

The Health Care Leadership Forum

*Paying for Clinical Excellence:
Strategies for Crossing
the Quality Chasm*



Anthem  

Event Monograph
December 2004

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It is a generally accepted tenet in the health care industry that people should receive only that medical care which maintains and improves health. There is also a shared commitment to preventing the delivery of unnecessary or potentially harmful treatment. On October 12, at the Brown Palace Hotel in Denver, Anthem Blue Cross and Blue Shield hosted over 100 Colorado health care, business, legislative and community leaders at its third annual Health Care Leadership Forum. The forum, entitled, "Paying for Clinical Excellence: Strategies for Crossing the Quality Chasm," explored outcomes of several working models designed to ensure the delivery of safe, evidence-based, medically necessary health care.

The keynote speaker was Alice Gosfield, Esq., a Principal at Alice G. Gosfield and Associates, PC., a national practice specializing in physician representation, managed care, and quality. Ms. Gosfield delivered an intellectually stimulating, entertaining and highly provocative perspective on programs that have successfully improved the quality of health care – as well as those that haven't. In addition, participants had the opportunity to share their perspectives and experiences, and propose solutions.

Anthem hosted this forum in acknowledgement that the quality of health care is a critical problem and that its

improvement will save lives and minimize resulting complications and unnecessary hospitalizations or procedures. The intent was to engage Colorado thought leaders in on-going dialogue about the importance of quality in making health care decisions and to act as a catalyst to stimulate new initiatives and innovative thinking within the health care industry.

The program featured:

John Bell, MD
President and Chairman of Colorado Springs Health Partners

Alice Gosfield, Esq.
Principal, Alice G. Gosfield and Associates, PC

The Honorable Mark Hillman
Colorado State Senator

Robert Ladenburger
CEO, St. Mary's Hospital and Medical Center

Robert London, MD
Vice President, Health Care Management, Anthem Blue Cross and Blue Shield, West Region

Caroline "Caz" Matthews
President, Anthem Blue Cross and Blue Shield, West Region

Alethia Morgan, MD
President, Colorado Medical Society

Sam Nussbaum, MD
Executive Vice President and Chief Medical Officer, Anthem Inc.

About Anthem Blue Cross and Blue Shield in Colorado

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“ It’s time to get back to the doctor-patient relationship as the business case for quality care. Go get ‘em.”

Alice Gosfield

Principal, Alice G. Gosfield and Associates, PC

Anthem Blue Cross and Blue Shield would like to acknowledge the contributions of several associates who orchestrated this event.

Sheila Ducello, Health and Wellness Project Manager

Lisa Latts, M.D., M.S.P.H., Regional Medical Director

Sally Vogler, Director, Public Relations

For additional copies of this monograph, or for information on the forum, please contact Sheila Ducello, at 303-831-3352, or sheila.ducello@anthem.com.



Caz Matthews

In her opening remarks, Caz Matthews, President of Anthem Blue Cross and Blue Shield's West Region, likened the national health care industry to a speeding motorcycle. "The health care system is hurtling forward like a motorcycle going 200 miles per hour. If we don't find ways to slow down and really address a myriad of quality and safety issues, we can anticipate a tragic crash."

Kicking off the 2004 Fall Health Care Leadership Forum, Matthews recognized the 100 attendees as the

best thinkers and leaders in Colorado from health care, business, legislature, and from the community at-large. She then challenged participants to keep in mind the motorcycle metaphor throughout the morning, as technology advances the science of medicine at breakneck speeds, and where the health care system struggles to ensure that patients receive safe, timely evidence-based care.

Matthews said the focus of this year's forum, "Paying for Clinical Excellence: Strategies for Crossing the Quality

Chasm," builds upon the findings and strength of previous forums conducted in 2002 and 2003. Yet studies continue to report an alarming number of clinical errors in hospitals, leading Matthews to conclude, "Patient care misses the mark and is sometimes harmful."

"This a great segue to today," Matthews said, "and you will have a voice in recommending what actions we can take now to heal a system that's clearly hurting. To quote Henry Ford, "Whether you believe you can or believe you can't, you're probably right."



Doing Well by Doing Good: Improving the Physician Business Case for Quality

The Quality Problem

Alice Gosfield got to the point quickly in her remarks at the 2004 Fall Health Care Leadership Forum. She expressed frustration that, while findings from the Institute of Medicine's (IOM) *Crossing the Quality Chasm* and the notable efforts by the Leapfrog Group to improve and report health care quality are encouraging, progress overall appears slow. "It's great," said Gosfield, a practicing health care lawyer and past president of the American Health Lawyers Association, "but no one does anything about it."

The symptoms are clear of a system in need of overhaul. Errors and patient safety are continuing concerns. Misuse, underuse, and overuse are evidence of not delivering care in a correct manner. Gosfield said what's happening now is what Donald Berwick meant when he said, "Every system is perfectly designed to achieve the results it gets."

Based on her experience, she noted, "The connection of poor quality to malpractice cases ought to be acknowledged in a more significant way."

The industry also places too much emphasis on "green eyeshade values," meaning an

over-reliance on inadequate business models. "This," Gosfield said, "is what is behind the backlash in managed care." Gosfield recognized pay-for-performance (P4P) as more of a transitory solution. Solutions to date, though, provide too little attention to the "critical and unique role physicians play in making quality initiatives real," an element most P4P programs lack.

Gosfield said a quote by Berkeley economist James C. Robinson captures the all-or-nothing way that health care works in the U.S. today. In part, Robinson said, "Everything that is not mandatory is prohibited."

Today's Quality Context: Welcome to Wonderland

Improving the quality of health care must account for the evolution of the federal and state regulatory environment surrounding quality. Gosfield summarized the most recognizable programs:

- Professional Standards Review Organization (PSRO)
- Quality Improvement Organizations (QIO)
- Emergency Medical Treatment and Labor Act (EMTALA)
- Quality Improvement System for Managed Care (QISMC)

- Quality Assessment and Performance Improvement Act (QAPI)
- Healthcare Quality Improvement Act (HCQIA)

Even with this blanket of regulations, fraud and abuse cases based on quality issues are occurring more frequently. The rise in the number of false claim cases against nursing homes is troubling, where questions arise as to appropriate levels of care. Gosfield cited familiar cases where quality issues were at the center of criminal enforcement.

She concluded that the many promises made by managed care have not been kept. The examples noted were where "patients crashed through safety nets."

Overuse or underuse violations or poor quality by health care providers can lead to exclusion from federal health care programs. Civil monetary penalties may be assessed in particular situations. State laws frequently mandate quality regulations and reporting.

Have all these regulations done anything to improve quality? Gosfield said she was hard pressed to say yes. Regulations, said Gosfield, "have not engaged physicians or



persuaded them that quality initiatives merit their attention.” The climate now is to punish bad behavior rather than incentivize process improvements.

Physicians: The Nexus of Quality

Gosfield believes strongly that the physician is the fulcrum of the health care system. They are the center of the legal authority and portal for all patients to the health care system. The most expensive medical technology is not a CAT scan machine – it is a ballpoint pen in the hands of a physician with which to write their orders.

The first question patients have when selecting a health care plan is, “Is my physician in the network?” Not only do physicians have the most personal and intimate contact with patients, they are the ones who help patients interpret insurance benefits and the rest of the health care experience.

Physicians fill the primary role explained by Reinersten's Axiom, that is - they explain, they change, and they predict a patient's future. All else, according to Reinertsen, “are secondary to this primary task.”

The IOM adopted this as their central theme in *Crossing the Quality Chasm*, stating, “The transfer of knowledge is care.” Physicians take into account a patient's personal needs, “custom crafting” science into a blend of time and touch. Our goal, said

Gosfield referring to all attendees, should be to optimize that transfer and better manage the complex interactions that serves each patient's needs.

Barriers to Quality Care

The barriers to quality care, according to Gosfield, are easy to recognize. Irrelevant documentation frustrates physicians the most. The requirements of evaluation and management codes and managing risk of alleged false claims are all relics of poorly designed managed care systems. The same goes for documenting medical necessity. None of these are clinically useful, and Gosfield claimed all the other adminis-trivia and redundant safeguards “steals time that might otherwise be spent transferring knowledge and engaging in healing relationships.”

Rampant consumerism, alternative therapies, and exploding information posted on the internet create a challenge to quality care. It takes time for physicians to debunk radical theories, moderate requests for aggressive treatment options, or address the risks of alternative therapies suggested by patients.

Just managing a practice or staff in a hospital is difficult enough, noted Gosfield. Managing the exploding knowledge base of medicine is even harder.

The biggest barrier to quality care, in Gosfield's view, is irrelevant payment systems. Fees for service are overused, perpetuating the theory that the more services are rendered, the more income is derived. Capitation, the method by which risk is covered for a particular population, is under-utilized. Gosfield said that taken to its logical conclusion under the capitation payment system, “The only way to make money is not to do anything.”

Gosfield sees pay-for-performance systems as merely add-ons to existing payment systems designed to pay for services that increase quality. The great hope of P4P was it would depend more on science, provide more patient safety and focus, with results being more transparent. It was thought that P4P processes and systems would evolve to accommodate the new purchasing power of the patient looking for the best results. As such, P4P will produce changes faster.

Gosfield listed a number of P4P initiatives launched by the industry employing a variety of payment schemes and features. Some success occurred and some systems clearly failed. The success so far of this business case is not clear as improvements in care are marginal at best. Given the increased burden of reporting to earn bonuses, said Gosfield, it doesn't appear the return in income is significant. Furthermore, P4P programs don't align with the needs of patients and employers, thereby extending



the chasm of quality care even wider. Gosfield concluded that P4P has yet to prove it can increase physician margins, improve quality, and sustain itself over time.

What Makes Physicians Different?

Before beginning her discussion of possible solutions, Gosfield said that having a cardiologist for a father gives her a unique insight into what motivates a physician. She said there is an unspoken anxiety felt by all who practice and are accountable for the life and death of patients. This bond to patients fuels a fierce responsibility for the care of each individual. "These are the values," said Gosfield, "we have to accommodate."

In addition, physicians are the legal captains of the ship. They, more than anyone, should promote evidence-based, scientific decision-making. Most physicians are willing to share knowledge and embrace the concepts of outcomes and quality improvement feedback.

Five Principles for Escaping the Rabbit Hole

Gosfield identified five principles to help unravel the frustration experienced in the health care industry. First, standardize processes, documentation, facilities, and equipment. Eliminate the idiosyncrasies and inefficiencies.

Second, simplify those same processes. Develop standards that are relevant to evidence-based-medicine (EBM). All other requirements need not apply. Consolidate disparate and duplicitous measurements. "In ways too numerous to list," argued Gosfield, "the current environment is simply too complex."

Thirdly, make what happens clinically relevant. Gosfield cited the refusal of a hospital staff to use a new automated, multi-million dollar physician order entry computer system. Physicians complained that the program was dangerous and not user-friendly.

Fourth. Engage the patient. Said Gosfield, "The most powerful risk management technique to prevent malpractice litigation is a good doctor-patient relationship. Patients do not sue doctors whom they love." Preliminary results from programs employing strong doctor-patient features suggest that engaged patients are more likely to follow the orders of their physicians.

Lastly, establish accountability at the locus of control. We must recognize that physicians have limited control over outcomes, but that their knowledge and application of science is key to their interaction with their patients.

"Doing any one of these would change the face of medicine," Gosfield said. "Doing all of them would revolutionize medicine."

Add to those principles the STEEP values of a quality health care system embodied in IOM's *Crossing the Chasm*:

Safe – avoiding injuries

Timely – reduce waits and harmful delays

Effective – base medicine on scientific knowledge, giving patients no more or no less than what they need

Efficient – avoiding waste of equipment, supplies, ideas, and energies

Equitable – provide care that does not vary in quality because of gender, ethnicity, location, and socioeconomic status

Patient-centered – respectful and responsive to patient preferences, needs, and values

Gosfield's Unified Field Theory (UFT-A)

The five principles expressed above form the foundation on which Gosfield proposes a new business model, one which seeks to simultaneously:

- Simplify the work environment
- Make payment and support systems clinically relevant to the delivery of care
- Address evidence-based medicine or clinical practice guidelines
- Improve the quality of health care delivery



Gosfield identified nine steps needed as crucial elements of her UFT-A (whimsically pronounced UF-ta) theory:

- 1 Establish a national Clinical Practice Guideline (CPG)
- 2 Translate guidelines into appropriate payment codes
- 3 Establish standard templates for documentation
- 4 Document the full pathway of care (not just physicians)
- 5 Accommodate deviations where appropriate
- 6 Engage the patient
- 7 Price all services
- 8 Measure compliance
- 9 Analyze and improve

Anticipated Results

As proposed by Gosfield, UFT-A represents the ability to demonstrate real value, that is accepted standards of care that have known costs attached to it. Thinking creatively, UFT-A could create brands of health care that differs from others based on quality. Communicating and marketing these innovative plans would resonate with patients when they highlight quality health care.

UFT-A also unifies the clinical management of patients. It shifts the focus from protecting turf to seeking new collaborative relationships. Physicians would integrate better within hospital support systems, and the systems would allow physicians more

touch time which translates into better quality of care. Payments are self-regulating, that is, payments increase for underused services and decrease for overuse. Direct time costs decrease significantly in all cases due to the use of CPGs and simplification.

The benefits of EBM are clear. Practicing EBM lowers the risk of fraud and abuse for plans, hospitals, and physicians and preempts malpractice claims.

Embracing the principles of UFT-A would create common goals throughout the industry, eliminate administrative minutia, and maximize efficiency without sacrificing quality.

With UFT-A, Gosfield said, "You can do well by doing good if you make the right thing to do the easy thing to do."

Boundaries to UFT-A

Gosfield did note a number of limitations to her UFT-A theory. First, the UFT-A payment approach won't work for all situations or for all patient conditions. Secondly, UFT-A should not be mandated, but rather eased into the system. UFT-A will initially work best with innovators, those practices, groups, or hospitals that are already well run but are willing to try a new model. As the theory is untried, the best chance of success is to start on a small scale, employing "small tests of big ideas."

UFT-A must also work within the existing regulatory environment.

Conclusion

Health care reforms and P4P programs to date have had only marginal effects on improving the quality of health care in the U.S. Substantial progress will take a vastly different approach. Physicians must be at the core of any thrust for change since they provide the most direct contact with the patient. The Unified Field Theory Applied to Health Care seeks to simplify all health care processes by focusing on evidence-based medicine and patient-centered care.

Gosfield concluded her remarks with a quote by economist J.D. Kleinke. "The only progress we make in health care is the progress we make in medicine. In the daily chaos that is the U.S. health care system there are but three elements that matter: patients, caregivers and medical technologies. Everything else is noise".

Gosfield then added encouragement of her own. "It's time to get back to the doctor-patient relationship as the business case for quality care. Go get 'em."

Forum attendees divided into groups to develop answers to four basic questions central to the debate of Paying for Clinical Excellence.

Question One

Should hospitals be required to measure and publicly disclose statistics on issues such as medication errors, infection rates, patient falls, physician/staff errors, sentinel events, unintended outcomes, or other medical mistakes?

Question Two

From a provider perspective (hospitals and physicians), what is missing from current pay-for-excellence programs?

Question Three

How can we bring the public in as part of the solution to improving the quality of health care that is delivered?

Question Four

What other strategies, other than pay-for-performance, should we consider implementing as a health care community that would lead to improved quality of health care delivery in Colorado?

Two groups tackled an assigned question. Each group consisted of attendees from a cross-section of the health care industry to ensure a diversity of opinion. The working sessions, moderated by Robert London, MD, Vice President of Health Care Management for Anthem Blue Cross and Blue Shield's West region, yielded the following results.



Should hospitals be required to measure and publicly disclose statistics?

(Solutions from the group facilitated by Colorado State Senator Mark Hillman)

The group agreed this is a suitable goal toward ensuring quality health care, but they also identified specific challenges and conditions for doing so. Any plan to publicly disclose statistics should include:

- A standard of what is measured and how
- A process where state agencies collect the data, then compile and report results to the public
- Statistics that are both understandable and useful by the public

Other barriers identified included:

- Implementation will have an initial cost, and needs to be electronic for efficiency
- Recognize that rural providers have special and different needs
- Hospitals can facilitate physician involvement

The group also said a debate needs to ensue on what measures need to be mandatory versus voluntary. Whatever statistics are finally adopted, this group expressed concern over how to consistently educate both providers and the public on the methods and meanings behind each statistic.

(Solutions from the group facilitated by Robert W. Ladenburger, CEO, St. Mary's Hospital and Medical Center)

Yes, hospitals should be required to submit the data. If you focus on and measure quality, it will improve. Currently, physician referrals drive the hospital choice for most patients. Will public reporting make a difference in the choices patients make? Only when the consumer becomes educated and providers are held accountable for quality care. Reporting requirements should include:

- Mandatory requirements that are not so complex that compliance for collecting the data is overly burdensome
- Measurements that are meaningful, verifiable, understandable, and comparable
- How stratified should the data be? Should or can the data be collected and reported to the lowest level, i.e., by department?

One major barrier noted by this group was the high degree of coordination needed between the hospital and its entire medical staff.



From a provider perspective (hospitals and physicians), what is missing from current pay-for-excellence programs?

(Solutions from the group facilitated by
Alethia Morgan, MD, President, Colorado
Medical Society)

In this group's opinion, any pay-for-excellence program should be based on guidelines and indicators such as U.S. Task Force for Preventative Services Guidelines, the Health Plan Employer Data and Information (HEDIS) program, or comparable programs that define standardized performance measures. All health plans should adopt these types of standards.

In addition, pay-for-excellence programs should include:

- Features to address high cost conditions
- Programs designed around early detection and health maintenance
- Optional fee schedules for extra time and touch a doctor spends with patients as measured in the previous two items
- Employer plan discounts for lifestyle changes and wellness

Adhering to standard guidelines for care will lead to earlier diagnosis and reduce hospitalizations for those with chronic illnesses. Allowing patients the option of more time and touch with their doctors involves them more in their own health care. The group also noted the pay-for-excellence movement should extend to the independent physician market and address the needs of rural areas.

(Solutions from the group facilitated by
John Bell, MD, President and Chairman
of Colorado Springs Health Partners)

As an enhancement to pay-for-performance, outcomes should also measure patient expectations and feedback for meeting those expectations.

Other enhancements include:

- Establish best practices and key milestones as benchmarks for improvement and quality.
- Link performance and incentivize physicians and the hospitals in a way that drives improvements.

Quality improvement will occur when the expectations of an educated patient are met or exceeded by the care provided by hospitals and physicians.



How can we bring the public in as part of the solution to improving the quality of health care that is delivered?

(Solutions from the group facilitated by Dave Ferrill, Director of Regional Cooperation in the office of Denver Mayor John Hickenlooper)

The fact is, patients and the public are more concerned with issues affecting their health than ever. However, the group pointed out some pitfalls of this growing awareness, specifically:

- Most assume that all care is at least adequate from a quality perspective and are generally ignorant of differences in quality.
- Consumers follow the direction of their physician without concern for quality, having few if any sources to dispute physician referrals.
- The Internet helps in mobilizing consumers, but many are misguided by bad science and confused with too much data.

Improving the public's engagement in seeking out quality health care will take education at the grass-roots level. Defining acceptable standards is the first place to start. Other solutions could include publishing current quality standards, measurements, results, and comparisons

online. Disclosing service fees will encourage consumers to search for value and quality.

Today, typical market forces do not exist in the physician-patient relationship. When patients have more of a financial stake – more “skin in the game,” both physicians and insurance providers will need to align their referral networks to accommodate the value formula.

(Solutions from the group facilitated by Dwight Cunningham, Science and Health Editor for the Denver Post.)

This group said segments of the public are either ambivalent or fickle when it comes to quality care issues. For many, health care is seen as a temporary need. Others view health care as compulsory without regard to costs or who ends up paying, as long as it's not them. Efforts should be made to employ techniques allowing patients to take a more active role in their health care decisions.

Some examples being:

- Provide information/education for common definition of quality standards
- Provide information/education for risks and results of procedures and protocols
- Increased transparency of quality data
- Reporting system for patient feedback on encounters
- Cost sharing and financial incentives (such as Health Care Savings Accounts)

The group concluded the public needs to be included in the debate to help influence the required changes.



What other strategies, other than pay-for-performance, should we be looking to implement as a health care community that would lead to improved quality of health care delivery in Colorado?

(Answers from the group facilitated by Tambor Williams, Executive Director for the Colorado Department of Regulatory Agencies (DORA))

This group aligned with the others in their agreement that basic elements of quality care should include:

- Measuring patient satisfaction
- Establishment and adherence to quality measures and guidelines
- Gaining united support from insurance companies, providers, and consumers for quality measures
- Disclosing costs of health care options

They suggested more basic methods to improve the quality of health care delivered in Colorado:

- Doctors need more time with patients
- Improve customer service
- Give the patient the ability to waive the right to sue a doctor
- Offer cost/benefit/risk analyses for treatment options
- Convince patients that sometimes no treatment is the best treatment

One chronic problem that will need to be overcome is patients don't always follow protocols, therefore outcomes may not be

indicative of a doctor's skill. On the other hand, there is still too much over-treatment and over-testing to mitigate perceived culpability if a diagnosis is wrong.

(Answers from the group facilitated by Jacqueline Stiff, MD, Vice President and Medical Director for United Healthcare of Colorado, Inc.)

This group focused on a myriad of solutions being considered throughout the health care industry.

Consumer Directed Health Plans

Given an adequate design, these plans have a chance of working. Plans should promote preventative care and provide adequate incentives to economize. Consumers will not be able to shoulder high deductibles and co-pays alone, so any plan should include an employer contribution element.

Redesign of benefit packages to emphasize health/wellness

Employers should provide more incentive toward consumerism. An example is giving non-smokers a percentage discount off their premium contribution. Engage patients in knowing the root-cause of wellness issues and sharing in the incentives for reducing health risks.

Increased use/funding of technology and infrastructure

It costs \$300,000 for an electronic medical record system, not including the costs to convert the medical records. At this price, most physicians can't afford to "go it alone." The industry must find a way to include financial incentives to help build this technology infrastructure. Another need is a collaborative effort to link all disparate information technology systems.

Redesign of health care delivery system around a "team of care" approach

Great idea, but it will be hard to overcome the embedded referral process. Current "team" approaches are fragmented. Redesign would mean entirely new functional systems to ensure collective team efforts.

Closing Remarks

Caz Matthews

All of us have a responsibility to improve the quality of health care, and all of us are culpable for its current state. We must do better. We don't yet know how but everyone is looking for a way.

The 2004 Fall Health Care Leadership Forum continues the debate to find the solutions leading to reform of the U.S. health care system. The diversity of experience and opinions expressed by attendees helps to bring us closer to these solutions.

We found many areas where we agree. There is an opportunity to educate the patient and bring them along with us as we strive to improve quality. Prevention is so key, and we are mindful to consider each patient's unique combination of mind, body, and spirit.

Paying for performance is a good intermediate step, but it's just a step. P4P will not ultimately get us where we need to go. We need to consider what's next in Alice Gosfield's Unified Field Theory. Her UFT-A model seeks to redesign the health care system in a physician-centric model and reform every aspect of the system in a way that makes clinical sense, including how we reimburse for care.

During our "Working for Solutions" breakout session, we heard common agreement on the need for more measurement and reporting of quality data, ideally employing current incentives. There was consensus that what gets measured gets improved.

We realize that pay-for-performance mechanisms are a good intermediate step but they must be standardized, administratively reasonable, and reach a broad range of providers, including sole practitioners.

We detected some skepticism about the potential for the current trend in consumer health plans and Health Care Savings Accounts (HSAs) to move to the quality agenda. There did appear to be a consensus, though, that consumers would start to care more if they were financially incented.

Lastly, the need was clear among attendees to bring clinical guidelines and evidence-based medicine to the bedside. The amount of information needed to make informed health care decisions is unbelievable and we will need to find technological solutions to help us do that.

I draw your attention once again to Reinertsen's Axioms from Alice Gosfield's talk – the physician's job is to explain, predict, and change the outcomes. I saw a lot of heads nodding as Alice mentioned this and it seemed to resonate with many of us. We need to collaboratively determine how to best redesign a system that will enable the physician to return to that.

If this sounds overwhelming to you, and if the goal of quality health care seems a near impossibility to achieve, please remember a wonderful quote by Thomas Edison; "Many of life's failures are experienced by people who did not realize how close they were to success when they gave up."