1071.
- ¹⁷⁷ Tollen L, *Physician Organization in Relation to Quality and Efficiency of Care: A Synthesis of Recent Literature*, New York: Commonwealth Fund; 2008. Available at www.commonwealthfund.org/usr_doc/Tollen_physician_org_quality_efficiency_1121.pdf?section=4039. Last accessed October 2008.
- ¹⁷⁸ Chaudhry B, Wang J, Maglione M, et al., Systematic review: impact of health information technology on quality, efficiency, and costs of medical care, *Ann Intern Med*, 2006;144(10):742-752.
- ¹⁷⁹ Bodenheimer T, Coordinating care: a perilous journey through the healthcare system, *NEJM*, 2008;358(10):1064-1071.
- ¹⁸⁰ National Committee for Quality Assurance, *Physician Practice Connections*. Available at www.ncqa.org/tabid/141/Default.aspx. Last accessed October 2008.
- ¹⁸¹ Reports available at AHRQ’s website at www.ahrq.gov.

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