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FOLDER TITLE:

Preventing Medical Errors [5]

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THE STATE OF FLORIDA

WASHINGTON OFFICE

444 NORTH CAPITOL STREET
SUITE 349
WASHINGTON, D.C. 20001

TELEPHONE # (202) 624-5885
FAX # (202) 624-5886

FOLLOWING 2 PAGES

TO: CHRIS JENNINGS

FAX # _____

FROM: CHARLIE SALEM

DATE: 5/29/98 TIME: 12:45

NOTE: AS discussed



Central Florida Health Care Coalition

BECKY J. CHERNEY

Becky J. Cherney is President/CEO of the Central Florida Health Care Coalition in Orlando, Florida. Representing 750,000 members from public and private employers, the Coalition has been recognized nationally for its Quality Initiative. The Initiative has clinical quality, overall community health status and patient satisfaction components in place. The clinical component alone has saved health care consumers in Central Florida over \$300 million in five years while improving the health of the community.

The Coalition's Quality Initiative has been profiled on *World News with Peter Jennings* and in *The New York Times*. *The Times* article asked, "What is the best health care alliance in the country? Maybe this one."

Prior to assuming this position in 1994, Cherney served as a Consultant to Florida's Agency for Health Care Administration. She was responsible for implementing the state's cutting-edge legislation for Community Health Purchasing Alliances.

Becky spent 23 years in the private sector with three Fortune 500 companies. It was during her 11 year tenure with Tupperware International that she founded the Coalition.

A graduate of the University of Wisconsin, she has always been very active in the community. She is the founder of the Central Florida Women's Resource Center and has served as President of the Human Services Council and Florida Executive Women. She is currently serving her second appointed term on the Florida Board of Medicine.

In an *Orlando Business Journal* survey in March, 1998, Cherney was voted unanimously to the list of the Top 25 Influences in Health Care. The survey said, "One of her greatest strengths is her leadership in opening up communication between physicians and employers." That is an essential skill for any quality initiative.

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A PURCHASING ALLIANCE

Employers in Orlando Create an Envied Model

By LARRY ROHTER
Special to The New York Times

ORLANDO, Fla. - When Jim Coleman took over as personnel director for the town government in the Orlando suburb of Longwood four years ago, he was alarmed to find that the cost of providing health care coverage for its 155 employees was rising by as much as 25 percent a year. There was little he could do about it, though.

"We really didn't have any bargaining power" with the insurance companies that offered health care packages, Mr. Coleman recalled. "Some providers wouldn't even let us bid. They were not making any money off cities, so they didn't want our business."

Then Longwood joined the Central Florida Health Care Coalition, a health purchasing alliance that enables employers both large and small in the Orlando area to shop for health care coverage as a single entity. The coalition had been created in the mid-1980's, entirely free of any Government prodding or incentive, by corporate heavyweights like the Walt Disney Company, General Mills, Tupperware and Martin Marietta. In joining it, Longwood got immediate results.

"The first year, our rates were a little lower than the previous year, and we have had no premium increases in three years," Mr. Coleman said. "We've turned the clock back to pre-1990 rates, and they have stayed there," saving Longwood taxpayers tens of thousands of dollars.

Lower Costs, Better Care

The City of Longwood is hardly alone in welcoming the competition that the purchasing group, which represents more than 100 companies with over 500,000 employees and dependents, has brought to health care here. At Orlando Regional Medical Center, the largest hospital in the area, administrators and doctors say efforts to meet the cost and quality standards that the coalition encourages have resulted not only in millions of dollars in savings but also in lower mortality and morbidity rates that reflect improved patient care.

There are already more than 100 similar health care purchasing alliances around the country, organizations that got the jump on President Clinton's health care plan, which would require the creation of a vast national network of such alliances. Whether or not the President's plan is enacted - indeed, whether or not Congress enacts any health care legislation this year - many of these private-sector health care initiatives have long since proved successful. And none more so than the Central Florida Health Care Coalition, one of the

oldest and largest of them.

"Orlando is a pioneer in making health care more effective, so that all the actors in the system can get the best quality at the lowest cost," said Sean Sullivan, president of the National Business Coalition on Health. "They offer a model that others are following because they have demonstrated results."

For the same reason, the coalition's operations have been closely studied by officials in Tallahassee and even Washington. The State of Florida's Agency for Health Care Administration acknowledges that its new system of government-organized purchasing alliances for businesses with 50 or fewer employees is inspired by Orlando's example.

Edward Towey, a spokesman for the state agency, said the Orlando coalition was a model for the rest of Florida on at least two counts. "It's not only that they are pooling their buying power," he said. "Equally important is the comprehensive collection of data, which lets purchasers see what kind of value they are getting for their money."

Resistance, but Not for Long

The coalition was born nearly a decade ago out of the dissatisfaction of employee-benefits managers at several of the largest companies in the Orlando area. Health care costs here were rising by double-digit percentages each year, and the benefits managers, who had begun to analyze hospital bills, could find no correlation between cost and quality.

At first, doctors and hospitals resisted. "Many of the providers didn't even see a reason to talk with us," said Dennis Loney, manager of employee benefits for Disney, whose 34,000 workers here make it the largest member of the coalition. "And some of those who did talk with us refused to talk about quality."

But the coalition plunged ahead anyway. And as its members looked systematically at hospital records, many questions arose. Why, for example, were so many patients being held for observation over weekends, a practice so routine that Monday was the No. 1 day for discharge? When the coalition simply pointed out that circumstance, administrators and doctors quickly made adjustments in their procedures.

Over time, the coalition and hospitals learned that by sharing information and pinpointing areas for improving performance, all sides could benefit.

"It's not a threatening or accusatory relationship," Mr. Loney said of the coalition's dealings with hospitals here. "All we do is share the data and express a concern, and let them do the rest."

By the late 1980's, new tools were available, and the coalition was quick to take advantage of them. Any health care provider who wished to do business with

the coalition was required to install a national computerized data-gathering system developed by MediQual, a company based in Westborough, MA, to track every piece of information that went onto a patient's chart during a hospital stay.

That database, gathered from some 550 hospitals around the country, allowed the coalition and local hospitals for the first time to measure the relationship between the price and the quality of medical care. Because of the system, which cost about \$50,000 to install, it became possible to compare the effectiveness not only of one hospital to another but also of individual doctors.

A Recent Phenomenon

"Health care has not really been competitive until quite recently," said Eric Kriss, president of MediQual. "As a result, you have tremendous variations in both quality and cost, far more than you would find in a truly competitive industry. We routinely find variations of price and quality of 200 to 400 percent."

At first, said Rindy Rudy, business director at Orlando Regional Medical Center, "all of us were very nervous" about the data-gathering system. The main questions, she said, were two: "Could a computer system really measure quality? And how would we look?"

Doctors in particular were initially dubious. "I thought that as our costs dropped, quality would suffer," said C. Gordon Wolfram, former chief of medicine at the medical center. "But the opposite has occurred. As our costs have dropped, our mortality and morbidity rates have actually improved."

One important reason for the improvement, Dr. Wolfram said, is that the hospital had previously had "a few doctors going overboard on ordering tests and procedures." In some instances, he said, "the tests themselves were causing some morbidity."

The data allowed doctors to compare

What is the best health care alliance in the country? Maybe this one.

their treatments against those of colleagues, and it was this feature that eventually won them over.

One cardiologist, for example, had routinely prescribed an expensive clot-busting medicine for his patients, believing that it was by far the best thing on the market and therefore worth the

\$2,000 that it added to a patient's bill. But a colleague who prescribed a less expensive medicine had the same success rates with his patients. When the doctor who prescribed the more expensive medicine was shown the results, he was at first surprised but agreed to try the cheaper drug. He was eventually convinced that his patients were not adversely affected by the change.

"That was a big eye-opener," Dr. Wolfram said, "to see that there was a huge diversity of treatment practice patterns and that quality did not directly correlate with cost."

That one change - in the medication prescribed by one doctor in only one of the hospital's 22 departments - has meant hundreds of thousands of dollars in savings, said Ms. Rudy, the hospital's business director. By taking an equally hard look in other departments, officials have reduced costs there as well.

Not long ago, for example, the hospital bought hip prostheses from 10 different manufacturers, at a cost ranging from \$1,500 to \$7,000 a unit. "Now we are down to three suppliers," Ms. Rudy said. "We told the physicians, 'You make the decision.'" Given the data, the doctors decided that the most expensive hip implant was no better than the competition, and cut it from the list.

Similarly an analysis of data on gall bladder operations indicated that a smaller incision reduced the likelihood of post-surgical infection, which in turn reduced the average length of a patient's hospital stay. The result: lower costs for the hospital and a smaller bill for the patient.

End to a Medicare Drain

As a result of these and other changes, Orlando Regional Medical Center is no longer losing money on the Medicare patients it treats. Three years ago the hospital was running \$12.4 million in the red on its Medicare cases, but by the first quarter of this year "we were actually making a little bit," Ms. Rudy said.

"By cutting our losses on Medicare, we can stop cost-shifting," Dr. Wolfram added. "That means we don't have to saddle patients from Disney with those costs. So Disney is happy, and we're happy."

For the most part, employees enrolled in the coalition's various coverage plans also seem satisfied. Trisha Fuston, a 25-year-old payroll clerk in Longwood, said that although doctors sometimes "rush you in and out," she recognizes that she is getting good value for the \$67 a month, plus \$5 an office visit, that her coverage costs her.

"This is the first time I've ever had insurance, and it's been pretty good," she said.

THE
Challenge
&
Potential

FOR ASSURING

quality
health care

FOR THE

21st century



Prepared by the
Department of Health and Human Services

THE CHALLENGE AND POTENTIAL FOR ASSURING QUALITY HEALTH CARE FOR THE 21ST CENTURY

I. Introduction

Millions of Americans receive high quality health care services. The United States has many of the world's finest health care professionals, academic health centers, and other research institutions. However, too often, the quality of care provided to patients is substandard. Too often, patients receive excessive services that undermine the quality of care and needlessly increase costs; and other times they do not get services that have proven effective at improving health outcomes and even reducing costs.

For example, one study found that only 20 percent of eligible patients received beta blockers following a heart attack, despite the fact that they have been proven to be an effective intervention, reducing mortality by 43 percent (Soumerai, et al., 1997). Another study found that antibiotics are frequently over-prescribed, contributing to microbial resistance to these drugs (Gonzales, et al., 1997). Such resistance could cost as much as \$7.5 billion a year for more expensive health care interventions (Phelps, 1989). Moreover, there is still an unacceptable rate of errors; one study estimates that preventable errors in hospital care lead to 180,000 needless deaths each year (Leape, 1994). There is also a wide variation of medical practices across the country. For example, hospital discharge rates were 49 percent higher in the Northeast than in the West (Graves and Gillum, 1997).

Poor quality care leads to sicker patients, more disabilities, higher costs, and lower confidence in the health care industry. As this report clearly documents, there is great potential to improve the quality of the nation's health care system, and there is widespread interest among representatives in the health care system to make these improvements.

Consumers want understandable and reliable information to help them make critical decisions about their health care. Most Americans consider it very important to know how well their health plan cares for members who are sick, catches health problems at an early stage, and keeps members as healthy as possible. In fact, 90% consider how well their health plan takes care of members who are sick very important and 90% consider it very important to know how easy their health plan makes it for members to get the care they need (AHCPR-Kaiser, 1996). However, the vast majority of Americans did not see any information comparing the quality of health care plans, doctors or hospitals within the last year.

Private and public purchasers have also demonstrated that they want more information about the quality of the care they purchase for their employees, their dependents and beneficiaries as well as new strategies to improve it. As this report illustrates, many private purchasers are developing quality improvement programs, report cards and other measurement tools to help assure that they

can purchase health care based on quality, not just cost and benefits. For example, GTE provides its employees with report cards so they can choose a plan based on cost and quality, and the Pacific Business Group on Health requires HMOs to set aside 2 percent of the premium dollar and allows plans to keep that money only if they attain the performance standards set in customer service, quality, data collection, and other areas.

Other efforts have emerged to measure and report on health care quality that have begun to provide consumers and purchasers the information they need to purchase quality health care and to enable health professionals and others to develop targeted strategies to improve care. Businesses as well as government agencies are working with health care providers, health insurers, health plans, accreditation organizations, labor unions, and others to encourage the development of these efforts. This report shows that where these representatives have come together to make targeted efforts to improve the quality of care, they have been successful in improving health outcomes, increasing confidence, and often lowering costs.

Some successful strategies have been identified and implemented, but there is clearly a need for a national effort. In its Final Report, the President's Advisory Commission on Consumer Protection and Quality in the Health Care Industry commends the investment in quality measurement and reporting made by some of the leading organizations in the field. But it notes that, "despite a growing number of efforts to measure and report on health care quality, useful information is neither uniformly nor widely available." Current efforts, the Commission added, "fall short of fully meeting users' needs and often are duplicative and unduly burdensome on health care providers, plans, and others." The Commission calls for "a national commitment to the measurement, improvement, and maintenance of high-quality care for all citizens."

While there has been a patchwork of successful efforts to improve health care quality, the current system leaves many gaps, and in many other cases is redundant. Moreover, there is no mechanism to share best practices and successful strategies; many purchasers simply do not have the information they need to assure they can purchase health care on the basis of quality, and not just what it costs or what it covers.

To address these concerns, the President's Commission called for the creation of two complementary entities to advance efforts to measure and report on health care quality -- a public sector Advisory Council on Health Care Quality and a private sector Forum for Health Care Quality Measurement and Reporting. President Clinton has called on Congress to create a Quality Council through legislation, which would establish national goals to improve health care quality and develop strategies to achieve them. He has asked Vice President Gore to help assure the development of the private Quality Forum that would bring together the public and private sectors to identify a core set of measures to be adopted by health plans across the country that would ensure that, for the first time, consumers have a consistent set of standards so they can choose health plans based on quality -- not just on cost.

The Council and the Forum are part of the Quality Commission's overall recommendations to improve the quality of health care. In its first report to the President, the Quality Commission recommended a patients' bill of rights to assure that all Americans get the protections they need in a changing health care system. The Commission's recommendations build on the Administration's longstanding commitment to increase access to and improve the quality of health care. For example, last year the President enacted the largest investment in children's health care as well as unprecedented Medicare reforms that extended the life of the Medicare Trust Fund for a decade while improving plan choices and preventive benefits. However, access to health insurance is, of course, not sufficient to assure quality of health care.

As envisioned by the Commission, the Quality Forum will build the systemwide capacity to evaluate and report on health care quality. For the first time, representatives of private and public purchasers will work hand in hand with consumers, providers, and other interested parties to develop a comprehensive plan for implementing quality measurement, data collection, and reporting standards and ensure the widespread availability of this type of information to consumers, providers, purchasers and others.

The Forum will help eliminate duplicative and overlapping demands for information from health care providers and plans, and it will provide consumers and other purchasers with a common yardstick to make direct comparisons of health plans, hospitals, nursing homes, or physician. Because purchasers will be speaking with a more unified and pragmatic voice on quality information needs, accreditors, health plans, health professionals and providers will be able to be much more responsive. In so doing, it will help assure that health plans will compete on the basis of quality as well as cost and benefits.

II. Evidence of Quality Problems

While millions of Americans receive high quality health care services, there are a number of areas where the quality of care is falling short. This section documents some of these quality problems including underuse, overuse, misuse and variation in use of health care services.

Underuse of Services. The failure to provide needed health care services often leads to unnecessary complications, higher costs, and premature mortality. There are numerous examples where services that have proven effective in improving care and often lowering costs are not being used. They include:

Diabetes Care. People living with diabetes require annual eye exams to avoid potential blindness (NIH, 1998). Yet, in its survey of managed care plans, the National Committee for Quality Assurance found that only 40% of diabetics in 1996 had received an eye exam during the previous year (NCQA, 1997).

Mammograms. Early detection of breast cancer through mammograms can prevent up to 30% of breast cancer deaths each year (CDC, 1998). However, NCQA found that 30% of women age 52 to 69 in surveyed managed care plans had not received a mammogram in the previous two years (NCQA, 1997).

Cervical cancer screening. As a result of early detection efforts, the incidence of invasive cervical cancer has decreased (CDC, 1998). Yet in 1996, nearly 30% of women between the ages of 21 and 64 had not received at least one Pap smear in the previous three years (NCQA, 1997). In 1998, an estimated 13,700 women will be diagnosed with cervical cancer and 4,900 women will die from the disease.

Heart Attacks. The use of beta blockers after heart attack has been shown to reduce mortality by 43%. Yet, in a sample of Medicare patients in New Jersey, only 21% of eligible patients received beta blockers (Soumerai, et al., 1997). Experts at the Mount Sinai School of Medicine have estimated that more consistent use of beta-blocker therapy could prevent an estimated 18,000 deaths each year (Chassin, 1997). The use of aspirin after heart attacks has also been shown to reduce mortality. But, in one study, a third of Medicare patients who survived a heart attack failed to receive aspirin within two days of hospitalization (Krumholz, et al., 1995).

Overuse of Services. Excessive and unnecessary health care services can increase health care costs without improving health and can place patients at greater risk for injuries and complications. Examples of overuse of services that include:

Antibiotics. In 1992, half of all patients diagnosed with a cold and 66% of patients diagnosed with acute bronchitis received antibiotics (Gonzales, et al., 1997). Yet antibiotics offer little or no benefit for these conditions. In that year, twelve million antibiotic prescriptions were written during office visits for colds, upper respiratory tract infections and bronchitis. These prescriptions accounted for one out of every five antibiotic prescriptions to adults in that year. Overuse of antibiotics imposes unnecessary health care costs, places patients at risk for adverse drug reactions and contributes to the emergence of antibiotic-resistant pathogens. Such resistance could cost as much as \$7.5 billion a year in unnecessary costs (Phelps, 1989).

Hysterectomies. A study of the use of hysterectomies in seven managed care plans found that 16% were unnecessary (Bernstein, et al., 1993).

Tympanostomy tubes. From 1991 to 1992, 23% of tympanostomy tube insertions for children with ear infections were found to be inappropriate (Kleinman, et al., 1994).

Misuse of Services. Errors in health care services cause missed or delayed diagnoses, unnecessary injuries, premature death and often increased costs. Evidence of high rates of misuse of services include:

Hospital Injuries. In the landmark Harvard Medical Practice Study of hospitals in New York State, adverse events, where injuries result from medical management rather than underlying disease, occurred in 3.7% of all hospitalizations (Brennan, et al., 1991). Of these adverse events, nearly 14% resulted in death. Investigators attributed negligence as the cause of 27.6% of the adverse events and 51.3% of the deaths. Based on this study, Dr. Lucian Leape of Harvard School of Public Health has estimated that preventable errors in hospital care lead to 180,000 needless deaths each year (Leape, 1994).

Laboratory Tests. After rescreening, experts determined that anywhere from 10-to-30% of Pap smear test results were incorrectly classified as normal (Wilbur, 1997). These errors can result in missed or delayed diagnoses, sometimes meaning that patients have to go through more extensive and costly treatment.

Medication Errors. A study of two tertiary care hospitals found that among nonobstetrical patients that suffered an adverse reaction to a prescribed drug, an estimated 28% of these injuries were deemed preventable (Bates, et al., 1995). As a result, these patients spent more time in the hospital and health care costs increased. In fact, the authors of the study estimated that preventable adverse drug events would cost an additional \$2.8 million for a 700-bed teaching hospital (Bates, et al., 1997). If the costs in this study were representative of and extrapolated to the nation's acute care hospitals, these investigators estimated that the hospital costs of preventable adverse drug events would be \$2 billion annually.

Ear infections. One study demonstrates that the use of less expensive types of antibiotics for ear infections reduced the need for a second antibiotic course within 24 days of the initial therapy, was associated with a reduced rate of adverse drug reactions (ADRs), and led to similar or better outcomes than the more expensive alternatives. Yet these more expensive alternatives are still commonly prescribed. If only half of the prescriptions for these antibiotics were written for the low-cost alternatives instead, the Colorado Medicaid program would have saved \$400,000 in 1992, and nationwide, expenditures would decrease 36% with the possibility for a reduced rate of ADRs and drug resistance (Berman, et al., 1997).

Variation in Services. There are significant geographic differences in practice that cannot be accounted for by differences in the health status of patients, available resources, patient preferences, or even clinical uncertainty. Such variation in services has contributed to disparities in mortality and morbidity.

Hospital services. Hospital discharge rates and lengths of stay in the Northeast were 49% and 40% higher, respectively, than those in Western states (Graves and Gillum, 1997).

Cesarean section rates. Cesarean section rates in Washington State hospitals ranged from 0% to 43% (McKenzie and Stephenson, 1993).

Diabetes care. Researchers found a twofold variation in routine care provided for diabetics (glycosylated hemoglobin measurement, eye exams, and total cholesterol measurement) across three states (Weiner, et al., 1995). The National Committee for Quality Assurance found a similar variation in the rate of eye exams routinely recommended for diabetics, with over 50% of diabetics receiving annual eye exams in New England managed care plans compared to 32.6% in plans in the South Central region of the country (NCQA, 1997).

III. From Quality Measures to Quality Care: Examples of Quality Improvement at Work

Federal and State governments, private purchasers, physicians, nurses, insurers, labor unions, health plans, hospitals, accreditation organizations, and others have begun to address some of the significant quality problems in the U.S. health care system. One approach they have taken is to improve the ability to measure and report on the quality of care being delivered. The reporting of quality measures prompts a closer look at provider or health plan practices both as feedback for clinicians or as publicly available scorecards for consumers and purchasers to evaluate. Several of these endeavors have led to improvements in the quality of care and in the health outcomes for consumers, while often saving costs. Among these are:

The Prevention of Heart Attacks with Beta-Blocker Treatment

Despite the clear medical evidence that the use of beta blockers can significantly reduce the odds that a heart attack patient will have a second, and often fatal, attack, researchers have shown that too often these patients are not prescribed this life-saving therapy. Faced with this problem, the Medicare Peer Review Organizations in Alabama, Connecticut, Iowa, and Wisconsin have launched a concerted campaign to increase use of beta blockers. They monitored beta-blocker use after heart attacks in Medicare patients and provided feedback to all practitioners in their states. As a result, beta-blocker use climbed from 31.8% of cases to 49.7% of cases (Marciniak, et al., 1998). Based on these promising findings, Medicare expanded this campaign nationwide among its PROs beginning in 1995.

With support from the Agency for Health Care Policy Research (AHCPR), the Minnesota Clinical Comparison and Assessment Program worked to generate consensus and commitment from providers to increase use of life-saving drugs like beta-blockers (Soumerai, et al., 1998). Using local medical opinion leaders at twenty hospitals, they focused on the evidence, identified

barriers to change, and offered feedback of comparative performance. Their efforts yielded a 63% increase in the use of beta-blockers.

Using another life-saving treatment for heart attack patients, the Middletown Regional Hospital in Ohio reported decreased mortality rates by reducing the time from hospital admission to the administration of thrombolytic therapy. Mortality rates decreased from 10.9% to 6.5% in less than one year. For their efforts, this hospital received the Joint Commission on Accreditation of Healthcare Organization's 1997 Codman Award, recognizing excellence in the use of outcome measurement to improve quality.

The National Committee for Quality Assurance has begun requiring health plans to submit data on the use of beta blockers after a heart attack as part of its Health Plan Employer Data Information Set, version 3.0 (HEDIS 3.0), which is a standardized set of measures that assesses the performance of managed care organizations. This information assures that purchasers and consumers have comparative information about the use of beta blockers by the health professionals in a particular health plan. In 1998, the Health Care Financing Administration, the Federal agency that administers and oversees the Medicare and Medicaid programs, began requiring health plans participating in Medicare to submit HEDIS data, including information on beta blocker use.

Improving the Quality of Care for Heart Bypass Surgery

More than half a million Americans undergo coronary artery bypass surgery each year, but the quality of that surgery varies from hospital to hospital. To help consumers choose the best care, the State of New York and a consortium of hospitals have been using quality measurement and reporting techniques to flag problem areas and to improve the quality of care for bypass patients. For nearly a decade, the New York State Department of Health (DOH) has collected and released hospital-specific data on coronary artery bypass surgery. Using these data, New York targets quality improvement efforts to those hospitals with quality problems, including site visits, comprehensive consultations, and probationary action taken against facilities until they agree to implement necessary changes. As a result of these efforts, between 1989 and 1992, the risk-adjusted mortality rate for bypass patients in New York State declined 41% (Hannan, et al., 1994). By 1993, the cardiac surgery mortality rate had declined by 52% (Hannan, et al., 1994a).

The New England Cardiovascular Project, involving five hospitals in northern New England, was begun in 1990 to reduce mortality rates among coronary bypass patients. Similar to the New York program, this effort includes site visits, data reporting, and training for health care professionals. At the end of the project, researchers reported a 24% reduction in CABG mortality among the five hospitals (O'Connor, et al., 1996).

THE CHALLENGE AND POTENTIAL FOR ASSURING QUALITY HEALTH CARE FOR THE 21ST CENTURY

Executive Summary

In its landmark report to President Clinton, the Advisory Commission on Consumer Protection and Quality in the Health Care Industry called for a "national commitment to the measurement, improvement, and maintenance of high-quality care for all Americans." As part of that effort, the Commission called for the creation of a Forum for Health Care Quality Measurement and Reporting "to develop and implement effective, efficient, and coordinated strategies for ensuring the widespread public availability of valid and reliable information on quality."

This report documents some of the existing quality problems in the health care system and identifies current strategies that have proven effective at improving quality outcomes, increasing confidence, and often reducing health care costs. It also underscores why a national effort is needed to improve the quality of health care.

Confronting Quality Problems

There are several areas where the quality of American health care is falling short, including underuse, overuse, misuse, and variation in use of health care services.

Underuse of services: The failure to provide a needed service can lead to additional complications, higher costs, and premature deaths. For example, a study of heart attack patients found that nearly 80% did not receive life-saving beta-blocker treatment, leading to as many as 18,000 unnecessary deaths each year. A survey by the National Committee for Quality Assurance (NCQA) found that only 40% of diabetics received a recommended eye exam in the previous year. The NCQA survey also found that 30% of women age 52 to 69 had a mammogram in the previous two years. A CDC study estimated that only 30% of women between 21 and 64 had a Pap smear in the previous three years, despite the fact that early screening reduces mortality.

Overuse of Services. Unnecessary services add costs and can lead to complications that undermine the health of patients. For example, half of all patients diagnosed with a common cold are incorrectly prescribed antibiotics. Overuse of antibiotics has been shown to lead to resistance and as much as \$7.5 billion a year in excess costs. Another study found that 16% of hysterectomies performed in the U.S. were unnecessary.

Misuse of Services: Errors in health care delivery lead to missed or delayed diagnoses, higher costs, and unnecessary injuries and deaths. A study of New York State hospitals found 1 in 25 patients were injured by the care they received and deaths occurred in 13.6% of those cases. Negligence was blamed for 27.6% of the injuries and 51.3% of the deaths. Based on this study, researchers estimated that preventable errors in hospital care led to 180,000 deaths per year. Researchers estimate that as many as 30% of Pap smear test results were incorrectly classified as normal.

Other groups have undertaken quality measurement and reporting projects aimed at improving survival rates among heart bypass patients. General Motors, First Chicago NBD, and others initiated the Southeast Michigan Health Care Consortium, which is collecting outcomes data for all health care centers in the region. They plan to publish data on angioplasty and coronary artery bypass surgery in the fall of 1998 (The Business Roundtable, 1997). Similarly, the California Office of Statewide Health Planning and Development and the Pacific Business Group on Health have developed the California Coronary Artery Bypass Graft Mortality Reporting Program, which collects and reports risk-adjusted, hospital-level mortality data for California hospitals that perform bypass surgery. Both of these groups hope to stimulate quality improvement by enabling comparisons among participating hospitals and health care providers (Meyer, et al., 1997).

Reducing Unnecessary Cesarean Deliveries

In 1995, nearly 4 million women entered hospitals to give birth and 785,000 women underwent cesarean section. Research into the variations in the rates of cesarean section procedures have raised questions about whether cesarian sections are being used when they are not necessary. While clinically indicated for some deliveries, this surgical procedure carries risks as well as morbidity when used as an alternative to vaginal delivery. Studies show that women living in Southern states had the highest cesarean rates while women living in Western states had the lowest rates (Clarke and Taffel, 1996). Even within states, wide variations exist. For example, cesarean section rates in Washington State hospitals ranged from 0% to 43% (McKenzie and Stephenson, 1993).

The Greater Cleveland Health Quality Choice Coalition produces a biannual report card documenting patient outcomes in 27 local hospitals. In a consumer report card released in tandem with this analysis, the Coalition has tracked the number of cesarean section deliveries as a measure of performance in those hospitals. As a result, several Cleveland hospitals have developed and implemented practice guidelines and have fostered collaboration efforts with physicians to improve care. Over three successive reporting periods, the aggregate trend of total cesarean section rates in local hospitals has declined (Cleveland Health Quality Choice Program, 1997).

The Missouri Department of Health also developed a consumer report on obstetrical services. The *ShowMe Buyer's Guide: Obstetrical Services*, issued in 1993, covered all 90 Missouri hospitals (Longo, et al., 1993). The guide looked at the length of stay, number of births, level of perinatal care, availability of labor, delivery and recovery beds at each hospital. It reported the cesarean delivery rate, high-risk infant transfer rate, ultrasound rate, vaginal birth after cesarean, very low birth weight of each facility along with the rates of neonatal mortality and patient satisfaction. Within one year of the report, approximately 50% of Missouri hospitals had taken action to address some of the issues raised by the guide; instituting or planning formal transfer

agreements with tertiary care centers for referral of high-risk infants, developing car seat programs to improve safety, and training nurse educators for breast-feeding. On follow-up, hospitals previously performing a high level of cesarean deliveries also had reviewed their procedures and significantly lowered their rates for this procedure.

Various firms and group purchasers have embarked on similar efforts to improve obstetrical care. The Massachusetts Healthcare Purchaser Group, a coalition of 27 corporate and government health care purchasers, released a 1994 report card to coalition members on obstetric care and held a "best-practice forum" on cesarean sections (Jordan, et al., 1995). The Dallas-Ft. Worth Business Coalition has initiated a pilot study to develop best practices for pregnancy and childbirth through quality measurement and reporting. General Motors, Chrysler, and the United Auto Workers union have also joined together to develop best practices for cesarean section in Flint, Michigan (AFL-CIO, 1997).

Reducing Asthma-Related Deaths

Despite advances in treatment, mortality from asthma has risen 58% from 1979 to 1992 (NAEPP, 1998). Over the same period, both the incidence of asthma cases and hospitalizations related to it climbed. In 1993, asthma led to 468,000 hospitalizations, 100 million days of restricted activity annually, and a yearly cost of \$6.2 billion. However, there are a number of examples of quality improvement efforts that have been effective at improving health outcomes and reducing costs for people with asthma, including fewer emergency room visits and hospital stays. For example:

In 1989, the National Institutes of Health initiated the National Asthma Education and Prevention Program (NAEPP). One of its landmark accomplishments was the 1991 release of the *Expert Panel Report: Guidelines for the Diagnosis and Management of Asthma*. In this guideline, the NIH recommends the use of anti-inflammatory therapy (e.g., corticosteroids) for long-term control of persistent asthma, along with patient/provider education and other measures (NAEPP, 1991). The NAEPP disseminated the report widely to health care professionals, medical schools, health care organizations, professional societies, and patients and updated the guidelines in 1997 (NAEPP, 1997). Prior to the guideline's release, only 21% of emergency physicians reported using early corticosteroid administration in asthma. In 1994, 82% of physicians reported that they followed this practice recommended in the guideline (Lantner, et al., 1995).

Parkland Memorial Hospital in Dallas, TX, has implemented a plan of increased education for asthma patients and providers, coupled with more intensive treatment (NAEPP, 1996). The hospital recorded a 53% reduction in emergency department visits by asthma patients during the first two years. In an inner-city program in Boston, children with asthma experienced an 86% reduction in hospital admissions and a 79% decline in emergency department visits in response

to interventions, including one-on-one consultations with an asthma outreach nurse, patient education in self-management, and regular monitoring of patient progress (Greineder, 1995).

The Mayo Clinic of Rochester, MN, reduced asthma-related emergency department and urgent care center visits 22%. Hospitalization rates for Family Medicine asthma patients under 65 also fell, by 47% for those patients between the ages of 45 and 64. Their approach involved improved monitoring of asthma severity through the use of peak flow meter readings and site visits to physician offices to promote prescribing of anti-inflammatory drugs for asthma. By creating slots in the Family Medicine scheduling system, the hospital ensured that asthmatics could make follow-up appointments before leaving the Center (Weiss, 1997).

The National Committee for Quality Assurance has required health plans to report on use of appropriate medications for people with asthma in its HEDIS 3.0 test set of measures. The Office of Personnel Management and the Foundation for Accountability (FACCT) have also embarked on a collaborative effort to improve asthma disease management (AFL-CIO, 1997).

Employers like AT&T, First Chicago NBD, and Deere and Company have also made efforts to improve the care of employees with asthma and reduce costs for such care (The Business Roundtable, 1997). In the first year of its program, Deere and Company, an Illinois-based manufacturer of farm equipment, recorded a 12% reduction in asthma-related treatment costs (Strickland, 1997). The company has achieved this by inviting workers and dependents with asthma to participate in an asthma education program, and facilitating the development of "personal action plans" with their physicians to guide employees' self-management of this chronic condition.

Health plans have also recorded success with disease management programs in asthma. The Family Health Plan Cooperative of Milwaukee, Wisconsin, has developed an Asthma Treatment Plan based on the NIH guidelines. They have identified the population at high risk, developed an education plan for asthmatics focusing on self-management, and encouraged physicians to work with their patients to create effective, customized asthma management plans. From 1993 to 1994, the Family Health Plan Cooperative reported a 22% reduction in asthma admissions for patients between the ages of 2 and 19 (GHAA, 1995).

Increasing Influenza Vaccination Among Adults

Influenza and pneumonia is the sixth leading cause of death in the United States (NCHS, 1997). For the elderly, influenza and its complications are particularly problematic, with 95% of the resulting deaths occurring in Americans over the age of 60 (Govaert, et al., 1994). Studies of influenza vaccine demonstrate saved lives and lower costs. In one clinical trial, influenza vaccination halved the incidence of the flu among patients over the age of 60 (Govaert, et al., 1994). Yet only 52% of people aged 65 and over received the vaccine in 1993 (CDC, 1995).

The National Committee for Quality Assurance now requires health plans to report on the number of older adults in the plans who receive flu shots each year. Similarly, the Department of Veterans Affairs has encouraged local VA hospitals to immunize 100% of its patients against the flu (VA, 1996). Under a four-year program, the Centers for Disease Control and Prevention (CDC) and the Health Care Financing Administration (HCFA) have implemented the Medicare Influenza Vaccine Demonstration project to promote use of this preventive measure (CDC, 1992). HCFA distributed letters to Medicare beneficiaries, provided physician reminders, trained nurses to recognize high-risk patients, and piggybacked vaccination messages on telephone company mailers. Over a three-year period, overall flu vaccination rates climbed from 26% to 48%. In a few of the intervention sites, vaccination rates surpassed 60%.

Building on the success of this demonstration project, influenza vaccine became a covered benefit under the Medicare program, and HCFA has undertaken a national effort to increase the use of the influenza vaccine. HCFA is working with its Peer Review Organizations (PROs), the Centers for Disease Control and Prevention, and the National Coalition for Adult Immunization to determine how best to improve immunization rates. It is also working with states, community-based organizations, and senior advocacy groups to promote this practice. The overall goal of the HCFA effort is to achieve a 60% influenza immunization rate among Medicare beneficiaries age 65 and older by the year 2000.

Reducing the Incidence of Pressure Ulcers

For the hospitalized and home care patient, pressure ulcers, or bed sores, can be a serious and chronic problem. While bedbound or immobile, unrelieved pressure on the skin can lead to its breakdown and damage to the underlying tissue. Patients in critical care, with hip fractures or with spinal injuries are at particular risk. Studies have also found that as many as one in four nursing home patients experience pressure ulcers and the cost of treating them is more than \$1.3 billion annually (Bergstrom, et al., 1994).

The Agency for Health Care Policy and Research has published two clinical practice guidelines addressing the prediction, prevention, and treatment of pressure ulcers (Bergstrom, 1992; Bergstrom, 1994). Various groups have implemented quality improvement programs to prevent and treat pressure ulcers based on these guidelines (Suntken, et al., 1996).

In its 140 long term care facilities, the Department of Veterans Affairs has undertaken a major quality improvement program to reduce the rate of pressure ulcers. In 1991, the VA Office of Quality Management began a program of calculating facility-specific incidence rates of pressure ulcers and disseminating the results to all long term care facilities in the VA system (Berlowitz, 1997). The VA viewed pressure ulcer development as an ideal indicator because they are common, required the coordinated efforts and attention of multiple health care providers, and could serve as a sentinel for more systemic problems in a facility. A VA facility in Memphis,

TN, employed a team-based approach to monitor patients and provide skin care. The rate of pressure ulcer development dropped from 11.5% to zero. Overall, the VA has experienced a decline in the incidence of pressure ulcers from 4.9% in 1990 to 3.1% in 1993. This offers another example where the feedback of quality measures prompts improvements in the quality of care.

Reducing Low-Birthweight Births

Though infant mortality rates in the United States have declined, the incidence of low birthweight babies has not. This trend is troubling since seventy percent of infant mortality traces to low birthweight newborns (Goldenberg, et al., 1998). Also, low birthweight babies often require extensive and costly treatments. An AHCPR-sponsored Patient Outcome Research Team (PORT) studied the use of drugs called corticosteroids as one treatment to reduce morbidity and mortality in these newborns. For these premature newborns, the PORT found that corticosteroids prevented many of the complications associated with prematurity—respiratory distress syndrome, brain hemorrhage and death.

Based on the PORT's work and other findings, an NIH consensus panel issued a guideline recommending corticosteroid treatment of women at risk of very pre-term deliveries (NIH, 1994). The NIH disseminated this guideline to Federal health agencies, health care organizations, continuing medical education directors at hospitals, deans of medical schools, and directors of state and county medical societies. The media and major medical journals also covered the release of the guideline. Prior to the release of the guideline, only 30% of women who delivered prematurely received corticosteroids. By 1996, this had risen to 70% (Goldenberg et al., 1998). Another study found that nearly 87% of obstetricians surveyed after the release of the NIH consensus statement believed that corticosteroids could reduce infant mortality. Consistent with the NIH guidelines, 91 percent of obstetricians reported that they would prescribe this drug therapy to prevent the complications of pre-term deliveries (Wright, 1996). An NIH-commissioned study concludes that if corticosteroids were used in 60% of cases threatening preterm delivery, \$157 million could be saved annually (NIH, 1994).

Preventing Adverse Drug Reactions

Preventable adverse drug events cause 180,000 deaths a year (Leape, 1994). There have been several efforts by providers that have resulted in significant improvements in the quality of patient care.

LDS Hospital in Salt Lake City, Utah, has taken steps to improve its rate of adverse drug events. From 1990 to 1993, they discovered 2.43% of hospital patients experienced an adverse drug event (Classen, 1995). The hospital projected that if 50% of these reactions were prevented, cost savings would total \$500,000, and hospitalization would be reduced by 450 days annually. The

hospital took a multi-pronged approach that involved providing timely feedback to physicians to prevent severe problems; more effective tracking of patient drug allergies; a program that monitors kidney function while patients receive certain antibiotics with toxic effects on the kidneys; and a computerized disease management program for antibiotic use that integrates all of these components. These efforts led to a 75% decline in adverse drug reactions related to antibiotics.

Through the Institute for Healthcare Improvement's Breakthrough series, Michigan's Pontiac Osteopathic Hospital Medical Center achieved an 80% reduction in adverse drug events in its cardiac monitoring unit in one year (Leape, 1998). The program included standardization of physician order forms, especially for common conditions covered by standardized treatment regimens; thorough notation of patient drug allergies through computerized systems and wristbands; education on and easy access to drug incompatibility information; increased availability of needed medications; and routine monitoring of drug distribution. In total, 43 health care organizations participated in this effort, setting a goal of reducing adverse drug reactions by 30% or more. After one year, one-third of the organizations had exceeded those targets.

The American Medical Association recently launched a National Patient Safety Foundation with broad support from accreditation organizations, academic institutions, health plans, and other partners. Their mission is to "enhance the safety of the US health care system" by (1) promoting research on human and organizational error and its prevention; (2) increasing awareness and communication in patient safety and errors; and (3) encouraging the application of knowledge in this field (National Patient Safety Foundation, 1998).

The Joint Commission on the Accreditation of Healthcare Organizations has established a Sentinel Event Policy, which encourages accredited health care organizations to voluntarily report unexpected events or errors that lead to death, serious physical or psychological injury (JCAHO, 1998). If an organization does not conduct an acceptable analysis of the root cause of the error, the JCAHO will place that hospital on Accreditation Watch, a fact that may be publicly disclosed as part of the organization's existing accreditation status. This designation signifies that the organization is under close monitoring by the Joint Commission.

The Department of Veterans Affairs has also designed an error reduction system in health care for use throughout its delivery system. This VA effort has taken lessons from the Aviation Safety Reporting System. Under this system, the Federal Aviation Administration has increased the reporting of errors in aviation and improved safety with steps ranging from better air traffic control procedures to a recognition of problems with pilot fatigue (Final Report, 1998).

IV. Private Sector Efforts in Value-Based Purchasing and Quality Improvement

Employers, labor unions, and other private group purchasers have increasingly demanded higher quality care for the dollars they spend on health coverage. One official at GTE stated, "We think that improved quality inherently costs less. Improve the quality of health care and, in turn, improve the quality of life" (The Business Roundtable, 1997). GTE found that in 1995, its high performance managed care plans had hospital costs that were 11.5% below the national average. Risk-adjusted mortality rates were 8% lower than previously expected. On the other hand, low performance managed care plans had costs that were 3.6% above the national average and risk-adjusted mortality rates that were only 2% lower than expected (Sheffler, 1996). Many private purchasers are developing quality improvement programs, developing report cards and other measurement tools to help assure that they can purchase health care based on quality, not just cost and benefits. By measuring and rewarding quality, all of these purchasers have invested their resources in an effort to improve care, increase satisfaction, and reduce costs. For example:

- ◆ GTE provides its employees and their families with financial incentives to enroll in "exceptional quality" plans (those with high ratings on quality measures and satisfaction surveys). Employees receive report cards on plans so that they can choose a plan based on cost and quality. Initial analyses of this approach showed that employees who considered making a health plan change were most sensitive to cost. However, they also relied significantly on specific quality information, with 30% considering GTE's designation of "exceptional quality," and 45% considering the quality scores based on HEDIS and participant satisfaction measures (Sheffler, 1996).
- ◆ General Motors blends several measures of health care quality into one amalgamated quality measure and draws from direct indicators of quality from HEDIS, employee satisfaction measures, accreditation status, and impressions gained from site visits. GM also works with its plans to develop quality improvement strategies and facilitate the sharing of best practices (Meyer, et al., 1997).
- ◆ Digital Equipment Corporation emphasizes value (which it defines as the sum of quality of care and consumer satisfaction, divided by costs) in its health care purchasing decisions. Using information yielded from its performance reporting requirements, Digital identifies the best plan in each region as the "benchmark" plan, and bases its contribution to the cost of health coverage on the premium charged by that plan (Meyer, et al., 1997).
- ◆ The Pacific Business Group on Health requires HMOs to set aside 2 percent of the premium dollar and allows plans to keep that money only if they attain the performance standards set in customer service, quality, data collection, and other areas (Bodenheimer, et al., 1998).

- ◆ Seven leading business and employer organizations have recently announced a new initiative, the Employer Quality Partnership (EQP), to “accelerate the growing emphasis on quality in private health plans.” EQP’s has released informational guides and launched a Web site as part of their efforts to educate the public about the role of employers as health care purchasers.
- ◆ The United Auto Workers labor union requires quality accreditation for all health plans offered to its members, and it is working on a strategy to provide information, including NCQA accreditation status and some quality assessment based on HEDIS measures (AFL-CIO, 1997).

Recognizing that quality health care can also lead to increased worker productivity, health plans are developing quality improvement programs that improve productivity and reduce costs. For example, the Southern California Region of Kaiser Permanente developed an “Intervention for Employment Maintenance for Members with End Stage Renal Disease.” This program involves a pre-dialysis orientation for patients. Six months before beginning dialysis, patients and their families are referred to a clinical social worker and nurse educator for evaluation and education. This collaborative team effort continues throughout the periods prior to and during dialysis, and routine monitoring and education is available for the patient. As a result of this program, blue-collar workers in the Kaiser program were 2.8 times more likely to maintain employment than a control group, with these individuals working an average of 35 hours per week. According to Kaiser, “ ‘working patients had increased quality of life, self-esteem, better health, and a more positive attitude toward work and life than nonworkers’ ” (Kaiser Permanente, 1996).

V. Why We Need a National Effort to Improve Quality

Some effective strategies have been developed to improve the quality of health care delivered to patients every day. The promising developments described in this report, along with other efforts by private industry, labor unions, States, and the Federal government, are reason for optimism. However, it is also clear that a patchwork of efforts will not lead to significant, continuous nationwide improvements in health care quality.

As the President’s Commission noted, “Incentives to improve quality have been diluted by measurement efforts that vary widely in their aims and scope, and that have been, at best, only informally coordinated” (Final Report, 1998). There are many areas that have been left unaddressed by the current system. For example, there are few quality measures or quality improvement programs on chronic conditions, and little data about quality care in institutional settings, such as nursing homes or home health agencies. Moreover, there are millions of consumers and public and private purchasers that do not have access to any of this type of information.

Also, the current system is often burdensome and redundant. For example, health plans and providers often have to collect excessive data to satisfy the variety of different reporting requirements and information needs of purchasers and consumers. Testifying before the President's Advisory Commission, Dr. Steven Udvarhelyi of Independence Blue Cross of Pennsylvania characterized the development and application of performance measures as essential to improving quality. However, he also noted that to report separate versions of HEDIS 3.0 required for commercial, Medicaid and Medicare populations and for each of three states, Independence Blue Cross had to file nine different reports with a total of 675 indicators. State-by-state mandates for ad hoc performance measures add to the quality measurement burdens facing his organization.

Moreover, at present, employers, labor unions and other group purchasers do not have a central repository for learning about best purchasing practices, nor do they have affordable access to the technical assistance that would permit replication of the practices of pioneers (Meyer, et al., 1997). Therefore, a program that has proven effective in lowering mortality following cardiac surgery in New York hospitals or a model asthma program that has improved health outcomes and saved purchasers money may never be borrowed by others interested in implementing similar initiatives.

VI. Proposing a Forum for Health Care Quality Measurement and Reporting

It is clear that directing attention to measurement gaps, reducing the burden of multiple reporting requirements, and encouraging the sharing of best practices will require much greater coordination across sectors of the health care industry.

In its Final Report to the President, the Advisory Commission on Consumer Protection and Quality in the Health Care Industry recommended a Forum for Health Care Quality Measurement and Reporting that would:

- Develop a comprehensive plan for implementing quality measurement, data collection, and reporting standards to ensure the widespread public availability of comparative information on the quality of care furnished by all sectors of the health care industry;
- Establish measurement priorities that address the national aims for improvement and that meet the common information needs of consumers, purchasers, Federal and State policymakers, public health officials, and other stakeholders;
- Periodically endorse core sets of quality measures and standardized methods for measurement and reporting;
- Make recommendations regarding an agenda for research and development needed to advance quality measurement and reporting, and sponsor research and development activities if resources are available;

VII. Planning for a Forum

To launch a Forum for Health Care Quality Measurement and Reporting, the Quality Commission recognized the need to resolve important issues of governance, organizational structure, and financial support under the auspices of a neutral convener. The first stage of this process will be a six-month period where a planning committee will work to lay the groundwork for the operations of the Forum, recruit stable funding, and ensure broad representation of stakeholders. Private and public purchasers, consumer groups, health plans, and healthcare accrediting organizations have welcomed the efforts to create this private sector entity and affirm the need for collaborative and coordinated efforts.

Building on the work of the Advisory Commission, this report highlights some of the best examples of what the public and private sectors can do to improve health care quality. Their leading edge efforts tell us that we can do better. By moving from a patchwork of public and private efforts to systemwide changes, we can bridge the gap between actual practice and best practice. Creating a Forum for Health Care Quality Measurement and Reporting is a critical step in this direction.

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MEMBERS OF THE QUALITY FORUM PLANNING COMMITTEE

Gail Warden, currently serves as the President and Chief Executive Officer of the Henry Ford Health System. He will serve as the Chair of the Planning Committee.

James Tallon, is the President of the United Hospital Fund of New York and will serve as the Executive Director of the planning committee.

Carmella Bocchino, is a professional nurse and the Vice President of Medical Affairs at the American Association of Health Plans.

Bruce Bradley, is the Director for the Health Care Initiative at the General Motors Corporation.

Nancy-Ann DeParle, is the Administrator for the Health Care Financing Administration.

Mary Jane England, is the President of the Washington Business Group on Health.

John Eisenberg, is currently the Administrator of the Agency of Health Care Policy and Research and the Operating Chair of the Quality Interagency Coordinating Task Force (QuIC) which represents all of the Federal purchasers on quality.

Janice LaChance, is Director of the Office of Personnel Management.

David Lawrence, is the Chairman and Chief Executive Officer of Kaiser Permanente in California.

Joe Laymon, is the Director of Human Resources and Vice President at Eastman Kodak.

Shelia Leatherman, is the Executive Vice President of United Health Care Corporation.

Brian Lindberg, is the Executive Director of the Consumer Coalition for Quality Health Care.

Judy Litchman, currently serves as the President of the National Partnership for Women and Families.

Meredith Miller is the Deputy Assistant Secretary and soon to be the Acting Assistant Secretary in the Pension and Welfare Benefits Administration at the Department of Labor.

Beverly Malone, currently serves as the President of the American Nurses Association.

Paul Montrone, is the Chairman and Chief Executive Officer of Fischer Scientific International, Inc.

Pat Nazemetz, is the Director of Total Pay for the Xerox Corporation.

Pat Powers, is the Executive Director of the Pacific Business Group on Health.

Chris Queram, is the Chief Executive Officer of the Employer Health Care Alliance Cooperative (The Alliance).

Thomas Reardon, currently serves as the Chair of the American Medical Association and Medical Director of the Adventist Medical Group.

John Rother, is the Director of Legislation and Public Policy for the American Association of Retired Persons.

Jerry Shea, is the Assistant to the President for Governmental Affairs at the AFL-CIO.

Gregg Sylvester, is the Cabinet Secretary, Delaware Health and Social Services. ????

Peter Thomas, is a principal in the law firm of Powers, Pyles, Sutter, and Verville, P.C.

THE CHALLENGE AND POTENTIAL FOR ASSURING QUALITY HEALTH CARE FOR THE 21ST CENTURY

Executive Summary

In its landmark report to President Clinton, the Advisory Commission on Consumer Protection and Quality in the Health Care Industry called for a "national commitment to the measurement, improvement, and maintenance of high-quality care for all Americans." As part of that effort, the Commission called for the creation of a Forum for Health Care Quality Measurement and Reporting "to develop and implement effective, efficient, and coordinated strategies for ensuring the widespread public availability of valid and reliable information on quality."

This report documents some of the existing quality problems in the health care system and identifies current strategies that have proven effective at improving quality outcomes, increasing confidence, and often reducing health care costs. It also underscores why a national effort is needed to improve the quality of health care.

Confronting Quality Problems

There are several areas where the quality of American health care is falling short, including underuse, overuse, misuse, and variation in use of health care services.

Underuse of services: The failure to provide a needed service can lead to additional complications, higher costs, and premature deaths. For example, a study of heart attack patients found that nearly 80% did not receive life-saving beta-blocker treatment, leading to as many as 18,000 unnecessary deaths each year. A survey by the National Committee for Quality Assurance (NCQA) found that only 40% of diabetics received a recommended eye exam in the previous year. The NCQA survey also found that 30% of women age 52 to 69 had a mammogram in the previous two years. A CDC study estimated that only 30% of women between 21 and 64 had a Pap smear in the previous three years, despite the fact that early screening reduces mortality.

Overuse of Services. Unnecessary services add costs and can lead to complications that undermine the health of patients. For example, half of all patients diagnosed with a common cold are incorrectly prescribed antibiotics. Overuse of antibiotics has been shown to lead to resistance and as much as \$7.5 billion a year in excess costs. Another study found that 16% of hysterectomies performed in the U.S. were unnecessary.

Misuse of Services: Errors in health care delivery lead to missed or delayed diagnoses, higher costs, and unnecessary injuries and deaths. A study of New York State hospitals found 1 in 25 patients were injured by the care they received and deaths occurred in 13.6% of those cases. Negligence was blamed for 27.6% of the injuries and 51.3% of the deaths. Based on this study, researchers estimated that preventable errors in hospital care led to 180,000 deaths per year. Researchers estimate that as many as 30% of Pap smear test results were incorrectly classified as normal.

Variation of Services: There are significant variations in the practice of medicine across the U.S., among regions, and even within communities. For example, hospital discharge rates are 49% higher in the Northeast than they are in the West. A person with diabetes is twice as likely to get a needed eye exam in New England than in a Southern state.

The Role of Quality Measurement in Improving Care

In the last decade, Federal and State governments, private employers, health insurers, health plans, health care professionals, labor unions, and consumer advocates have developed successful strategies to measure and improve the quality of health care. For example:

The New York State Department of Health releases data on the quality of heart bypass surgeries at all of the hospitals in that state. Use of that data has helped reduce mortality in bypass cases by 50% in six years.

A Michigan hospital has reduced complications due to drug reactions in their cardiac care unit by 80%. At the LDS Hospital in Salt Lake City, Utah, a quality improvement program decreased adverse drug reactions related to antibiotics by 75%.

An asthma program in Boston has led to an 86% reduction in hospital visits and 79% reduction in emergency room visits. In 1992, asthma led to 468,000 hospitalizations in the United States and an annual cost of \$6.2 billion.

The use of NIH guidelines has led to a 100% increase in the use of a drug to prevent death among premature babies.

Minnesota hospitals have increased the use of beta-blocker therapy to prevent second, often fatal, heart attacks in patients by 63% through provider education and performance feedback.

Private employers and health plans have also used quality measurement and reporting to improve care and inform consumers. For example:

General Motors provides its employees with report cards rating health plans' quality of care. The reports include quality measures, satisfaction ratings, accreditation reports, and reports from site visits.

The Pacific Business Group on Health requires health plans to set aside 2% of the premiums they receive and only allows high-performance plans to retain those funds.

The United Auto Workers requires all health plans serving its members to be accredited by the NCQA.

Kaiser Permanente of Southern California has launched its "Intervention for Employment

Maintenance for Members with End State Renal Disease," to help patients cope with this life-threatening illness and continue to work during treatment. Workers in the Kaiser program were 2.8 times more likely to maintain employment.

THE NEED FOR A NATIONAL EFFORT

While there have been successful efforts to improve health outcomes, increase confidence, and reduce costs, the President's Commission noted that current efforts "vary widely in their aims and scope and have been, at best, only informally coordinated." In some areas, such as chronic disease, very little is being done to measure quality. In other areas, health plans are being overwhelmed by conflicting and redundant requests. The Commission's call for the creation of a Quality Forum is designed to accomplish the following:

- Identify core sets of quality measures for standardized reporting by all sectors of the health care industry;
- Establish a framework and capacity for quality measurement and reporting;
- Support the focused development of quality measures that enhance and improve the ability to evaluate and improve care;
- Make recommendations regarding an agenda for research and development needed to advance quality measurement and reporting;
- Ensure that comparative information on health care quality is valid, reliable, comprehensible, and widely available in the public domain.

The Commission recommended that the Forum be broadly representative of key stakeholders in health care including: public and private purchasers, consumers, health care providers, health plans, labor unions, and experts in quality measurement and reporting. The Forum will help eliminate duplicative and overlapping demands for information from health care providers and plans, and it will provide consumers and other purchasers with a common yardstick to make direct comparisons of health plans, hospitals, nursing homes, or physicians. Because purchasers will be speaking with a more unified and pragmatic voice on quality information needs, accreditors, plans, and providers will be able to be much more responsive. This progress will help assure that health plans will compete on the basis of quality not just cost and benefits.

THE WHITE HOUSE

Office of the Press Secretary

For Immediate Release

March 13, 1998

REMARKS BY THE PRESIDENT
ON HEALTH CARE QUALITY

The East Room

2:45 P.M. EST

THE PRESIDENT: Thank you very much. Mr. Vice President, thank you for your work on this issue and your interest in it. I thank Secretary Shalala, Secretary Herman, Secretary West, the members of the White House staff who worked on this. But especially let me thank the members of the commission and the Executive Director of the commission, Janet Corrigan. They have done a remarkable citizen service for the people of the United States of America and we're all very grateful to them. (Applause.)

As we approach a new century with all its stunning advances in science and technology, we know that many of them will come in medicine and health. We must act now to spread these breakthroughs and improve the quality of health care for every American. I accept the commission's report. I endorse your recommendations.

For five years we have worked to expand access to quality health care for the American people, step by step: health insurance coverage for people who move between jobs; expanded health care coverage for millions of children; strengthened Medicare with more preventive benefits. Last year, as the Vice President said, this commission recommended a Patient's Bill of Rights. Last month I acted to ensure by executive order that one-third of all Americans -- those in Medicare, Medicaid, veterans health care systems and other federal plans -- enjoy the benefits of this Patient's Bill of Rights.

Now these protections must be extended to all Americans. And in the remaining 68 days of this congressional session, Congress must take the next step and make the Patient's Bill of Rights the law of the land. (Applause.)

Now, as you have told America in this report, we must also seize this moment of opportunity to improve the quality of health care for all our people. For all its strengths, our health care system still is plagued by avoidable errors -- overused and underused procedures and gaps in the quality of care. For example, when hundreds of thousands of Americans are needlessly injured while in the hospital, when 18,000 Americans die of heart attacks that did not have to be fatal, when 80,000 women undergo unnecessary hysterectomies every year, surely we can do better.

This commission has drawn a road map for higher quality across American health care. Above all, our nation must develop uniform national standards so that health plans can compete on quality, not just cost; and so that health care consumers can judge for themselves. This is the best way to assure quality health care for all Americans.

We can take three steps to advance these high health care

standards. First, health care quality standards should be set at a forum bringing together providers, business and labor, consumers, insurers and government. I've asked the Vice President to convene this health care quality forum this June.

Second, I'm ordering federal agencies to create a task force to find ways to improve quality in the health care systems that we operate. The federal government must lead the way in lifting health care quality for all our people.

Third, I support this commission's recommendation to create a permanent Health Care Quality Council to set new goals and track our progress in meeting those goals. A council should be established by any health care quality legislation enacted this year.

We can make this year a time of real achievement in our mission to improve health care for every American. The American health care system has been the best in the world in the 20th century. If we press forward with medical research, enact a Patient's Bill of Rights, insist on high quality everywhere in America, continue to expand quality affordable coverage, protect and preserve Medicare and Medicaid, we can make American health care the best in the world in the 21st century.

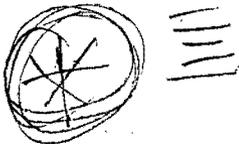
Now I intend to sign an executive order to all the relevant agencies to make sure they work together to develop the standards you recommend for quality health care, first for those whom we reach, and hopefully as a model for all Americans.

Again, I thank this commission. I ask the people and the members of the press here present to remember just the single instances I cited from the commission's report of examples where we still have serious quality changes. And I ask you all to rededicate yourself to this purpose on this day.

Thank you very much. (Applause.)

END

2:52 P.M. EST



Forum Fh

Chris Jennings Call/To Do List on Forum

I. State and Local Government Person

HHS's person was Woody Myers who is currently at Ford but was a former state and local person.

Charlie Salem's person

II. David Lawrence -- CJ to call and confirm (or ask Eisenberg if he wants to)

III. Paul Montrone -- 603-929-2204

IV. Discussion with John Eisenberg re: Federal participants.

V. - Reach out to Beverly Malone
FYI -- VP's office reviewing this list right now as well.

How to address COST issues

- Doctors & patients in charge?
- Where does money go?
- There is what good plan or already done?

- patient protection
- NO rights of reg

costs justify saved

Abortion

- We can't with law a we
can't find a way to do this.

- Disproportionate
practice

restrictive costs to

Reduction

JUN 11 1990 3:13 PM

Candidates for Forum Planning Group

(Name in italics indicates person has not been invited to participate yet)

Providers

Gayle Warden, chair; President and CEO, Henry Ford Health System, Detroit, MI
Sheila Leatherman, Executive VP, United Health Care Corporation, Minneapolis, MN
Thomas Reardon, general practitioner and Chair of AMA Board of Trustees, Portland, OR
Beverly Malone, President, American Nurses Association, Greensboro, NC
David Lawrence - health plan

Purchasers

J. Randall MacDonald, Executive VP for Human Resources and Administration, GTE, Stamford, CT
Paul Montrone, Chair, President and CEO, Fisher Scientific International, Hampton Falls, NH
Christopher Queram, CEO, Employer Healthcare Alliance Cooperative, Madison, WI
Woodrow Myers, VP for Human Resources, Ford Motor Company
Mary Jane England

Consumers

Brian Lindberg
Jerry Shea, Director of Employee Benefits, AFL-CIO, Washington, DC
Peter Thomas, Principal in Powers, Pyles, Sutter and Verville, Washington, DC
John Rother, Director of Legislation and Public Policy, AARP, Washington, DC

Feds

John Eisenberg, Administrator, AHCPR
Meredith Miller, Assistant Deputy Secretary of Labor

State Government

?

Staff

Tracy Miller, United Hospital Fund
Jim Tallon, United Hospital Fund

Others to be at the public event

Feds

Secretary Herman, Dept of Labor
Secretary Shalala, Dept of Health and Human Services
Secretary West, Dept of Veterans Affairs
Secretary Cohen, Dept of Defense
Director Lachance, OPM

Purchasers

M. Anthony Burns, Ryder Truck, Miami, FL, and Business Roundtable
Mary Jane England, Washington Business Group on Health
Greg Lehman, National Business Coalition on Health (from Tennessee) (Initial contact by C Queram)
Pat Powers, Pacific Business Group on Health (Initial contact by C Queram)
James Mortimer, Midwest Business Group on Health (Initial contact by C Queram)
Becky Cherney, Central Florida Health Coalition. (Initial contact by C Queram)

Providers

David Lawrence, Kaiser Permanente, San Francisco, CA (J. Eisenberg to contact)
Brent James, Intermountain Health Care, Utah

POTUS CLOSES ? BEFORE CHINA

- ~~E~~ EXPERTS FORUM → Johnson - family centered care outcome. Examples.

→ Pro
→
→

FLHBO
ATA

= Roundtables

- Report back to VP people



Form File



Central Florida Health Care Coalition

BECKY J. CHERNEY

Becky J. Cherney is President/CEO of the Central Florida Health Care Coalition in Orlando, Florida. Representing 750,000 members from public and private employers, the Coalition has been recognized nationally for its Quality Initiative. The Initiative has clinical quality, overall community health status and patient satisfaction components in place. The clinical component alone has saved health care consumers in Central Florida over \$300 million in five years while improving the health of the community.

The Coalition's Quality Initiative has been profiled on *World News with Peter Jennings* and in *The New York Times*. *The Times* article asked, "What is the best health care alliance in the country? Maybe this one."

Prior to assuming this position in 1994, Cherney served as a Consultant to Florida's Agency for Health Care Administration. She was responsible for implementing the state's cutting-edge legislation for Community Health Purchasing Alliances.

Becky spent 23 years in the private sector with three Fortune 500 companies. It was during her 11 year tenure with Tupperware International that she founded the Coalition.

A graduate of the University of Wisconsin, she has always been very active in the community. She is the founder of the Central Florida Women's Resource Center and has served as President of the Human Services Council and Florida Executive Women. She is currently serving her second appointed term on the Florida Board of Medicine.

In an *Orlando Business Journal* survey in March, 1998, Cherney was voted unanimously to the list of the Top 25 Influences in Health Care. The survey said, "One of her greatest strengths is her leadership in opening up communication between physicians and employers." That is an essential skill for any quality initiative.

BOARD OF DIRECTORS

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Orange County Public Schools

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Dennis Loney
Walt Disney World

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Frank Abbate
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Tony Blanco
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Ray Eriksen
EQ&G Florida, Inc.

Reginald Coar
Greater Orlando Aviation Authority

Nick Heidreich
Harris Corporation

Teresa L. Evans
Johnson Controls World Services

Desna Hunte
LYNX-Central FL Reg. Trans. Auth.

Larry Dennis
Lockheed Martin Elect. & Missiles

Sharon LaFaire
Orange County Government

Peter N. Geisler
Orlando Utilities Commission

Nancy Tallent
Seminole County Government

Karen Griffiths
SunTrust Bank, Central FL, N.A.

P. Jeffrey Ladd
SPRINT

Gary Wright
United Space Alliance

Chairman Emeritus
Jon R. Reiker
Darden Restaurants, Inc.

President/CEO
Becky J. Cherney

A PURCHASING ALLIANCE

Employers in Orlando Create an Envid Model

By LARRY ROHTER
Special to The New York Times

ORLANDO, Fla. - When Jim Coleman took over as personnel director for the town government in the Orlando suburb of Longwood four years ago, he was alarmed to find that the cost of providing health care coverage for its 155 employees was rising by as much as 25 percent a year. There was little he could do about it, though.

"We really didn't have any bargaining power" with the insurance companies that offered health care packages, Mr. Coleman recalled. "Some providers wouldn't even let us bid. They were not making any money off cities, so they didn't want our business."

Then Longwood joined the Central Florida Health Care Coalition, a health purchasing alliance that enables employers both large and small in the Orlando area to shop for health care coverage as a single entity. The coalition had been created in the mid-1980's, entirely free of any Government prodding or incentive, by corporate heavyweights like the Walt Disney Company, General Mills, Tupperware and Martin Marietta. In joining it, Longwood got immediate results.

"The first year, our rates were a little lower than the previous year, and we have had no premium increases in three years," Mr. Coleman said. "We've turned the clock back to pre-1990 rates, and they have stayed there," saving Longwood taxpayers tens of thousands of dollars.

Lower Costs, Better Care

The City of Longwood is hardly alone in welcoming the competition that the purchasing group, which represents more than 100 companies with over 500,000 employees and dependents, has brought to health care here. At Orlando Regional Medical Center, the largest hospital in the area, administrators and doctors say efforts to meet the cost and quality standards that the coalition encourages have resulted not only in millions of dollars in savings but also in lower mortality and morbidity rates that reflect improved patient care.

There are already more than 100 similar health care purchasing alliances around the country, organizations that got the jump on President Clinton's health care plan, which would require the creation of a vast national network of such alliances. Whether or not the President's plan is enacted - indeed, whether or not Congress enacts any health care legislation this year - many of these private-sector health care initiatives have long since proved successful. And none more so than the Central Florida Health Care Coalition, one of the

oldest and largest of them.

"Orlando is a pioneer in making health care more effective, so that all the actors in the system can get the best quality at the lowest cost," said Sean Sullivan, president of the National Business Coalition on Health. "They offer a model that others are following because they have demonstrated results."

For the same reason, the coalition's operations have been closely studied by officials in Tallahassee and even Washington. The State of Florida's Agency for Health Care Administration acknowledges that its new system of government-organized purchasing alliances for businesses with 50 or fewer employees is inspired by Orlando's example.

Edward Towey, a spokesman for the state agency, said the Orlando coalition was a model for the rest of Florida on at least two counts. "It's not only that they are pooling their buying power," he said. "Equally important is the comprehensive collection of data, which lets purchasers see what kind of value they are getting for their money."

Resistance, but Not for Long

The coalition was born nearly a decade ago out of the dissatisfaction of employee-benefits managers at several of the largest companies in the Orlando area. Health care costs here were rising by double-digit percentages each year, and the benefits managers, who had begun to analyze hospital bills, could find no correlation between cost and quality.

At first, doctors and hospitals resisted. "Many of the providers didn't even see a reason to talk with us," said Dennis Loney, manager of employee benefits for Disney, whose 34,000 workers here make it the largest member of the coalition. "And some of those who did talk with us refused to talk about quality."

But the coalition plunged ahead anyway. And as its members looked systematically at hospital records, many questions arose. Why, for example, were so many patients being held for observation over weekends, a practice so routine that Monday was the No. 1 day for discharge? When the coalition simply pointed out that circumstance, administrators and doctors quickly made adjustments in their procedures.

Over time, the coalition and hospitals learned that by sharing information and pinpointing areas for improving performance, all sides could benefit.

"It's not a threatening or accusatory relationship," Mr. Loney said of the coalition's dealings with hospitals here. "All we do is share the data and express a concern, and let them do the rest."

By the late 1980's, new tools were available, and the coalition was quick to take advantage of them. Any health care provider who wished to do business with

the coalition was required to install a national computerized data-gathering system developed by MediQual, a company based in Westborough, MA, to track every piece of information that went onto a patient's chart during a hospital stay.

That database, gathered from some 550 hospitals around the country, allowed the coalition and local hospitals for the first time to measure the relationship between the price and the quality of medical care. Because of the system, which cost about \$50,000 to install, it became possible to compare the effectiveness not only of one hospital to another but also of individual doctors.

A Recent Phenomenon

"Health care has not really been competitive until quite recently," said Eric Kriss, president of MediQual. "As a result, you have tremendous variations in both quality and cost, far more than you would find in a truly competitive industry. We routinely find variations of price and quality of 200 to 400 percent."

At first, said Rindy Rudy, business director at Orlando Regional Medical Center, "all of us were very nervous" about the data-gathering system. The main questions, she said, were two: "Could a computer system really measure quality? And how would we look?" Doctors in particular were initially dubious. "I thought that as our costs dropped, quality would suffer," said C. Gordon Wolfram, former chief of medicine at the medical center. "But the opposite has occurred. As our costs have dropped, our mortality and morbidity rates have actually improved."

One important reason for the improvement, Dr. Wolfram said, is that the hospital had previously had "a few doctors going overboard on ordering tests and procedures." In some instances, he said, "the tests themselves were causing some morbidity."

The data allowed doctors to compare

**What is the best
health care alliance
in the country?
Maybe this one.**

their treatments against those of colleagues, and it was this feature that eventually won them over.

One cardiologist, for example, had routinely prescribed an expensive clot-busting medicine for his patients, believing that it was by far the best thing on the market and therefore worth the

\$2,000 that it added to a patient's bill. But a colleague who prescribed a less expensive medicine had the same success rates with his patients. When the doctor who prescribed the more expensive medicine was shown the results, he was at first surprised but agreed to try the cheaper drug. He was eventually convinced that his patients were not adversely affected by the change.

"That was a big eye-opener," Dr. Wolfram said, "to see that there was a huge diversity of treatment practice patterns and that quality did not directly correlate with cost."

That one change - in the medication prescribed by one doctor in only one of the hospital's 22 departments - has meant hundreds of thousands of dollars in savings, said Ms. Rudy, the hospital's business director. By taking an equally hard look in other departments, officials have reduced costs there as well.

Not long ago, for example, the hospital bought hip prostheses from 10 different manufacturers, at a cost ranging from \$1,500 to \$7,000 a unit. "Now we are down to three suppliers," Ms. Rudy said. "We told the physicians, 'You make the decision.'" Given the data, the doctors decided that the most expensive hip implant was no better than the competition, and cut it from the list.

Similarly an analysis of data on gall bladder operations indicated that a smaller incision reduced the likelihood of post-surgical infection, which in turn reduced the average length of a patient's hospital stay. The result: lower costs for the hospital and a smaller bill for the patient.

End to a Medicare Drain

As a result of these and other changes, Orlando Regional Medical Center is no longer losing money on the Medicare patients it treats. Three years ago the hospital was running \$12.4 million in the red on its Medicare cases, but by the first quarter of this year "we were actually making a little bit," Ms. Rudy said.

"By cutting our losses on Medicare, we can stop cost-shifting," Dr. Wolfram added. "That means we don't have to saddle patients from Disney with those costs. So Disney is happy, and we're happy."

For the most part, employees enrolled in the coalition's various coverage plans also seem satisfied. Trisha Fuston, a 25-year-old payroll clerk in Longwood, said that although doctors sometimes "rush you in and out," she recognizes that she is getting good value for the \$67 a month, plus \$5 an office visit, that her coverage costs her.

"This is the first time I've ever had insurance, and it's been pretty good," she said.

Forum (Quality) File

TO: Ad Hoc Group on the Forum
FROM: Janet Corrigan, PhD *JC*
RE: May 1, 1998 Meeting
DATE: April 24, 1998

Enclosed please find the agenda and meeting materials for the May 1st meeting. **Please Note:** the meeting will begin at 9:30 am (EST) and adjourn at 1:30 pm. The location for the meeting is Conference Room 640H of the H.H. Humphrey Building, 200 Independence Ave., SW, Washington DC.

The objectives of this meeting are twofold: 1) to plan for the Forum kick-off meeting to be convened by the Vice President in June 1998; and 2) to identify and discuss key issues related to the 6 month planning process that will commence in June and culminate with the establishment of the Forum in early 1999.

If you have any questions, please contact me at 202/205-3045 (or pager #202-490-0321). I look forward to seeing you on May 1st.

Distribution

Toby Donnenfeld, Office of the Vice President
John Eisenberg, AHCPR
Nancy Foster, AHCPR
Chris Jennings, Office of the President
Sheila Leatherman, United Health Care Corporation
Randy MacDonald, GTE
Meredith Miller, DOL
Paul Montrone, Fisher Scientific International
Christopher Queram, Employer Health Care Alliance Cooperative
Thomas Reardon, Adventist Medical Group
Gerald Shea, AFL-CIO
James Tallon, United Hospital Fund
Peter Thomas, Powers, Pyles, Sutter and Verville, P.C.
Gail Warden, Henry Ford Health System

~~John~~ ~~John~~

Carl John

Jim Miller

- Under New Rule
- RWJ
- Keller

DRAFT AGENDA

John

John Amgen

AD HOC GROUP ON THE FORUM
May 1, 1998 Meeting

parsons

- 9:30 am Welcome and Introductory Comments
 - Introduction of participants
 - Purpose of the meeting

- 9:50 Discussion of Forum Planning Process (draft proposal attached)
 - Facilitator and Institutional Base
 (see attached biographical sketch for James Tallon)
 - Foundation Support
 - Discussion of Process
 - Planning Committee
 - Composition
 - Nominees

- 11:45 Break for Lunch

- 12:15 Discussion of June Kick-off Event
 - Background Information on Other Activities Underway
 - Messages
 - Participants

- 1:30 Adjournment

**PROPOSAL TO FUND A PLANNING PROCESS
FOR A NATIONAL
FORUM FOR HEALTH CARE QUALITY MEASUREMENT AND REPORTING**

DRAFT - APRIL 24, 1998

This is a proposal to fund a process for planning the development of a Forum for Health Care Quality Measurement and Reporting ("the Forum"), a private-sector entity to be established to provide coordination and guidance to the multiple public- and private-sector parties involved in evaluating health care quality. Creation of the Forum was one of the major recommendations of the Advisory Commission on Consumer Protection and Quality in the Health Care Industry ("the Quality Commission") in its final report to the President.

This proposal begins by describing the need to coordinate ongoing work in the area of health care quality measurement and reporting, and by laying out the specific objectives, activities, and organizational characteristics of an entity to be created to undertake that effort. It then describes the objectives, time line, and budget of the proposed process for convening key stakeholders to assist in operationalizing the entity.

BACKGROUND

Need for Standardized Information on Health Care Quality

Routinely generating comparable, standardized information on the quality of health care is critical for both motivating and enabling improvement. Standardized measures of quality are needed to track the health care industry's progress in achieving national quality improvement aims and to guide public planning and policy making. Comparative information on quality also is needed for individual consumers, employers, and others to use in selecting health care providers and health plans. Furthermore, valid and stable quality measures are integral to health care providers' efforts to improve their performance. When standardized, such measures provide an opportunity for health care organizations to make comparisons and identify "best performers."

Despite a growing number of efforts to measure and report on health care quality, useful information is neither uniformly nor widely available. Improving our ability to measure quality has been the object of significant public and private-sector activity over the last decade, reflecting the expectation that measurement can serve as both a catalyst and a tool for improvement as well as to facilitate consumer choice. While considerable advancements have been made in the quality measurement field in recent years, current efforts fall short of fully meeting users' needs, do not provide measures for many of the most important health burdens (e.g., chronic conditions), and often are duplicative and unduly burdensome on health care providers, health plans, and others.

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Forum for Quality Measurement and Reporting

Objectives. The Forum for Health Care Quality Measurement and Reporting is being established to build the systemwide capacity to evaluate and report on the quality of care. The Forum would develop and implement effective, efficient, and coordinated strategies for focusing incentives for quality improvement on national priorities while assuring the public availability of information needed to support the marketplace and the efforts of the various existing quality oversight entities.

Activities. To achieve its objectives, the Forum will need to:

- develop a comprehensive plan for implementing quality measurement, data collection, and reporting standards to assure the widespread public availability of comparative information on the quality of care furnished by all sectors of the health care industry;
- establish measurement priorities that address national aims for improvement and that meet the common information needs of consumers, purchasers, federal and state policy makers, public health officials, and other stakeholders;
- periodically endorse core sets of quality measures and standardized methods for measurement and reporting;
- foster an agenda for research and development needed to advance quality measurement and reporting and to encourage collaborative funding for such activities;
- develop and foster implementation of an effective public education, communication, and dissemination plan to make quality measures and comparative information on quality most useful to consumers and other interested parties; and
- encourage the development of health information systems and technology to support quality measurement, reporting, and improvement needs.

To evaluate the success of its efforts, the Forum will need to create and utilize feedback mechanisms designed to assess the feasibility and acceptance of the measurement sets it promulgates as well as the extent to which information is reported, available, and used by interested parties. Armed with this information, the Forum will be able to initiate improvement strategies as necessary.

Structure. The key organizational characteristics of the Forum that will enable it to accomplish its objectives are its status as a private-sector organization and its representation of key

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stakeholders from both the public and private sectors.

Operating in the private sector will provide the Forum with two needed characteristics. First, it will have greater flexibility and the means to act quickly to respond to changes in the health system and advances in technology that have implications for measurement and reporting strategies and capacity. Second, it will be well-positioned to harness and coordinate the market forces needed to drive this initiative.

Because the Forum will operate in the private sector as a voluntary initiative, its success will depend upon the commitment and influence of a critical mass of stakeholders in the health care marketplace. The Forum will therefore need to be broadly representative of stakeholders. The users and potential users of information on quality must be involved in the process of identifying core quality measures for reporting if those processes are to succeed in addressing their common information needs. The Forum also will need to include a core constituency of influential stakeholders that can assure the implementation of the measures once they are promulgated. Compliance with reporting requirements will be attained by purchasers and oversight bodies (i.e., accreditation, certification and licensure entities) by the mechanisms available to them (e.g., purchasing contracts and oversight processes). A decision to participate in the Forum would be viewed as constituting an endorsement of its work and an agreement to leverage compliance with the results to the full extent of the participant's ability.

Also critical to the Forum's efforts will be the participation of key organizations involved in promulgating quality measures and collecting information on the performance of various sectors of the health care industry. Key organizations include those that undertake efforts on a national basis, as well as those emerging and established groups organized at the regional, state, or local levels. The Forum will need to work with these organizations to determine how best to assure that information on health care quality is available, affordable, and easily accessible in the public domain. The Forum itself would not compete with the innovative work already under way in the public and private sectors by developing performance measures itself, but would instead seek to encourage the progress being made in this area and improve it through greater coordination. It would help to identify areas of needed fundamental research related to quality.

PROPOSED PLANNING PROCESS

A planning process is needed to provide key stakeholders with the opportunity to work through critical issues related to the Forum's governance, organizational structure, and source(s) of financial support. The Vice President will begin this process by inviting key stakeholders to a June meeting to form a Task Force to jump-start the planning process. He will select individuals to participate in this planning process based on their expertise and stature, as opposed to organizational affiliation. The decisions to use a neutral convener and to seek funding support from a private foundation were made as a means of ensuring impartiality and promoting

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participation by stakeholders.

The planning process should take place over a 6-month period, commencing in May 1998 with the issuance of invitations to participate. Over the course of that time, during which three meetings will be held, the Task Force will accomplish four critical objectives:

- define the Forum's functions, operations, working relationships and membership criteria;
- determine the composition of the Forum's governing board;
- determine the source(s) of start-up and ongoing financing; and
- initiate a process to recruit the Forum's Executive Director.

Objectives of the Planning Process

1) Define the Forum's functions, operations, and working relationships.

Defining the Forum's functions, operations, and working relationships will be among the most important objectives of the planning process. The Quality Commission's work provided a starting point for defining these characteristics, but additional work is needed to refine and operationalize those recommendations.

A number of issues to be addressed pertain to the manner in which the Forum will function. For instance, the planning process may identify policies and procedures designed to assure the public of the integrity of the Forum's work, promote widespread confidence in its outcomes, and minimize potential conflicts of interest. The planning process can serve to articulate specific policies and procedures that will provide for public input, public deliberation, and public access to documents produced.

Operational issues to be addressed include the Forum's organizational structure, budget, facilities, and meeting schedules. In defining these aspects, participants in the Forum's planning process may wish to look to the organizational structures of entities charged with undertaking functions that are similar in nature, scope, and scale. Entities such as the Financial Accounting Standards Board and the American National Standards Institute -- although not analogous to the Forum in all respects -- may provide alternative models for examination by the Planning Task Force.

Task Force Planning process participants will need to carefully consider how the Forum will relate to the public- and private-sector organizations whose work will influence or be influenced by the Forum's activities. Formal working relationships will in some cases need to be established; for instance, in the case of organizations responsible for the development of the health care quality measures that will be evaluated for inclusion in the core sets of measures to be

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periodically endorsed by the Forum. Similarly, the ways in which the Forum will interact with existing local, regional, state, and national organizations that serve as repositories of data on quality will need to be considered.

2) Determine the composition of the Forum's governing board.

The composition of the Forum's governing board is a key issue to be addressed through the planning process. Both the precise number and the allocation of slots on the Forum's governing board will need to be determined.

The Quality Commission recommended that the Forum be governed by a board that includes:

- public and private group purchasers;
- individuals and organizations focused on representation of consumers/patients;
- providers;
- labor unions;
- experts in quality assurance, improvement and measurement;
- quality oversight organizations;
- health care researchers; and
- public health experts.

Balancing the need to have a strong purchaser role and representation of the full array of key constituencies will be a delicate and challenging task for the planning process participants. Substantial representation on the board of purchasers from both the public and private sectors and of consumer organizations will be critical to provide strong incentives for organizations to participate in these efforts and to abide by the decisions of the Forum. Representation of the full array of key constituencies on the board will be equally critical, so as to assure the buy-in of all participants and the requisite expertise to effectively carry out the Forum's responsibilities.

3) Determine source(s) of start-up and ongoing financing.

Participants in the planning process will need to consider alternative sources of start-up funding to assist in establishment of the Forum. The potential for obtaining a start-up grant from a foundation or public source will need to be evaluated. Such funds may be used to allay one-time expenses that will be associated with initiating the Forum (e.g., expenditures associated with outfitting staff offices). External funding is unlikely to be made available for ongoing financing of the Forum, however.

Thus, it is essential for the Planning Task Force to establish an ongoing source of financing for the Forum. Participants in the planning process will need to estimate the Forum's first-year operating budget and develop a dues-paying schedule for members. Such a schedule will need to account for the varying levels of resources available to different categories of stakeholders. For

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instance, cross-subsidies may be required so that the Forum is able to attain adequate representation of consumer interests.

4) Begin Recruitment of an Executive Director.

Once the planning process has resolved operational, representation, and financing issues, the Planning Task Force will initiate a process to identify an Executive Director capable of providing leadership for the Forum. This will require defining the skills and qualifications of ideal candidates for the position, and seeking and conducting initial reviews of candidates. Responsibility for selecting an Executive Director from qualified candidates will fall to the initial Board of Directors of the Forum, but the Planning Task Force can expedite this process by initiating the search.

Candidates will need to possess a variety of professional skills and expertise to be successful as the Forum's Executive Director. These include strong leadership, management, and planning skills; a high level of credibility among the diversity of stakeholders represented at the Forum; technical knowledge regarding quality measurement, oversight, and health benefits; and the ability to effectively communicate in support of the Forum's mission. The Planning Task Force will need to determine the extent to which the Executive Director should be drawn from interests represented by the Forum. For example, a potentially highly qualified candidate may be a person with experience as a corporate benefits director with first-hand knowledge of purchasers' perspectives on the use of quality measures; negotiating experience with hospitals, clinicians, and oversight organizations; and an understanding of consumers' use of quality measurement information. Other individuals with the requisite experience and skills to serve as the Forum's Executive Director may include health plan executives, quality oversight managers, or experts in quality measurement and improvement.

The planning process for selecting an Executive Director will require identifying the desired qualifications of candidates as soon as the functions and operations of the governing body of the Forum are defined. This definition of the Executive Director position and desired skills of candidates needs to occur early in the Planning Task Force's process to allow time to recruit highly qualified candidates. The Task Force may elect to contract with an executive search firm to assist in the recruiting of suitable candidates. Once eligible candidates have been identified, the Task Force will need to review the qualifications of candidates applying for the position and identify top candidates for consideration by the Board of Directors.

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Time Frame for Planning Process

June 1998	First meeting of planning process Purpose: Define Forum's functions, operations, and working relationships
September 1998	Second meeting of planning process Purpose: Determine the composition of the governing board, sources of ongoing financing for the Forum, and qualifications of Executive Director
November 1998	Third Meeting of planning process Purpose: Name governing board, and screen Executive Director candidates
December 1998	Convene prospective members of governing board, select Forum's Executive Director, release start-up funds
January 1999	First meeting of the Forum's Board of Directors

Budget for Planning Process [Note: Preliminary, rough estimates]

Personnel costs	\$120,000
<i>[Estimated as 1 FTE * \$100,000 annual compensation (including benefits) * 0.8 years + 1 FTE * \$50,000 annual compensation (including benefits) * 0.8 years]</i>	
Administrative expenses and overhead	\$ 40,000
Meeting expenses (3 meetings)	\$ 85,500
-- facilities <i>[estimated as \$3000 * 3 meetings]</i>	
-- travel expenses <i>[estimated as 20 people * \$800/mtg * 3 mtgs]</i>	
-- overhead for services of contractors responsible for meeting logistics <i>[estimated as 50 percent of total meeting expenses]</i>	
Honoraria for Planning Committee	\$ 60,000
<i>[estimated as 6 days meeting time * 20 participants in planning committee * \$500 daily rate]</i>	
Contract for executive search services	\$ 39,000
<i>[estimated as 30% of Executive Director's annual salary of \$130,000]</i>	
<hr/> Total	<hr/> \$344,500



United Hospital Fund of New York

JAMES R. TALLON, JR.

James R. Tallon, Jr. is president of the United Hospital Fund of New York. The Fund, the nation's oldest federated charity, addresses critical issues affecting hospitals and health care in New York City through health services research and policy analysis, education and information activities, and grantmaking and voluntarism.

Mr. Tallon serves as chair of the Kaiser Commission on Medicaid and the Uninsured and is a member of the Joint Commission on the Accreditation of Healthcare Organizations (JCAHO). He serves as secretary for the Alpha Center and for the Association for Health Services Research, and is also on the boards of the Alliance for Health Reform, The Commonwealth Fund, and the New York Academy of Medicine. He recently concluded a three-year term as a member of the Prospective Payment Assessment Commission (PropAC), and has held visiting lecturer appointments at the Columbia University and Harvard University schools of public health.

Prior to joining the Fund in 1993, Mr. Tallon served in the New York State Assembly for nineteen years, beginning in 1975. As majority leader from 1987 to 1993 and as chair of the health committee from 1979 to 1987, he spearheaded efforts to reform the Medicaid program while expanding eligibility for pregnant women, and children. His 1991 legislation required the implementation of Medicaid managed care programs statewide. Under his leadership, the Assembly also enacted measures to assure transitional health coverage for laid-off workers, reimburse hospitals in a fair and cost-effective manner, foster high-quality and cost-efficient home health care services, encourage organ donations, promote AIDS research and education, and foster regional health planning agencies.

Mr. Tallon received a B.A., cum laude, in political science from Syracuse University and an M.A. in international relations from Boston University. He has also completed graduate work at the Maxwell School of Citizenship and Public Affairs at Syracuse University. In 1995, he was awarded honorary doctorates of humane letters from the College of Medicine and School of Graduate Studies of the State University of New York Health Science Center at Brooklyn, and from New York Medical College.

February, 1998

Helm RW

- Need to be clearly & boldly defined & share

- Quality = cost containment & - Time / Or Area

- collecting better data

- Goal → NCOA & are partners regard.



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SHIRLEY SAGAWA
DEPUTY ASSISTANT TO THE PRESIDENT AND
DEPUTY CHIEF OF STAFF TO THE FIRST LADY

(202) 456-6266

FAX (202) 456-6244

THE WHITE HOUSE

SHIRLEY_S_SAGAWA@WH.OEOP.GOV

Electronic Medical Records
File

To: The First Lady

From: Paul A. London

January 6, 1999

Subject: **Electronic Medical Records, the VHA System, E Commerce and Related Issues.**

Per our conversation at Renaissance, the Veterans Health Administration probably has the best system of computerized-patient medical records in the world. Better understanding of what VA is doing in this area could save lives, reduce Medicare and healthcare costs, give the economy and e commerce a significant boost, show our interest in veterans, and add humanity and texture to the Administration's interest in technology.

The VA's Decentralized Hospital Computer Program (DHCP) links 160-70 hospitals. Forty to 60 of them already have modernized systems that allow the storage and transmission of records with graphical images, e.g. X-rays, MRIs, images from a range of "scopes", mammograms, sonograms, etc. A few other hospitals, i.e. Women and Brigham/Beth Israel, Columbia Presbyterian, Northwestern Memorial, the Salt Lake Medical Center, etc. have good systems, and Kaiser-Permanente is investing about \$1.5 billion in a system, but there is nothing like VA.

Healthcare as you know is a \$1.1 trillion "industry" where 300,000 medical offices and over 6,000 hospitals are notorious for primitive records and their inability to communicate with each other and with patients. Healthcare information systems for decades by and large have been designed to bill Medicare and Medicaid, the insurance companies, and patients, but not to improve care. It's an outrage.

The lack of modern medical information systems costs thousands of lives every year from adverse drug interactions, failure to follow best practices, and similar causes. Old ladies walk around with manila folders. X-rays and MRI's are lost. Everyone has a horror story. As much as 70 percent of the time, doctors don't have a full record when they treat you. Physicians are grotesquely dependent on information gleaned unsystematically from medical journals, meetings, and drug salesmen, and most patients learn about as much from their mechanics as they do from their doctors.

McKensie estimated in 1995 based on 1994 data that modern medical information systems could save \$230-270 billion a year. The head of the National Library of Medicine uses a \$100 billion figure. But medical researchers and NGOs do not think of healthcare as an "industry" and do almost no studies of this incredible "market failure".

Where Could We Go from the VA Base?

- The President, you, the Vice President, Donna Shalala, and Secretary Daley (in his role as lead in E Commerce) could take press, doctors' groups, business and payor groups, and others to see these facilities in D.C. and in most other cities around the country. I have talked to

several people at VA including Ned Powell, and I believe we could develop useful data and other materials for you. It is really something to see doctors call up a record on the screen, review graphics of an intestine or the inside of a knee, check on who else has seen the patient, review prescriptions, verify follow up, call up relevant medical articles and protocols.

- I want to see Sec. Daley more involved in the e commerce of healthcare because this is an economic issue in a major industry. The President's recent new set of e commerce directives should be expanded to include specific work on e commerce in healthcare to improve treatment, modernize the "businesses" of 300,000 smaller practices, and reduce costs. Business to business e commerce is growing exponentially in other areas, but not in this one. We need to understand why, and attack the market imperfections. This is not where Secretary Daley has focused his attention and it is hard for me to get to him, but it is an area where Commerce has several specific programs (developing advanced technology and standards for medical info systems, telemedicine, promoting medical-related exports). What is needed in my view is policy direction from the White House and perhaps the VP as well, and interdepartmental cooperation and cross-fertilization.

- The Vice President's focus on technology could be linked to the vital human issue of healthcare by drawing on the VA experience with electronic medical records. The VP has mentioned electronic medical records favorably from time to time and promised at his Family Weekend to think more about this area. However, press reports always have him focused on privacy --- the hole in the donut. Privacy is essential but speeches about the benefits of Computerized-Patient Medical Records might give many people a better understanding of the potential of computer technology, and VA would be a perfect source of material and backdrop.

- VA in my view could be a great test bed for Medicare reforms effecting the elderly as we discussed. I haven't thought this through, but it is a topic that one of the several task forces on Quality Care and related issues could explore. Most of VA's clients are over 65. Many bill Medicare. There are fewer privacy concerns. The elderly see doctors 6 or 7 times more frequently than younger people. The records of greatest relevance are the most recent ones, so you could start collecting them electronically when people become eligible for Medicare.

I look forward to talking with you.

Tools, not toys

Billions have been invested in information technology. Where are the results?

A failure to focus on productivity

Get practice guidelines to the point of care

Rob Chandra
Mark Knickrehm
Anthony Miller

IN THE US HEALTHCARE INDUSTRY, payors and providers* are spending on IT like never before, convinced that it will be a key strategic factor. Hospitals alone spent more than \$7 billion on IT in 1994 – nearly 2.5 percent of their net revenues. Payors and providers as a whole spent nearly \$17 billion. These sums are expected to increase to at least \$44 billion and perhaps even as much as \$75 billion by 2004.

Is this heavy spending bringing anything in return? So far, payors and providers have mostly succeeded only in adding to costs. Productivity is showing few signs of improvement. The chief beneficiaries of the spending boom have instead been IT suppliers. They have enjoyed average compound annual growth of 17 percent in revenues and 88 percent in profits since 1991 (Exhibit 1).

Yet payors and providers are right to see an important source of competitive distinction in the information they possess. As healthcare markets evolve, information will visibly reduce costs and raise clinical quality for purchasers. IT will be essential in managing the extra risks

We would like to thank Bernie Ferrari, Bill Huyett, Milt Gillespie, Irwin Goldstein, Rick Beckett, Robert Taylor, and Patrick Jeffries for their contributions to this article.

* Payors are the large insurance firms and federal and state agencies that fund healthcare expenses. Though employers are the primary funders of health plans through the health benefits they provide for employees, it is the insurance companies that manage the risk associated with offering these benefits. Providers are the hospitals and physicians that provide health services to patients. They are reimbursed for these services by the payors.

Rob Chandra is a consultant in McKinsey's Silicon Valley office; *Mark Knickrehm* and *Tony Miller* are consultants in the Los Angeles office. Copyright © 1995 McKinsey & Company. All rights reserved.

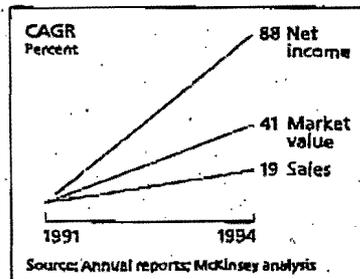
HEALTHCARE'S IT MISTAKE

Top 15 public healthcare IT suppliers

Exhibit 1

Sales and net income growth \$ billion	
Sales	Net income
1991 1.20	0.02
1992 1.40	0.08
1993 1.60	0.10
1994 2.00	0.14

Market value \$ billion	
1991 1.64	
1992 2.50	
1993 3.50	
1994 4.60	



associated with capitated revenues,* as well as in tackling the new managerial challenges presented by the industry's ongoing vertical and horizontal integration. Advantage will accrue to payors and providers that apply IT to address these market forces. In fact, we believe that a well-thought-out and well-executed IT strategy will differentiate winners from losers.

To succeed, participants will have to sidestep the pitfalls that have so far prevented their IT investments from paying off. The first of these pitfalls is failing to focus on productivity in purchasing and implementing technology. The second is allowing other players within and outside the industry to capture the value created. The third is that ancient managerial plague, poor execution. And the fourth is the temptation to buy gadgets (such as fancy point-and-click physician systems) that neither accomplish cost objectives nor improve quality – mere toys, instead of tools.

Many industries go through similar periods where IT investments run up costs while delivering neither improved productivity nor the competitive advantage that higher productivity is likely to yield. It took years for the commercial banking industry, for example, to wring acceptable profits from its heavy IT spending in the 1980s, as it struggled to match investments to strategy, improve productivity, and use technology to change consumer behavior. Payors and providers can learn from such experiences by following a few simple guidelines in order to capture value from IT:

- ◆ Focus, above all else, on improving the productivity of front-line care givers
- ◆ Make your IT investments in the right sequence
- ◆ Match your IT investments to your market position
- ◆ Develop superior IT executional skills.

* Capitated revenues are those where a provider agrees to perform a service for a predetermined fixed price. The provider only profits if it can treat a patient for less than the capitated revenue it receives. Some insurers and health plans set a cap on the revenues they will pay per member to a provider.

Focus on productivity

Some might argue that productivity discussions have no place in an industry where the quality of outcomes is so important. Certainly, it would be hard to find anyone who would advocate reducing the quality of outcomes in the pursuit of competitive advantage. Almost everyone, on the other hand, would be in favor of achieving the same outcomes at a lower cost, or better outcomes at the same cost.

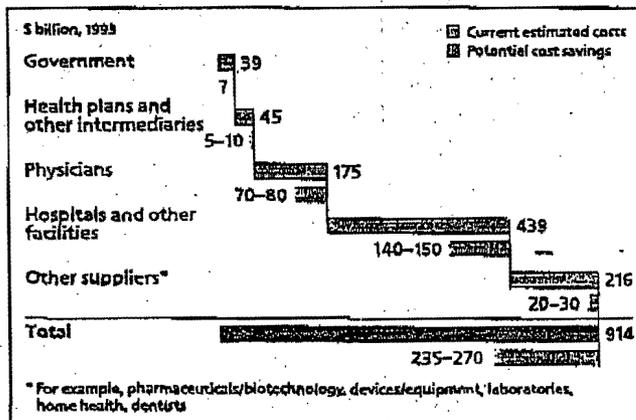
For payors and providers, the issue is clear: if you do not increase your levels of productivity – defined as the ratio of outputs to inputs – you may well find yourself on the short end of the competitive stick. Analysis of health maintenance organization best practices reveals a cost reduction opportunity of up to \$270 billion in the US healthcare industry (Exhibit 2).

Given current market pressures, the biggest opportunity – at least for the moment – will lie in reducing the input side of the equation. The US healthcare industry has yet to curb the tremendous inefficiencies arising from unmanaged care by individual physicians. Although treating any one patient will involve a unique combination of complex decisions, aggregating patient populations and examining variations in physician decision making will yield valuable insights for practitioners. At present, most physicians practise in relative isolation from their peers; considerable practice variability exists between providers (which frequently follows a consistent pattern); and only very limited information about care decisions is fed back to physicians.

Inefficiencies emerge clearly when we examine provider practice variations. Even after adjustments are made for patient populations, many provider organizations have sizable differences among their physicians in terms of the quantity of inputs needed to achieve a given outcome. Some physicians spend a lot more money than others in order to remedy the same illness.

How often, for example, do physicians see a diabetic patient? Once every two months? Every four months? How often do they screen for glaucoma? What lab tests do they order? Which medications do they prescribe? If physician A consistently achieves the same outcome as physician B for two-thirds the cost, what can physician B learn from physician A?

Exhibit 2
Opportunities for cost savings



HEALTHCARE'S IT MISTAKE

There is a real opportunity for physicians to use information to support the adoption of standards, or protocols, along the lines of what in an industrial setting would be called best practice. It is not that the healthcare industry actually lacks standards or protocols; rather, it is getting physicians to seek them out and actively use them that is the challenge. Information is a crucial enabler in this process, allowing physicians to engage in constructive discussions about practice pattern variations. If you have similar patient populations, adjusted for demographics and illness severity, you can look at the total costs of treating individuals and consider what drives the differences between them. In one case it may be pharmacy costs; in another, inpatient utilization.

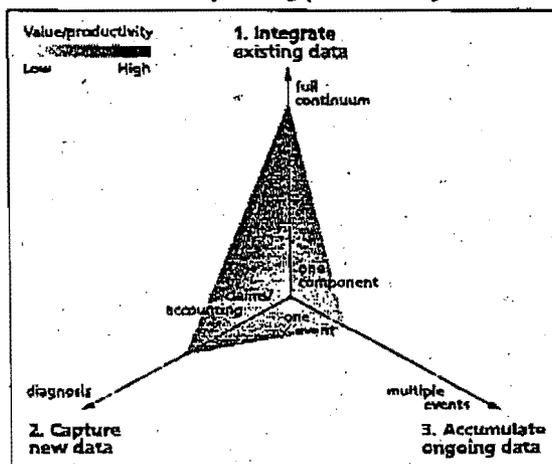
Information holds the key to improving productivity. Providers will have to change their approach to managing information – and information technology. Improving productivity will require providers to excel at three other things.

Get the sequence right

Sequencing IT investments correctly can go a long way toward helping them pay off. (By IT investments, we mean investments in IT applications – whether developed in-house or purchased off the shelf – and in the hardware and executional skills that support them.) Getting the order right involves three steps that apply to all payors and providers, no matter where they compete in the healthcare delivery chain (see Exhibit 3):

1. Integrate basic information (such as care data) across the business system (inpatient, outpatient, laboratory, pharmacy, radiology) to create a complete picture of what was done to the patient, who did it, and what it cost.

Exhibit 3
Three levers to improving productivity



2. Begin capturing clinical data regarding outcomes such as functionality or recovery time. Most payors and providers gather only financial claims and accounting data, which, though useful, hardly help in the understanding of practice variations.

3. Start gathering data longitudinally. Accumulating data over several years will prompt the kinds of insights into disease management that lead to more fundamental care delivery redesign.

HEALTHCARE'S IT MISTAKE

1. Integrate information

There are several reasons why integrating information across the business system should be the first step in this sequence. For one, it is the easiest to implement. Much of it can be done by automating current procedures; no process redesign is required. Claims data, for instance, is already captured on relatively standard forms, making collection and comparison straightforward. And the analytical tools that will allow payors and providers to get good value out of basic data already exist.

The second reason for tackling this step first is that a good deal can be accomplished by integrating basic care data. The new insights that can be gained are significant and reasonably easy to act upon. An organization might use the information to decide, for example, which diseases and patients to focus on. Our experience suggests that the 80/20 rule as applied to costs holds here — that is, 80 percent of costs are driven by 20 percent of patients.

Third, time is of the essence. Industrywide efforts to reduce costs in such areas as inpatient days and outpatient procedures and visits, not to mention current trends toward increased capitation and vertical integration or alliances, are fueling new data needs.

Finally, this step also goes first because it is the necessary precursor to capturing value from the steps that follow.

Players obviously vary in the ease with which they can obtain and process information. Integrated health plans should be in the best position to capture the value from this step quickly, while individual hospitals and physician groups need to be more creative to overcome the organizational barriers that often exist to collecting data.

2. Capture clinical data

Here the challenges begin getting stiffer. Most existing IT systems have been built around the patient's bill, and are designed to answer three questions: what procedure did we perform, what did it cost, and did we get paid for it? Shifting from this sort of billing data to information that captures diagnosis, severity of condition, functional status after treatment, and treatment paths will provide great value, and could become a real differentiating factor for payors and providers.

But accomplishing this shift will not be easy. First, basic care data must be integrated across the business system. Next, selective process redesigns may be needed to ensure that the captured data is "clean." And since most

Most existing IT systems are designed to answer three questions: what procedure did we perform, what did it cost, and did we get paid for it?

HEALTHCARE'S IT MISTAKE

clinical data currently exists only on paper, significant new software investments may also be required.

Why do it at all? Take a patient who needs a hip replacement. Clinical data from inpatient, outpatient, and long-term care is necessary when making decisions about appropriate (and cost-effective) treatment. Equipped with information from only one side of the care continuum (say, inpatient), the provider will have difficulty answering questions about the delivery process and its outcomes, such as: Is the patient better? How long did the treatment take? How important were individual elements of delivery in achieving a positive outcome? How can care delivery be reconfigured to employ lower-cost resources?

Another reason for assembling clinical data is that only limited insights can be drawn from claims data in the absence of corresponding clinical or outcomes data. Only clinical data can demonstrate the efficacy of the care provided – or, indeed, show whether it was necessary at all. Moreover, physicians are skeptical (and rightly so) about information that fails to incorporate outcomes.

Only clinical data can demonstrate the efficacy of the care provided – or, indeed, show whether it was necessary at all

One problem in collecting clinical data is that there are as yet no widely accepted standards within the medical community for

measuring outcomes. New analytical tools are needed. How, for instance, do you define functional status? The challenge will be to ensure that IT investments comply with evolving industry standards.

Note that capturing clinical data is likely to be a "ticket to play" for providers as healthcare markets mature, but it will not be enough to secure competitive advantage. Since nearly all providers will be seeking to use clinical data as a way to create efficiencies, doing so will merely ensure that you keep pace.

Keeping pace will also mean using the data you capture to reduce costs. Too many providers, hospitals in particular, have yet to reconcile themselves to the fact that all but a few of them will have to compete as low-cost suppliers. The exceptions – those that, like Memorial Sloan Kettering and the Mayo Clinic, can compete on the basis of a national quality brand – will be rare.

3. Pursue longitudinal data

This step is last in the sequence for three reasons: capturing the data will take several years; this step builds on the efforts that have gone before it; and at present only a few competitors have patient bases large enough to

HEALTHCARE'S IT MISTAKE

support longitudinal analysis. Collecting longitudinal data should begin only when the previous two data collection efforts are well under way. Without them, this third step would have limited value. How, for instance, do you use longitudinal data to determine whether a particular patient actually got better after a hip replacement operation ten years ago if you do not have inpatient and rehabilitation information?

Too many providers have yet to reconcile themselves to the fact that they will have to compete as low-cost suppliers

Keeping track of data over a period of years makes it possible to monitor the real impact of clinical decisions, whether preventive or not. This, in turn, will promote the acceptance of practice guidelines. Should breast cancer screens be performed every two or every five years for women over 45? Such questions can be answered much more readily if solid longitudinal data is available to underpin the debate.

Gathering longitudinal data is in many ways the most important of these three steps, and may lead to fundamental changes in care delivery: say, fewer physicians or more nurse practitioners for a specific disease. But the challenge of collecting the data should not be underestimated. The storage requirements alone are immense. The necessary analytic tools are only just emerging. And the minimum efficient scale calls for a large patient base – probably bigger than a single hospital, for instance, will be able to muster.

Match strategy to market position

Payors and providers should also match their IT strategies to the stage of market evolution at which they find themselves. Healthcare markets in the United States follow a consistent evolutionary path, from a fee-for-service stage through timid, turbulent, and potentially restructured stages.*

Since the basis of competition shifts as the market evolves, IT strategies should change accordingly.

The challenge of collecting the data should not be underestimated. The storage requirements alone are immense

Payors and providers finding themselves in a fee-for-service or timid stage of market evolution

should confine themselves to investments aimed at integrating data across the business system. For them, claims administration, risk management, and the strength of physician relationships act as the basis of competition. IT investments are best geared to back-office systems, typically those designed to capture claims data.

* See Bernard T. Ferrari and Scott Grimes, "Will HMOs pass their physical?" pp. 78-89, and in particular Exhibit 1, p. 80.

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HEALTHCARE'S IT MISTAKE

More turbulent markets call for investments in clinical data systems. These become necessary as aggressive competition requires rapid reductions in costs and prices in order to maintain share position. IT investments during this stage of market evolution should be focused on utilization review, quality assurance, and other systems for reconfiguring care processes and reducing practice pattern variations among physicians.

Getting practice guidelines to the point of care will boost productivity, increase quality, and reduce costs

In potentially restructured markets, the basis of competition may shift to a focus on clinical outcomes. Here, IT investments should be devoted to helping to implement

clinical protocols. IT systems must strive to get real-time information into the hands of front-line providers. Getting practice guidelines to the point of care will boost productivity, increase quality, and reduce costs. This reflects the increasingly "partnered" role that providers must adopt with care givers as markets mature and the old "stick" approach to managing relationships becomes obsolete.

Base your strategy on your starting point

Obvious though it may seem, payors and providers should examine where they are in the healthcare delivery system before jumping in and investing in IT. Your starting point determines which strategies will work best for you.

There is value to be found in IT investments at every point in the delivery system. In general, though, hospitals are in a weak position in relation to other payors and providers because they have little influence over their delivery costs, most of which are controlled by physicians. They must find ways to strengthen their position by collecting more clinical data across the business system and by helping physicians to change delivery decisions. Such an approach can be difficult for hospitals because it means reducing the utilization of their biggest asset – beds.

Hospitals should focus on reducing costs, creating focused clinical value (probably a viable strategy only for the national quality brand leaders, such as Memorial Sloan Kettering), and integrating information with physician practices so as to get up to scale. They will have to structure their contracts with these practices carefully, however, to avoid letting physicians capture all of the value created.

Physician groups are probably in the best position to benefit from information systems in the future. Ultimately, physicians are the care providers and can best put new insights into practice. But physician groups are mostly too fragmented to gain access to capital and make the necessary investments. All the same, some large groups – Mullikin and Pacific

HEALTHCARE'S IT MISTAKE

Physicians among them – have been spending heavily on IT, and the early signs are that they are reaping substantial efficiencies from their investments. Such groups are growing rapidly, but still represent only a small percentage of physicians.

For their part, health plans enjoy the best current position for gaining strategic advantage from IT investments, but they must find ways of using information to redefine their value proposition as local markets mature. If they fail to secure a role in actual care management, they run the risk of becoming marketing and administrative appendages to provider organizations – or, worse still, of being disintermediated altogether. In addition, health plans will have to change their approach to provider management and form more effective partnerships with physicians if they are to maintain the same kind of growth in revenues and profits that they have seen in the past eight to ten years.*

If health plans fail to secure a role in actual care management, they run the risk of being disintermediated altogether

Improve execution

This last guideline is probably the most important – and most difficult – of all. Healthcare IT skills are among the lowest in US industries, mostly because IT has not been strategically critical to success until now, and payors and providers have not had to focus on the kind of executional excellence that is needed to make IT investments pay off.

Given the shortage of in-house talent, payors and providers would do well to look for opportunities to buy software off the shelf and outsource much

Given the shortage of in-house talent, payors and providers would do well to buy software off the shelf and outsource much of their IT capability

of their IT capability. The experience of other industries indicates that major in-house development projects – in which teams of software writers develop code for a customized application – rarely deliver value, take a very long time, and unwittingly impose constraints on

operational flexibility. Such projects often overreach as managers try to find the IT Holy Grail, a solution to all of their problems. Winning organizations will take more of a “Do it, try it, fix it” approach to implementation, making sure they exhaust all opportunities to build user-friendly front-ends for current systems and seek out package solutions before they begin developing their own software in-house and buying new hardware.

* Again, see “Will HMOs pass their physical?” pp. 78–89.

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viii Foreword

trated on billing and financial functions. Instead, VA addressed challenges in the implementation of clinical and management systems in a large healthcare network. We concentrated on the needs of the individual healthcare facility for patient identification and tracking (registration, admissions/discharge/transfer) and for efficiently managing high-cost operations, such as laboratory and pharmacy, which are often the profit centers in other institutions. For these latter services, the emphasis was on managing and recording the workload and on decreasing the costs, including the distribution of results to the front-line clinicians, rather than generating a bill. As new modules were added, a similar focus was maintained. Moreover, front-line VA users, including clinicians, were involved in the design of the software in order to improve the volume and accuracy of the information they needed to deliver care to veterans. The result is a combined clinical and management information system that is firmly based on gathering information during the course of clinical care and deriving management data as a byproduct of these interactions.

As VA established the authority and mechanisms for collecting reimbursement from the subset of veterans who were not entitled to free care, billing became a more important consideration. As VA reorganizes into its multi-facility networks (see Chapter 1 for more details), accurate management data across facilities become not just desirable, but vital to its future. Emphasis in the networks has been shifting from inpatient care to ambulatory care settings and to the formation of both integrated and virtual healthcare networks. Today, VA is moving into a managed care operation, charged with meeting the needs of its enrolled population. Now that VA no longer simply takes and reacts to whoever comes in the door for care, a managed care information system capability is becoming a necessity. Thus, VA's information needs are moving closer to those of other healthcare institutions, even though its budget currently remains primarily dependent on congressional appropriations.

At the same time that VA has been changing, other healthcare organizations have been shifting their emphasis from pure financial information systems to those that are more clinically oriented. As healthcare becomes more competitive and forces increase to consolidate resources and decrease costs, more and more healthcare institutions are recognizing the critical importance of their information systems and are increasing their investments accordingly. The most effective information systems will be those that contribute not only to cutting costs, but also to increasing both access to and quality of care. These multiple goals require that clinical information systems be an integral part of healthcare information systems.

The VA experience, detailed in this book, offers a model based on a long track record of developing and implementing a low-cost, highly integrated healthcare information system that has been designed to evolve and grow gracefully—changing hardware platforms, operating systems, and computer languages, and integrating a variety of commercial technologies—

without requiring the great computer system to an obviously robust and locally extensible system of healthcare facilities. From nursing homes to large, multi-facility hospitals, a variety of foreign countries in their native languages

Even the problems of the past 15 years provide a model for the private sector to understand and overcome them. Our presentations, so that others can learn from our experiences

These past 15 years, a new system was launched, have been participated. We sometimes mention healthcare information where no infrastructure existed. Our information capabilities, yet it has been a challenge. Critics accuse us of a closed system, often because of its size, rather than as a large, dynamic system. Key components of our system are robust solutions, but our system is a solution. So, as better graphical user interfaces, healthcare information systems, the creativity and dedication of our staff, national and the local level. Indian Health Service, with its unique barriers in the evolution of the system, become just another step to be discarded and replaced. development, maturity, and growth. Instead, VA's system development component has been or will be a success.

This book was constructed to provide the breadth of the automation support the day-to-day operations. We have not tried to describe the commercial decision-making process. Since 1982, DHCP has been a success. Although DHCP represents a challenge, local centers in 1985, it has been a success.

01/11/99 12:45 202 482 3610

facsimile
TRANSMITTAL

to: Shirley Sagawa
fax #: 202-456-6244
re: \$100 b Estimate by Director of NLM
date: January 11, 1999
pages: 2, including this cover sheet.

Shirley,

Re: the First Lady's question about my confidence in the McKinsey estimate of \$235-270 billion in saving, here is the other specific "global" estimate by the current head of the National Library of Medicine. Dr. Lindberg uses a range from \$36 billion to \$100 billion, and I bet he is low. As I said at the meeting, there are other relevant studies, but they are of specific savings at specific places, e.g. \$827 per admission at the Latter Day Saints Hospital in Salt Lake City, or \$10 per patient visit at some other place.

Experience in other industries like trucking, airlines, etc. makes me believe that before-the-fact estimates of consumer benefits from modernization/computerization/competition almost always are underestimated.

VA is setting up a meeting for me on Jan 20 or 22 to start exploring data. The Vice President's office is invited.

Paul

From the desk of...

Paul A. London
Senior Policy Advisor
U.S. Department of Commerce
14th & Constitution Ave., N.W. (Rm5027)
Washington, D.C. 20230

202-482-4730
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Advanced Technology Focus of 12 HP Health Care Awards

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Twelve contracts totaling \$26 million, designed to help physicians practice better medicine by utilizing advanced computing and networking capabilities along the "Information Superhighway," were announced today by the National Coordination Office for High Performance Computing and Communications and the National Library of Medicine.

The 12 projects, scattered across the nation, will fund health care applications such as testbed networks to share information resources, computerized patient records, and medical images; telemedicine projects to provide consultation and medical care to patients in rural areas; and advanced computer simulations of human anatomy for training via "virtual surgery."

The projects are the first awards in health care to be made under the High Performance Computing and Communications Program. The HPCC Program is a multiagency effort to focus the Nation's energies on developing and applying high performance computers, the software that will enable the computers to be applied to many of society's problems, and the National Information Infrastructure (or "Information Superhighway") that will put the vast amount of resulting information at users' fingertips.

"These awards are an important step in developing new computing and communications technologies to improve the quality of the Nation's health care," said Dr. Donald A.B. Lindberg, Director of the National Coordination Office for HPCC. Health care is a key component of the government's vision for a National Information Infrastructure. The new technology will allow a doctor in a rural area to send X-ray images and other medical information instantly to specialists at a faraway medical center for a second opinion.

HPCC technology to be developed by the projects will not only improve health care delivery, but reduce costs as well. "Twenty-five cents of every dollar on a hospital bill goes to administrative costs and does not buy any patient care," he said. "Better use of information technology and the development of health care applications for the NII can make important contributions to health care reform. Telecommunications applications such as computerized patient records could reduce health care costs by \$36 billion to \$100 billion each year, while improving quality and increasing access."

"The successful outcome of these projects will help to contain health care costs through sharing scarce resources while raising the quality of patient care," said Dr. Lindberg. "By using telemedicine, doctors and other health care providers can consult with specialists thousands of miles away, continually upgrade their education and skills, and share medical records and X-rays." The projects will also "provide practical experience with real-world applications, such as how to protect the privacy of medical records and images that are subject to computer network transmission, storage and retrieval."

Medical education and training will also benefit from high performance computing and communications technologies. "The first problem that all medical professionals face is that there is simply too much information to keep up, too much to remember. If your doctor were extremely conscientious and read two journal articles every night, at the end of a year he or she would be roughly 800 years behind. Computerized databases help medical professionals find the answers they need when they are needed." Some medical schools "are beginning to teach clinical problem solving methods that will continue to work even as the knowledge base of medicine changes and expands,"

FROM HALLELAND & LEWIS
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Congress of the United States
House of Representatives
Washington, DC 20515

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BK

November 15, 1996

Common Pkg

The Honorable Bill Clinton
The President
1600 Pennsylvania Avenue NW
Washington, D.C. 20500

Dear Mr. President,

I am aware that you are planning to appoint a Federal Advisory Commission on Health Care Quality and Consumer Protection. I am writing to urge you to appoint Sheila Leatherman to this Commission.

Sheila Leatherman currently serves as Executive Vice-President for the United Health Care Corporation, one of the largest health care organizations in the nation. In addition, Ms. Leatherman is founder and President of the Center for Health Care Policy and Evaluation of United Health Care Corporation. She is active in numerous organizations such as the Association of Health Services Research and the Association of American Health Plans. Her work has been in both the private and public sector, and Ms. Leatherman exhibits keen understanding of how corporate America can better work with health organizations.

I highly recommend her to you for appointment to the Federal Advisory Commission on Health Care Quality. I believe her expertise would greatly assist this commission.

Thank you for your consideration.

With best wishes, I am

Sincerely yours,

Roger F. Wicker

RFW/sd

Common File

MEMORANDUM

To: Harold Ickes
Assistant to the President and Deputy Chief of Staff

From: Tom Umberg, State Director
California Clinton/Gore '96

Celia Fischer, Director
California Victory '96

Date: November 14, 1996

Subject: Managed Care Quality Commission

Following the election, the President will appoint an Advisory Commission on consumer protection and quality in the health care industry. We are writing to strongly recommend that Art Levinson, CEO of Genentech, Inc., be appointed to this commission.

As you know, Genentech is a San Francisco Bay Area biotechnology company with \$1 billion/year in sales. Mr. Levinson is a research scientist who could add credibility to the commission's recommendations to the academic health sector. He is also on the "recommended" list from HHS for the Commission and could be an important member, as a health care provider from California.

Levinson's endorsement was an important addition from the biotech community to our Silicon Valley / high-tech CEO support list for Clinton/Gore just prior to the Chicago convention. His endorsement was significant because of his personal status and reputation in the high-tech community, but also due to the prestige of Genentech. Moreover, because Levinson's predecessor at Genentech had endorsed the President in 1992, it was critical that Levinson also endorse. Finally, the company is a major financial donor to the Democratic National Committee.

The Commission's first responsibility will be to lay the groundwork for benefit expansions for children and unemployed workers. Since Health Care provider support for commission recommendations is critical, it will be helpful to generate support and to blunt criticism if a California pharmaceutical CEO endorses the recommendations for benefits.

As always, thank you for your consideration.

cc: John Emerson
Chris Jennings ✓

Completed File

THE WHITE HOUSE
WASHINGTON

November 16, 1996

MEMORANDUM FOR CHRIS JENNINGS

FROM: MACK McLARTY

Map

SUBJECT: DICK HERGET

Per our recent conversation, attached is some additional information on Dick Herget. I believe Dick would be a good addition to your health care commission effort, but I know you are considering a lot of very well qualified and distinguished people.

Many thanks!

RICHARD P. HERGET, JR.

Mr. Herget is President and CEO of Sedgwick of Arkansas, Inc. and Adjunct Professor of Risk Management, University of Arkansas at Little Rock

Mr. Herget began his insurance career with Ford & Herget Agency, Paragould, Arkansas, in 1960. In 1969, Mr. Herget accepted the position of Executive Vice President of the Arkansas Association of Insurance Agents. In 1972, he joined Cobb, Atkins, Boyd & Eggleston as Vice President. Mr. Herget was elected Executive Vice President, Secretary/Treasurer and Director of Atkins Insurance Corporation in 1976. He was elected President of Atkins Insurance in 1982. Atkins was acquired by Marsh & McLennan, Inc. in 1985, and Mr. Herget was elected a Managing Director of Marsh & McLennan in 1987. In 1992, Mr. Herget served as Vice Chairman of Rebsamen Insurance, Inc. He has served as the Chief Legislative Representative for the insurance industry in the Arkansas General Assembly and has also served on the Executive Committee of the Arkansas Association of Insurance Agents. He was elected to the Board of Directors of Arkansas Power & Light Company in 1981, the Board of Directors of Union National Bank of Arkansas in 1982, and the Board of Directors of Union Modern Mortgage Corporation in 1985. Mr. Herget was elected to the Board of Sedgwick Group Development Limited of London in June, 1995.

In 1971, Mr. Herget was honored by the Arkansas Jaycees as Arkansas' Outstanding Young Man.

He was appointed in 1975 to a five year term on the Arkansas State University Board of Trustees by Governor David Pryor and reappointed for another five year term in January, 1980 by Governor Bill Clinton. In 1990, Governor Clinton appointed Mr. Herget a trustee of the Foundation for the Mid South.

Mr. Herget served as Chairman of the Board of Trustees of Arkansas State University in 1979-1984. In 1981, he was elected to the Board of Directors of the ASU Foundation.

He has served on the Board of Directors of both the Paragould Area Chamber of Commerce and the Little Rock Chamber of Commerce. In 1976, he was awarded the Arkansas Certificate of Merit, the highest award that is presented by the State of Arkansas, for his work in law enforcement. In 1977, he was a recipient of the State Chamber of Commerce's Arkansas Community Development Award. He served as Vice President for Governmental Affairs of the Greater Little Rock Chamber of Commerce for nine years. He is Chairman and Director of the Downtown Partnership of Little Rock. Mr. Herget is a member of the Executive Committee & Board of Directors of the Greater Little Rock Chamber of Commerce and the Arkansas State Chamber of Commerce.

JIM RAMSTAD
THIRD DISTRICT, MINNESOTA

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Congress of the United States
House of Representatives
Washington, DC 20515-2303

September 18, 1996

The Honorable William J. Clinton
President of the United States
The White House
1600 Pennsylvania Avenue NW
Washington, D.C. 20500-9900

Commissioner

Dear Mr. President:

I was pleased to learn about your plans to appoint a Federal Advisory Commission on Health Care Quality. I understand appointments to this Commission will be made after the November election, but you and your staff are in the process of reviewing the qualifications of potential Commissioners.

I strongly recommend Sheila Leatherman, the Executive Vice President of United HealthCare Corporation based in Minnetonka, Minnesota, for your consideration.

Throughout her professional career, Ms. Leatherman has been active in efforts to evaluate and improve the performance of health care delivery through health policy, research and management initiatives. Her work in this area has been both in the public and private sector on the state level as in Minnesota and Wisconsin, and also nationally. For example, she is responsible for creating the Center for Health Care and Evaluation in Minneapolis. The Center focuses on evaluating the performance of health care delivery systems for United HealthCare and a broad range of other organizations, including government entities and academic institutions.

Given Sheila Leatherman's exemplary qualifications and her vast experience as well as keen interest in the field of health care services, I highly recommend her to you for appointment to the Federal Advisory Commission on Health Care Quality. Enclosed, for further information, is her curriculum vita.

Thank you for your consideration.

Sincerely,

JR
JIM RAMSTAD
Member of Congress

JM:meh

*Sheila is truly an expert
in this area who would be
outstanding on this Commission.*



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October 28, 1996

FYI

Ms. Barbara Woolley, Public Liaison
The White House
Washington, D.C. 20500

Dear Ms. Woolley:

I am writing to strongly endorse and recommend Mr. John Crosby as the staff executive director for the president's Advisory Commission on Consumer Protection and Quality in the Health Care Industry. This new Advisory Commission is a most welcome and needed oversight function on behalf of patients in America, and requires expert leadership and guidance at the staff level if it is to successfully complete its mission.

John Crosby, currently Vice President for Health Policy at the American Medical Association is an individual who possesses the experience, the integrity, and the consensus-building skills required for the executive director position. I have known Mr. Crosby for the past eight years, and I have been favorably impressed at all times by his leadership, management, and policy-development skills.

Mr. Crosby developed particular experience and expertise in the area of quality assurance and the ethics of medicine through his activities at the American Medical Association, including bringing business, hospital and community leaders together with physicians to discuss such complicated issues as "medical care at the end of life", "racial and ethnic disparities in health care", and issues relating to the ethical aspects of various reimbursement systems.

John is an attorney with extensive experience in various management arenas, including the insurance industry, project HOPE'S center for health information, as an Administrative Assistant for congressman Dick Gebhart, and as an associate of the St. Louis law firm of Thomas Mitchell. He is a member of the American, Illinois, and Missouri Bar Association, and has lectured on medical, legal, and quality assurance issues at the nation's major universities and policy centers.

I hardily recommend John Crosby as an experienced and eminently qualified person to provide the staff leadership for the president's newly proposed-commission. Please feel free to call on me for elaboration or clarification of any of the preceding comments. I have full confidence that John Crosby will make an excellent choice for this challenging position.

Very truly yours,

John C. Lewin, M.D.

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DOCUMENT NO. AND TYPE	SUBJECT/TITLE	DATE	RESTRICTION
001. memo	Bob Nash to POTUS Re: Advisory Commission on Consumer Protection and Quality in the Health Care Industry (12 pages)	11/19/96	P2

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004. list	Short List of Candidates for Health Commission (3 pages)	nd	P2 <i>bx 25</i>

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005. memo	Diana Fortuna to Chris Jennings Re: Names from Carol (1 page)	10/11/96	P2

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- P4 Release would disclose trade secrets or confidential commercial or financial information [(a)(4) of the PRA]
- P5 Release would disclose confidential advise between the President and his advisors, or between such advisors [a)(5) of the PRA]
- P6 Release would constitute a clearly unwarranted invasion of personal privacy [(a)(6) of the PRA]

C. Closed in accordance with restrictions contained in donor's deed of gift.

PRM. Personal record misfile defined in accordance with 44 U.S.C. 2201(3).

RR. Document will be reviewed upon request.

Freedom of Information Act - [5 U.S.C. 552(b)]

- b(1) National security classified information [(b)(1) of the FOIA]
- b(2) Release would disclose internal personnel rules and practices of an agency [(b)(2) of the FOIA]
- b(3) Release would violate a Federal statute [(b)(3) of the FOIA]
- b(4) Release would disclose trade secrets or confidential or financial information [(b)(4) of the FOIA]
- b(6) Release would constitute a clearly unwarranted invasion of personal privacy [(b)(6) of the FOIA]
- b(7) Release would disclose information compiled for law enforcement purposes [(b)(7) of the FOIA]
- b(8) Release would disclose information concerning the regulation of financial institutions [(b)(8) of the FOIA]
- b(9) Release would disclose geological or geophysical information concerning wells [(b)(9) of the FOIA]

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Clinton Presidential Records
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OA/Box Number: 23753

FOLDER TITLE:

Preventing Medical Errors [5]

gf149

RESTRICTION CODES

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- P1 National Security Classified Information [(a)(1) of the PRA]
- P2 Relating to the appointment to Federal office [(a)(2) of the PRA]
- P3 Release would violate a Federal statute [(a)(3) of the PRA]
- P4 Release would disclose trade secrets or confidential commercial or financial information [(a)(4) of the PRA]
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