

Mark Masselli: This is Conversations on Health Care. I am Mark Masselli.

Margaret Flinter: I am Margaret Flinter.

Mark Masselli: Margaret, a picture perfect Memorial Day weekend. We had a great turnout at the Memorial Day parade. You know we love parades at the Community Health Center and we are very proud that our float won the veterans award this year.

Margaret Flinter: Well, I guess we are entitled to brag for just a second but it was a great and wonderful traditional event. And the long weekend, a much needed rest for everybody. But the hard work of implementing health reform that's back in full swing this week. In California, the legislature is looking at trying to pass as many as 20 different bills related to health reform before they adjourn for the session. Those provisions keeping adult children on their parents' policies till age 26, eliminating preexisting conditions for adults, and that all important creation of the state health insurance exchange. Federally funded but state run all of those on the agenda.

Mark Masselli: California is certainly a model state for implementation because of its large size, not to mention its significant population of uninsured. There are around eight million uninsured residents in California, about the size of State of New Jersey.

Margaret Flinter: And there is some level on which people are saying they will hopefully pass reform because the republicans they are calling the legislative activity premature. There are upcoming elections that could potentially put republicans back in power and that potentially could result in the repeal of the reforms. Going back to the surprise republican senate seat victory in Massachusetts earlier this year, I think Mark it's safe to say the democrats have learned to take nothing for granted.

Mark Masselli: And when there is a lot of potentials, there is a lot of anxious people and certainly the poll show Americans are still divided over the new law but a new NBC News/Wall Street Journal Survey found that the public is more likely to vote for candidates who would work to improve the bill versus repeal it.

Margaret Flinter: And that's exactly what people predicted back in March would happen and that's good news. Let's turn out to today's guest who has been an innovator in the practice and the science of health care delivery for over 20 years now. Dr. Brent James is a surgeon. He is also the Chief Quality Officer for Intermountain, a large health care system based in Utah. He has developed a very disciplined approach to measuring outcomes and from that creating standardized clinical treatment plans that have been successfully shown to

improve quality, improve safety, reduce cost and most importantly save lives. We are so happy to have Dr. James here with us today.

Mark Masselli: We are and there was a great New York Times magazine article about Dr. James. The author David Leonhardt puts Dr. James in a league with Don Berwick, Mark McClellan and Dr. John Wennberg of Dartmouth as he puts it for the past decade or so a loose group of performers who has been trying to figure out how to improve health care and also holding down the growth in cost. Dr. James is a real health care reformer.

Margaret Flinter: And that's quite a group of illustrious visionaries that he has been keeping company with. No matter what the story, you can hear all of our shows on our website Chcradio.com. You can subscribe to iTunes to get our show downloaded or if you would like to hang onto our every word and read a transcript of one of our shows, come visit us at Chcradio.com.

Mark Masselli: And as always, if you have feedback, email us at Chcradio.com, we would love to hear from you. Before we speak with Dr. Brent James, let's check in with our producer Loren Bonner with the Headline News.

Loren Bonner: I am Loren Bonner with this week's Headline News. In a very tangible demonstration of the impact of the passage of the Health Reform Bill, the Federal Government sent out brochures last week to more than 40 million Medicare recipients to tell them about their benefits under the new law. The first benefit will put \$250 in the pocket of 80,000 seniors who fall in the Medicare Part D's current coverage gap. The government will continue to mail checks every 30 days. The gap known as the Donut Hole will disappear eventually under the new legislation. Secretary of Health and Human Services, Kathleen Sebelius says this will be a huge relief to seniors.

Kathleen Sebelius: One of the biggest ways the new law is going to help seniors is by gradually phasing out the Medicare prescription drug Donut Hole that's made it hard for seniors to afford their medications. About eight million a year reach that Donut Hole gap and coverage.

Loren Bonner: But other Medicare news is making the headline. Congress did not act in time to avert a June 1st 21% pay cut to physicians who care for Medicare enrollees. The proposed doc fix, a last minute infusion of funds to stave off a looming cut has been continuously postponed. The uncertainty is making some doctors take a hard look at their participation in the program. Democrats have talked about a five-year fix then three years, now it looks like leaders are proposing postponement of the cut through the end of 2011.

Today on Conversations on Health Care we are exploring the broad area of transforming health care quality. Saving more lives, reducing costs and expanding the science of medicine to include the science of measuring health

care outcomes. Cost effectiveness research is an element of transforming quality. It quantifies how much better one treatment is over the next. How much reduction in mortality? How much increase in life expectancy? How much improvement in quality of life, does treatment A give a patient compared to treatment B. It also takes this comparison one step further and relates that quantified measure of incremental benefit to cost. How much does it cost to get a particular level of improvement in health outcomes? Almost every western country has adopted CER into their health care system in one way or another. CER encourages change that can improve both the efficiency and the quality of care. In the US however there is still a widespread fear that CER will prevent patients from receiving affective or life saving care. Milton Weinstein the Henry J. Kaiser Professor of Health Policy and Management in the Harvard School of Public Health refutes such a claim. Expensive life saving treatments and drugs are not ruled out under CER he says.

Milton Weinstein: Even very expensive drugs such as Imatinib which is used for leukemia among other forms of cancer, despite its high sticker price is an extraordinary value in terms of the cost per life-year saved for patients who previously didn't have any attractive treatment options.

Loren Bonner: There is also fear from the medical community that CER will do more harm than good in part by threatening individual physician's autonomy and professionalism. Weinstein agrees that this can be difficult but remedied.

Milton Weinstein: Getting physicians and healthcare institutions to change behavior require some tangible incentives. Many people talk about something called value-based insurance design whereby physicians and health care providers might be paid different amounts depending on the cost effectiveness of what it is they are being paid for so that holding everything else equals, such as the cost of delivering the service they might get paid a higher percentage of cost for procedures that are more cost affective.

Loren Bonner: The health reform legislation specifically prohibits the use of CER information and making coverage decisions. The bill will however fund a private organization called the Patient-Centered Outcomes Research Institute which will identify which patient-centered research will help providers and payers make informed decisions about how to treat patients effectively without wasteful over spending. The bill also sets up pilot projects that will examine new physician payment systems, penalize hospitals that have high readmission rates and establish an independent commission that will determine which treatments Medicare should cover. Let's turn now to our interview with Dr. Brent James, Surgeon, Scientist and Chief Quality Officer of Intermountain Healthcare, a Utah based health care system that has earned a national recognition for its work and achieving better than average patient outcomes at less than average cost, using principles that the rest of the country will need to consider and adopt.

Mark Masselli: This is Conversations on Health Care. Today we are speaking with Dr. Brent James, Chief Quality Office at Intermountain Healthcare. Welcome Dr. James. Your institution Intermountain Healthcare has been frequently cited in health reform discussions throughout the past year. Your Public Relations Department must be very happy but it's not about **vapor**, as Chief Quality Officer you had a strong influence in getting physicians and nurses to move toward the disciplined measurement of outcomes, and use of treatment guidelines based on data generated by that measurement. Could you start out by telling us how a cancer surgeon like yourself, a former physicist, started down this path?

Dr. Brent James: It was as usual a complete accident. I was at Dana-Farber Cancer Institute, a member of the faculty of Harvard School of Public Health studying new therapies for cancer patients. Mostly a personal circumstance I needed to move back home close to the family and had a job offer from Intermountain. Frankly that was a strange experiment. They were starting to reach out to physicians back in 1986, physicians who were interested in research and they wanted to start some sort of research program, got here and we had an interesting and we had an interest in measuring variation in care, a obscure branch of medical science but surprisingly well founded. Everybody till that point had looked at variation in hospitalization rates, we looked at what happened to people after they were hospitalized. What we showed was an extension of the existing knowledge. It turns out that where you live is more important than whether you have insurance and determining the care you actually received. We showed that one step further who treated you within the hospital was more important than any other factor in determining the actual care. And the problem was that the variation was so large, it was pretty much physically impossible that all patients even with full access to care were getting good care. Well the next step it's one of those happy accidents so I shared some of this data in the national meeting, met a fellow for the first time who became a very good friend, Dr. Paul Batalden then the Vice President for Quality at HCA back before they became part of the Columbia System, now at Dartmouth University. Paul looked at our variation analysis and sort of reminded him of the work of a statistician in industry. A fellow named W Edwards Deming, yeah and he introduced me to Dr. Deming and that was a match made in heaven. Well I came back home and tried some of Deming's ideas in trials, treatment, experiments so we had to go at Intermountain. Dr. John Burke was leading the team up at LDS Hospital, he was doing this research, we were all trained health services researchers. We know how to measure very precisely but we focused our attention pretty much exclusively on clinical outcomes. And Deming's idea was toss money in there, toss and cost is just one more outcome. He came back to Dr. Burke and said hey John have you ever thought about tracking cost? We thought it was a really cool idea and the question was how he measured the cost? Well, again pure serendipity. It turns out that Intermountain was one of the first systems in the world to build a system that could measure cost actually. The fellow who had done that was a guy named Steve Busboom, the Vice President for finance and I met him here. So I said to Dr. Burke, I said John, Busboom, he can help us. We

will get this done. Well we threw that cost metric in, we showed our infection rates off of 1.8% to 0.4% as part of the trial. But because we didn't have to pay to treat the infections the cost of operations at LDS Hospital fell by almost \$2 million a year.

Margaret Flinter: Dr. James, I think Dr. Deming hasn't got quite as much credit as he should in these health care reform discussions we have been having. So thank you so much for sharing that history with us. And you know, I have read some of your comments and I think you have spoken so eloquently about the role that intuition and experience in caring for patients, you clearly have a deep appreciation for the sixth sense health care providers develop about patients and treatment decisions. But you have made this point, usually when healthcare providers are talking about my experience they are really talking about the last few patients they treated and you were quoted in a New York Times article as saying, "My goal is for doctors and nurses not to say in my experience but rather to say in my measured experience", that's a culture change and I know that you are very involved in training the next generation of health care providers to embrace that change and you are doing it outside the academic institutions largely. Can you tell us a little bit about your work in that area?

Dr. James: We run a big training program called the Advanced Training Program in Clinical Practice Improvement. It started in 1992. It was an attempt to change the culture of Intermountain. Dr. Deming told me that if I wanted to change kind of the attitudes and beliefs and the approach that physicians showed, he said you don't need to get everybody but he said if you have got n individuals you need about square root of that. So we started the ATP the Advanced Training Program to do that. Trouble was as I wanted to bring in some very prominent faculty and that costs money, we couldn't afford it. So I opened it up to people from around the country. We run it at break-even that about I don't know 20% of the attendees are from Intermountain or the other care-delivery groups here in Utah. The other 80% come in literally from around the world. Since then we have trained about 3500 people in the principles of clinical quality improvement that's just playing the fun. I mean you get health experts from all around the world. People, who are doing that hands-on experience, get them together in a room it means when you bring up any issue you are going to see it from eight different directions including a British direction or an Israeli direction or a North American direction, you see.

Mark Masselli: Dr. James, speaking of other institutions, Mayo Clinic and Geisinger Clinic are also praised for their quality, outcomes and ability to avoid over-treatment and testing but one key difference between Intermountain and those systems is that the other systems are a staff model institution in which the physicians are employees. The model would seem to allow for greater control over physician practices and consequently incomes that are not based on volume of visits and procedures. Tell us about the challenges you face in trying

to drive change in improvement in a system like Intermountain where you don't have that level of control.

Dr. James Brent: Well the first thing that is a basic misunderstanding and that people think you can control a physician through employment, you can't. Physicians are mostly driven by professional goals. So what we did here, where most were physicians are community based we built our measures around shared professional goals. And what I can tell you from experience it pretty much always trumps some money. If you can show them what's really happening to their patients they all believe they are doing good. They all get up every morning and say how can I help people and in a very real sense the money they receive is just the _____ their force to bear for the good they are doing in our community, right, to make a little bit of a joke out of it. When we started to make care truly transparent so they could see the short and long term results their patients were experiencing it overwhelmed the money.

Margaret Flinter: Let's talk about the patients for a second Dr. James. We recognize that just because the treatment has been proven to be safe and effective doesn't mean we necessarily have the data and the science to know when it's effective and in which groups of patients it is most effective. And it makes sense to give patients a role in that you at Intermountain have developed a sheer decision model I understand, that's the responsibility patients may or may not be ready to accept. Can you give us your thoughts on that and do you have any data on the benefits of a sheer decision making model with patients?

Dr. James Brent: Well in truth we didn't develop it here so much as we brought up from Dr. Albert Mulley at Massachusetts General Hospital and the work he has done with Dartmouth. He went up to Dartmouth and Jack Wennberg and that group and now it's a little not-for-profit company called Health Dialog. Dr. Albert Mulley though did the initial scientific work. He measured the values of patients as he made decisions and he checked whether the decisions they made, the treatment decisions they selected match their values. He then would follow up after the fact kind of a buyer's remorse approach that I found to be pretty compelling about how did you feel about it after you had it done. He showed that if you prepared information for patients in a particular way on all of those metrics patients were much, much happier with their care experience. And then he started to develop tools to make that practical. It turns out it's not just showing statistics, you have to tell stories. But then he took people who would face the same choice and he interviewed them and made them into a series of short vignette. So if you had it he mentioned that you have ischemic heart disease, you have a potential for heart attack and you have some choices about how you treat them, lot about surgery. The way you sit down at a computer it tell us about your choices and the probabilities of each outcome you are interested in. Will I die? Will I have a major complication? Will I get a stroke or you know bad depression these sorts of things. The next thing though it will match you as a person to this library of vignettes and you might get all 8 or 10 little pictures on

your spin and you can click on and hear these people tell their story. It turns out that really works. Well the next thing they built in were metrics. They measure your values. Well what Dr. Mulley's approach did was match up the choices to the patient's values along these lines. So we are trying to deploy that.

Mark Masselli: Today we are speaking with Dr. Brent James, Chief Quality Officer and I guess storyteller at Intermountain Healthcare. Under your leadership Intermountain has successfully developed and implemented more than 50 detailed best practice standards and guidelines based on outcome data from care delivered in your own institutions. In many instances you clearly demonstrated patients were more likely to live if the doctor and the healthcare team followed the recommended standards. You didn't force it on your doctors. I understand that you have established these as default standards that the individual physician could overwrite. If you know the outcome will it be better using the developed standards? Why not require it and is it not enough to rely on just the persuasiveness of the data?

Dr. Brent James: The reason is that we have pretty good evidence that you cannot write a guideline or a protocol that perfectly fits a new patient except the very narrow circumstances. The way to think about it the humans who come to us for help we know that they are genetically different, I train them surgery, I know that every patient will be slightly different anatomically. It goes a level deeper they have different circulating enzymes. On top of that the way that we say on the drug or a medicine in the community you get different exposure to pathogens, things that cause disease. So you maybe exposed to something I am not, well different exposure, because of your different genetics you will have a different expression of the disease, different presentation, you will have a different response to treatment. Lay on top of that your different personal values, your resources, your preferences, it's no surprise that you can't really write a protocol that perfectly fits in a new patient. We used a form of quality three called Lean. Many people may have heard of this. The subset is mass customization. So what I say to our physicians, I say look we are going to take this evidence based on this practice protocol. We are going to build it into the flow it works so you don't have to remember it. If you just take the default that's what's going to happen, all right. On the other hand I actually say this to with some regularly guys it's not just that we allow or even that we encourage, we demand that you adjust that individual patient needs, and it has some real impact. First of all, you get these massive improvements in patient outcomes. We count our successes in lives very literally, thousands of lives, people who didn't die. The second thing is that it tends to be much more economical. When I say that it's more than 50% waste in care delivery today this is how you get after it.

Margaret Flinter: So Dr. James when you look around the country as you do and the world what do see that really excites you in terms of innovation and who should our listeners of Conversations be keeping an eye on?

Dr. Brent James: Well you should keep an eye on the American Board of Internal Medicine. They are the people who do board certification for interns. Chris Cassel a physician who leads that. Put this theory in the theory of quality the things we have been talking about as a testing requirement to become an internal medicine doctor. The following year the American Council Graduate Medical Education, the ACGME, did the same thing for all residency training programs across the entire house of medicine. Now you have to understand these groups are kind of the flame keepers I guess of our professional values, amazingly conservative organizations as they should be. I will suggest you, that when that kind of group makes that kind of transition it's a done deal intellectually. It represented the healing professions choosing a new course. Now it takes a while to deploy it. When I talked to Dr. Cassel she tells me that her biggest problem is finding faculty who can teach it. But it very clearly is on track. That transformation underneath works hand in glove, dovetails with developments in new electronic medical records. That allows us to give the data to physicians about what really happens. It opens their eyes I guess, takes off the dark glasses so you can see its transparency. That combination is transforming the field.

Mark Masselli: Today we have been speaking with Dr. Brent James, Chief Quality Officer at Intermountain Healthcare. Thank you so much Dr. James. Each week Conversations highlights a bright idea about how to make wellness a part of our communities in everyday lives.

Margaret Flinter: This week's bright idea comes from the National Complete Streets Coalition, a group that's making our streets and town more livable by taking a critical look at how we design our roadways. The coalition works to help cities build complete streets i.e. roadways to serve the needs of all users, not simply personal automobiles. The Complete Streets vision includes all members of the community from bicyclist to public transportation riders, from wheelchair users to pedestrians. Complete Streets can include many different components such as sidewalks, bicycle lanes, wide shoulders, well designed and well placed crosswalks, reduction in the number of driveways, and even traffic calming measures like center medians, street trees, and staggered parking. Any and all of these measures go a long way to increase residents' safety and therefore improve their health. Well the National Complete Streets Coalition considers any individual complete street a victory. Their goal is to help cities and states adopt comprehensive complete street policies in which every area roadway is designed according to a set of guidelines. As the benefits of Complete Street policies become more visible they are being enacted in more and more places across the country. Successful implementation of Complete Street Policies has already occurred in 14 states including California, Florida, Kentucky, South Carolina, and Pennsylvania. Well, attempts at Federal Complete Streets legislation stalled in the house last year but the advocates aren't giving up on what they see as essential protections of public safety and health. Jonathan Patz President of the

International Association for Ecology and Health said Complete Streets may present the greatest public health opportunity that we have had in the century. By taking the holistic approach to roadway design, The National Complete Streets Coalition is helping make our communities safer, healthier, and more cohesive one street at a time. Now that's a bright idea. This is Conversations on Health Care. I am Margaret Flinter.

Mark Masselli: And I am Mark Masselli. Peace and health.

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