

Capturing Value:

Increasing Efficiency in
Health Care



NIHCM
FOUNDATION

EXECUTIVE SUMMARY

The National Institute for Health Care Management (NIHCM) Research and Educational Foundation hosted a meeting on ways to increase efficiency in health care, including how to apply the groundbreaking work by Drs. Elliott Fisher and John Wennberg to real markets. Major points presented included the following:

- Evidence exists showing vast differences in efficiency (the ratio of spending to outcomes) across hospitals in specific geographic areas and among regions.
- The culture of U.S. health care, including the lack of perception of crisis and fear of constraints, leads to difficulty in better rationalizing health care resources; changing this culture will be challenging.
- Despite evidence to the contrary that “more care is better care”, this widespread belief, along with other factors such as “biomedical miracles”, contributes to the unsustainable increases in health care costs.
- After zero value care is eliminated, we are likely to continuously discover further efficiencies by radical increases in the use of health information technology (HIT) and then using it as a platform for continuously reengineering care delivery.
- Among other solutions, we must focus on greater professionalism in the delivery of medical care, assuring that physicians work more closely with their medical peers to improve performance.
- Redesign of the payment system – away from disproportionately rewarding high-intensity services and greater volume and toward a system that rewards quality and efficiency – will be essential.
- Approaches for change must profile the enormous cost of inaction. Sometimes only the threat of system collapse can drive necessary change.

Introduction

Few disagree that the amount Americans spend on health care cannot continue to increase indefinitely, but the preferred approaches to change vary widely. The National Institute for Health Care Management (NIHCM) Research and Educational Foundation hosted a small invitational meeting of national health care leaders from both the public and private sectors on September 6, 2005 in Washington, D.C. The meeting addressed the contribution of excess capacity to health care spending and how to develop practical approaches to improve the efficiency of the U.S. health care system. The group concluded the meeting by developing several potential action ideas outlined in **Table 2**.

NIHCM Foundation is a non-profit, nonpartisan organization dedicated to promoting improvements in health care access, management and quality through research, policy analysis and educational activities on a range of health care issues. NIHCM Foundation fosters dialogue and partnerships between the private and public sectors to find creative and workable solutions to health system problems.

The following health care leaders participated in the meeting:

- Nancy Chockley, President and CEO, NIHCM Foundation and meeting host
- Elliott Fisher, MD, MPH, Professor of Medicine and Community and Family Medicine, and Director, Health Policy Research at the Center for the Evaluative Clinical Sciences, Dartmouth Medical School and meeting co-facilitator
- Arnold Milstein, MD, Medical Director, Pacific Business Group on Health and National Health Care Thought Leader at Mercer Health & Benefits and meeting co-facilitator
- John Birge, PhD, Jerry W. and Carol Lee Levin Professor of Operations Management, The University of Chicago Graduate School of Business
- James Block, MD, President, J.A. Block Health Associates
- Carolyn Clancy, MD, Director, Agency for Healthcare Research and Quality (AHRQ)
- Elizabeth B. Gilbertson, Director of Strategic Planning and Public Policy for the Hotel Employees and Restaurant Employees International Union Welfare Fund

- Paul Ginsburg, PhD, President, Center for Studying Health System Change

- George Isham, MD, Chief Health Officer and Medical Director, HealthPartners

- Ralph Muller, Chief Executive Officer, the University of Pennsylvania Health System

- Robert Reischauer, PhD, President, The Urban Institute

Setting the Context

One of the goals of the meeting was to increase the application of the groundbreaking research of Drs. Elliott Fisher and John Wennberg conducted at the Dartmouth Medical School's Center for the Evaluative Clinical Sciences. Dr. Fisher opened the meeting by introducing a framework used in cases of conflict negotiation to address the discrepancy between health care spending and resulting health outcomes. Drs. Fisher, Milstein and Birge began the meeting with presentations, highlights of which are provided next.

Outswimming the Shark: Dr. Arnold Milstein

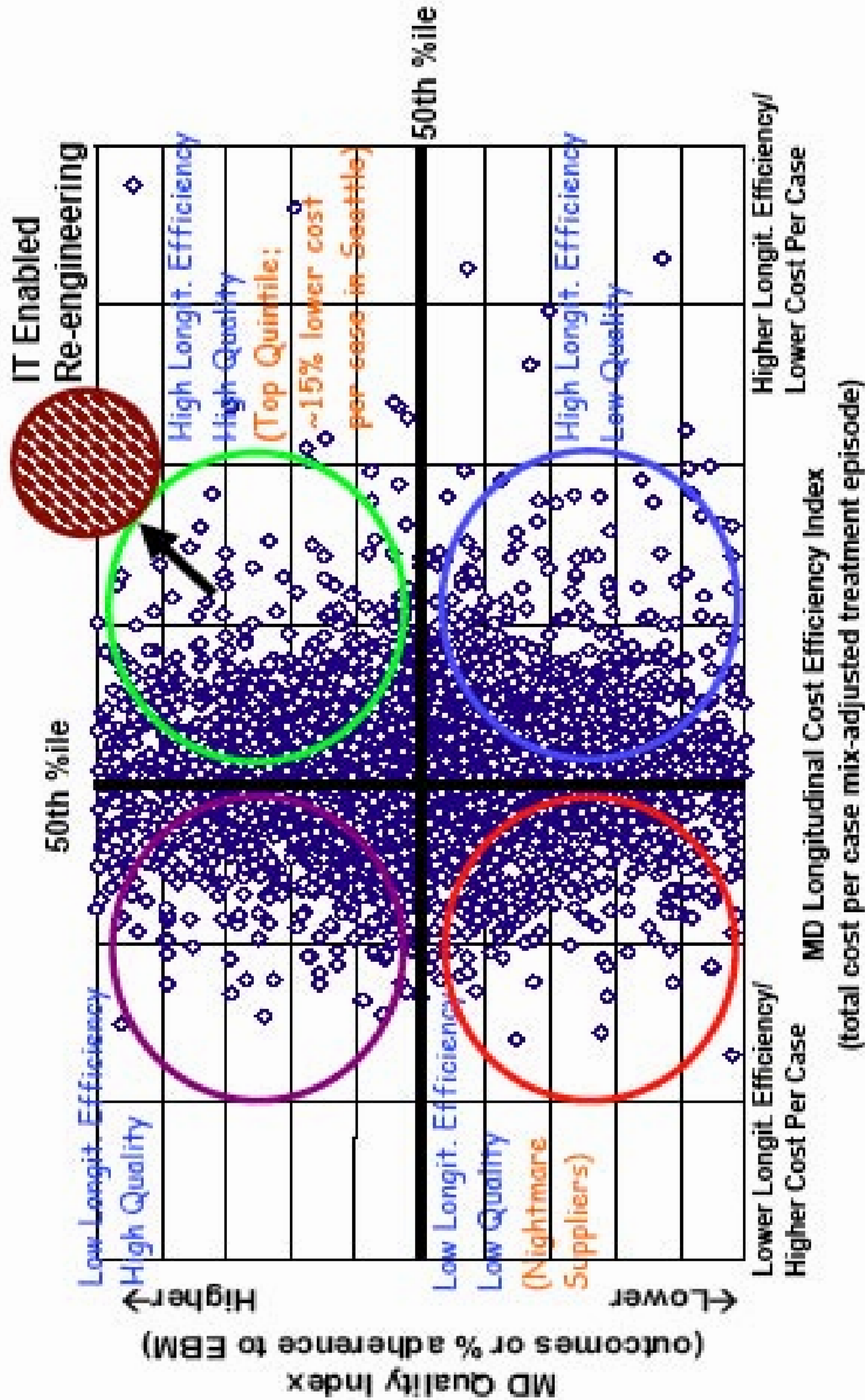
As a pioneer in efforts to improve performance in health care, Dr. Milstein framed the problem, demonstrated its magnitude and suggested avenues for savings. Dr. Milstein suggested that: (1) biomedical miracles are the chief cause of this unsustainable increase in health care costs and (2) growth rates in per capita health care expenditures will disenfranchise more and more individuals from timely access to effective care. Insurance has become unaffordable for many, and survey results from HarrisInteractive indicate that the more affluent are less willing to cover the cost for those in need.

Dr. Milstein then "guesstimated" net savings (-) or costs (+) from several potential health industry improvement options (the source and estimate are provided in the parentheses to the right of the option) that might address this unsustainable increase in health care costs:

1. Eliminate overuse, under-use and misuse (Rand, +5%)
2. Eliminate unwanted preference-sensitive big-ticket services (Dartmouth, -5%)
3. Eliminate the gap in supply-sensitive services between best decile regions and all other regions (Dartmouth, -30%)

Figure 1: Visualizing Savings Opportunity

Visualizing the Full 52% Savings Opportunity: Reengineering by Today's Benchmark Providers Within a Dartmouth Best Decile Region



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Adapted from Regence Blue Shield

4. Eliminate the quality-neutral gap between most cost-efficient quintile providers and other providers within top decile regions (Regence Blue Shield, -15%)
5. Reengineer all services to embody today's most efficient method of delivery for each unit of service (IHC and NAE/IOM, -30%)
6. Pay for a health care information technology platform and new industrial engineering expertise required for options 1-5 (+15%)

Dr. Milstein estimated, through consultation with other industry experts, that we would need an ongoing 3-4% “continuous dynamic efficiency capture” indefinitely into the future, after all six currently available “static” opportunities for ~50% static efficiency capture had been exploited. He ended his presentation with **Figure 1**, a visual representation of the 52% savings opportunity using improvement opportunities 1-6.

In this example, Regence Blue Shield plotted individual physician performance on two axes, the vertical axis showing the degree to which individual doctors comply with evidence-based quality rules. The horizontal axis shows each physician's case-mix adjusted total cost of resource use (“longitudinal cost efficiency”) per episode of acute illness, and per 12 months of chronic and preventive care. The scale is interpreted as follows: moving to the right, doctors are more efficient; moving up, doctors are providing higher quality. The most efficient quadrant is the upper right-hand quadrant. If all U.S. physicians were to practice with a longitudinal efficiency equal to the top quintile of Seattle providers (in essence, interventions 3 & 4), spending would decline by approximately 40%. The remaining interventions (1, 2, 5 & 6) would likely push the spending decline above 50%.

The Challenge of Supply-Sensitive Services: Dr. Elliott Fisher

As a lead investigator examining the health impact of the variations in care identified by the *Dartmouth Atlas of Health Care* studies, Dr. Fisher presented on the challenges of health service delivery, the Dartmouth findings on the health implications of variations in spending and the potential drivers, and the barriers faced in addressing these issues. His research findings challenge the belief that “more care is better care.”

Dr. Fisher noted that regions differ dramatically in per-capita spending without demonstrated improvements in quality. Higher-spending regions have more hospital stays, more physician visits and higher use of specialists, without demonstrating higher quality or access. In fact, evidence suggests that states with higher Medicare spending actually provide lower quality care. Medicare enrollees in regions with a high

intensity pattern of practice have slightly worse access to care, and receive lower quality of care than in those regions with the more conservative practice patterns, as shown by the association in **Figure 2**.

Evidence demonstrates that the additional care in high-spending regions is largely due to greater use of physician visits, consultations, imaging and tests, rather than major surgical procedures, as shown in **Figure 3**. Dr. Fisher made the point that physicians are not really trained about the appropriate length of time between patient visits, yet it impacts most spending. Over 40% of Medicare dollars on physician services are spent on evaluation and management services, visits and consultations, an area without guidance and one which explains a large part of the difference in spending across regions.

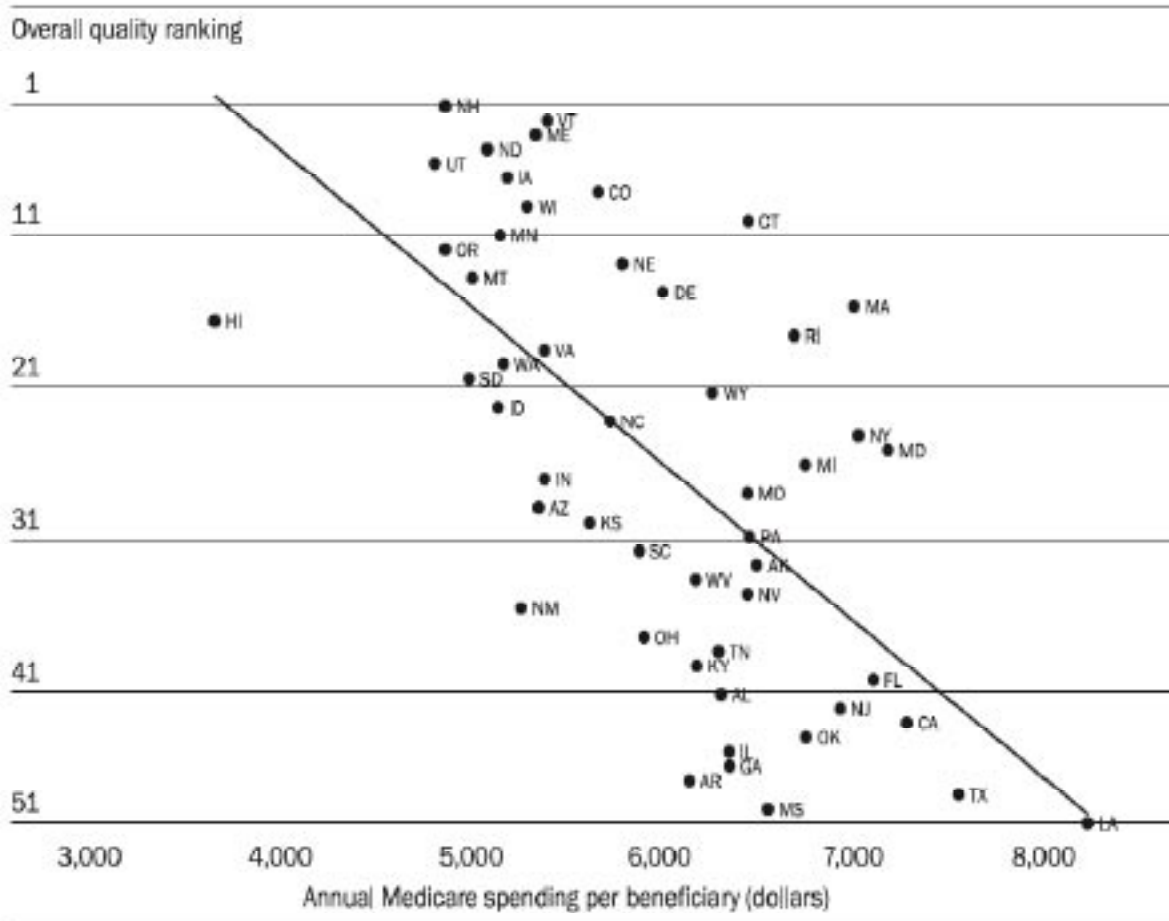
Dr. Fisher also discussed recent (not yet published) physician survey data. This work links data from the Center for Health System Change's Community Tracking Study, to data from the Dartmouth regions to learn more about physician practices. Results show that physicians in low-spending regions perceive that they have more freedom with respect to clinical decision-making, have adequate time to spend with patients and have sufficient levels of communication with other physicians. Physicians in high-spending regions, in contrast, are practicing with higher intensity, have more patients and are working harder on the patients they have. Dr. Fisher thinks that the data also shows that physicians in high-spending regions are less connected to their peers.

Dr. Fisher recommended that we move toward provider-specific performance measures, some of which he and Dr. Wennberg are crafting now. In November 2005 they released measures of provider-specific longitudinal costs in California. The data is based on patterns of practice across the end-of-life for Medicare beneficiaries (which is shown to predict how the institutions care for patients at other periods of their lives).

Building a Better Delivery System – A New Engineering Health Care Partnership: Dr. John Birge

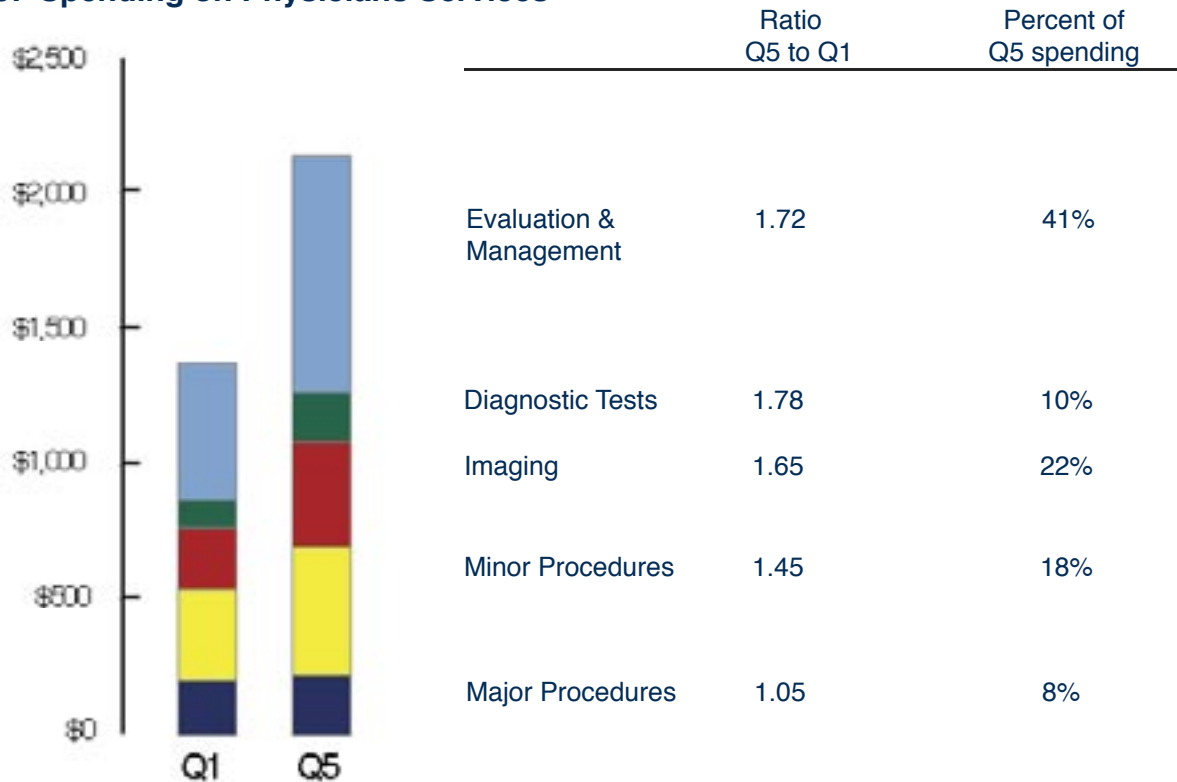
The 2001 Institute of Medicine report (IOM), *Crossing the Quality Chasm*, identified a crisis in the American health care system with regard to cost, quality, access and safety and pointed to the negative health outcomes of Americans resulting from these issues. Recognizing the need for a solution, the IOM and the National Academy of Engineering (NAE) convened a committee of 14 engineers and health care professionals to identify engineering tools and technologies needed to overcome these crises and deliver care that is safe, effective, timely, patient-centered, efficient, and equitable – the six quality

Figure 2: Association between Medicare Spending and Quality



Baicker and Chandra, Health Affairs, web exclusives

Figure 3: Spending on Physicians Services



aims of the IOM report. Dr. Birge highlighted the main findings and recommendations from the NAE/IOM report for meeting participants:

Findings

- Individual entities of the health care “system” actually function in isolation.
- Health care has been slow to embrace system-engineering tools despite their benefit to a small number of health care organizations and clinicians who have used them.
- Only when people are trained in the use of systems-engineering tools will benefits become fully available.
- Delivery aspects of health care have not been addressed.

Recommendations

- Provide greater incentives to providers to use system tools (i.e., expand reimbursement scope, bundling techniques, removal of regulatory barriers).
- Continue development of health care data standards.
- Increase technical and material support by the federal government for public-private partnerships.
- The committee endorses the recommendations of the President’s Information Technology Advisory Council: 1) application of lessons learned from advances in other fields (e.g., computer infrastructure, privacy issues, and security issues); and 2) increase coordination of federally supported research and development through the Networking and Information Technology Research and Development Program.

The systems approach presents an opportunity to wield the skills of the engineering and health care sectors to create a more efficient and higher quality health care system.

Discussion Framework

Drs. Fisher and Milstein facilitated the remainder of the meeting with an overarching goal of identifying underlying causes of the gap between where we are and where we want to be, using the conflict resolution framework, shown in **Table 1**.

Table 1: Framework

	NOW	FUTURE
THEORY	General Dimension: Causes, Barriers	Approaches
REAL WORLD	Gaps	Actions Ideas

Dr. Fisher shared that NIHCM Foundation’s goal for this meeting is that the group capture useful new ideas to flesh out in the future, and to identify those who could act to make a difference.

General Dimensions and Barriers to Change

1) **The nature of current quality measures.** There was significant concern expressed that current performance measures are inadequate to provide consumers with meaningful guidance, and do not meet consumers’ or decision makers’ needs. While work like Judy Hibbard’s has shown that providing measures to consumers can have positive impacts (e.g., increase satisfaction, empower individuals to ask questions and become more engaged in their care, increase effectiveness as advocates for improved quality care), consumers are overwhelmed by too many measures and have difficulty prioritizing them for their use. It was noted that many current measures are incomplete, not current enough and too complex (e.g., consumers misinterpret the directionality of the measures).

In addition, communication about existing measures has been slow, and the measures have not been translated into language that works for the public. This is closely tied to the idea that we have no clear idea of what success looks like and limited knowledge about how to export “best practices” and how to create conditions for innovation. The concept of disruptive innovation arose as a theme during the meeting, the idea of how to create conditions to encourage innovation that encourages something different from the status quo in terms of efficiency.¹ Action ideas that incorporate this concept are highlighted in **Table 2**.

2) **The public’s belief that there is not a crisis in health care,** which was contrasted with the automobile industry where there was a clear leader to identify a crisis. Because health care does not have a single decision-making board and is very decentralized, there is no obvious group to make a change, even if a crisis is identified.

3) **The public’s belief that constraints are harmful.** Tied to this is the widely held belief that “more care is better care.” The managed care experience has possibly had an

¹A concept credited to Clayton Christenson of Harvard University.

effect of changing consumer culture, leading to the belief that more care is better care. However, if consumers are in control (with greater cost sharing), the group questioned whether the trend might be reversed and they might be more judicious about seeking care.

4) **Current system attributes that create barriers.** The U.S. health care system has no locus of system authority and accountability. The reimbursement system rewards high-end services, paying more for more intensive and invasive services while also paying for low-value services and waste. It was also noted that the system has no influence over patients and that the political process blocks change (e.g., barriers to entry are so high that entities have had to build political clout to be successful).

Several participants noted that our system lacks independent, neutral advisors. While consumers still trust their physicians and think their physicians have their best interest at heart, there is no “trusted advisor” to help figure out the data or measures. The action ideas highlight this theme.

Approaches To Execute Change

Meeting participants identified several potential approaches to change, and possible action ideas, illustrated in **Table 2**. These ideas centered around better informing all the actors within the health care system, from better informing patients around clinical choices to fostering a new professional identity for physicians. As noted above, the barriers to entering the health care system are high, so health care entities do not feel threatened because they have formed strong political allies, which is an impediment to any quick change.

It was noted that there are no forces within states or regions driving professionalism, and there being a need to create a “learning professional” environment that is concerned

about system performance (e.g., it was noted that the medical community must use data efficiently before we can expect consumers to do so). Professional societies are not fulfilling their socially responsible role for professionals within the larger society; instead, they are more focused on maintaining financial stability for physicians. It was suggested that regional organizations be developed to foster improved performance and professional identity, but it was also acknowledged that health care is local and that it is difficult to persuade policy-makers that their approaches should be transferred on a more global level.

It was recommended by some that approaches be devised that threaten current institutions since some of the biggest quality and productivity improvements have been demonstrated when an entity felt threatened. While few medical entities find themselves threatened now, professional organizations greatly fear performance data and looking bad against their peers. When they show poor performance, they will make great steps to improve it, whether consumers are paying attention or not. Recent Center for Studying Health System Change interviews show that hospital leaders are very concerned about the data Medicare has been collecting and reporting, which might provide an impetus for change.

Some of the approaches identified by the group were tabled at this discussion since other groups are studying the approaches – these included better aligning incentives, which is being studied by an IOM task force, and health information technology, which is receiving significant attention by AHRQ and several other groups as well.

While no one answer may exist to increase efficiency in health care, all participants in the system must take on the challenge if we want to continue to deliver outstanding health care to U.S. residents.

Table 2: Summary of System Dimensions, Approaches and Action Ideas Developed

General System Dimensions (Gaps, Causes and Barriers)	Potential Approaches	Potential Action Items
Action Idea: Consumer Education Focus		
<ul style="list-style-type: none"> Public communication about existing measures has been slow, and they have not been translated into language that works. Making consumers respond to measures is difficult – Consumers are overwhelmed and have difficulty prioritizing and using them. Pennsylvania has shared provider-level data for several years, 	<ul style="list-style-type: none"> Better inform patients around clinical choices (not much evidence that consumers use data other than price to buy anything). Increase effectiveness as advocates for improved quality care by making purchasing decisions based on quality. 	<ul style="list-style-type: none"> Seed funding for a consumer education website – To access information on a number of expensive conditions. Combine education with engaging the consumer. Tie in with ICSI. Might provide checklists for consumers if they are diagnosed with a certain condition. Then build performance measures around those checklist items.



General System Dimensions (Gaps, Causes and Barriers)	Potential Approaches	Potential Action Items
Action Idea: Consumer Education Focus (continued)		
<p>and not only has it not shifted market share but consumers (and the media) do not react to the measures.</p> <ul style="list-style-type: none"> • Available measures do not meet consumers' or decision makers' needs – Measures are incomplete, not current and too complex (e.g., consumers misinterpret the directionality of the measures). • Public belief that constraints are harmful – Consumers fear they might not have access to perceived needed care if an external entity has decided that there should be constraints on providing care. Tied to this is the widely-held belief that “more care is better care.” However, if consumers are in control (with greater cost sharing), is the trend reversed and might they be more judicious about seeking care? • Lack of good agents or trusted advisors – Even when consumers educate themselves, they need an “agent” or “trusted advisor” to help figure out the data. 	<ul style="list-style-type: none"> • Encourage states to adopt strategies similar to the Institute for Clinical Systems Improvement (ICSI). Recent work complements the guidelines and is focused on changing the culture of the institutions engaging in the administrative leadership and other supports that are required to get people engaged in quality improvement. • Encourage public sources of informed patient choice and public dissemination of these ideas. 	<ul style="list-style-type: none"> • Work with the Foundation for Informed Medical Decision Making to create an open source library. Get a foundation to fund decision tools (estimated at \$100,000–\$200,000 per year to keep each current) and/or consider distributing costs across several interested parties. • Create new entryways to the primary care system – For example, in-store health clinics in major pharmacy and retail chains. The clinics offer quick access to medical care. Some have patients use touch-screen computer terminals that create electronic medical records. • Focus on trusted agent/ advisor – Can start for people who are spending most of the dollars. It could be a physician who is the individual's personal health coach. Think about models developed by Consumer's Union as examples. Encourage use of services like “Best Doctors”.
Action Idea: Focus on Professionalism		
<ul style="list-style-type: none"> • Professional culture and beliefs within local/ delivery system and group practice – The “microcultures” of expectations among physicians and institutions in different regions. Practice cultures differ from expectations regarding whether to accept Medicaid to perceptions of billing opportunities to relationships among physicians (working together or on their own to accomplish objectives). Message that some of what works in one marketplace is not transferable to other markets. • Public belief in physicians (now) – Consumers generally believe that physicians are always acting in the patient's best interest as opposed to the physician's economic interest. 	<ul style="list-style-type: none"> • Develop better health information technology that would allow redesign – As an enabler, not a stand-alone solution. Providers seem to be automating current processes instead. The “solution” might be creating new barriers when practices are hard-wired into health information systems. No quality improvement if continuing current practices. • Develop regional organizations to foster improved performance and professional identity – While there are places held up as examples of providing high-quality care in lower deciles (e.g., Minnesota, Seattle), partially because health care is local, it is difficult to persuade policy-makers that approaches should be transferred on a more global level. 	<ul style="list-style-type: none"> • Get/ fund research on cost-quality distribution of providers. • Try Rochester, New York again – Focus on what is driving cost (found in Rochester that patients coming to the emergency room for four types of diseases – alcoholism, drug abuse, AIDS and chronic mental illness – comprised the majority of visits). Rochester experiment fostered sense of system accountability; no one organization could do it alone. Included the major health plan (Blue Cross); multiple entities created a culture of responsibility. • Foster new professional identity – No forces within states or regions driving professionalism. Create a “learning professional” environment that is

General System Dimensions (Gaps, Causes and Barriers)	Potential Approaches	Potential Action Items
Action Idea: Focus on Professionalism (continued)		
<ul style="list-style-type: none"> Produced more physicians than needed to provide care that is beneficial. 	<ul style="list-style-type: none"> Professionalism – Lowest decile regions often have a physician community that shows greater receptivity to appeal to some sort of public interest. 	<p>concerned about system performance. Physicians do not have a sense of “system” unless they have worked at places like Mayo or Kaiser.</p> <ul style="list-style-type: none"> Make professional societies fulfill their socially responsible role within the larger society instead of focusing on financial stability – Sense of favorable movement by the American Board of Medical Specialties, including emphases on performance and professional standards.
Action Idea: Reimbursement Innovation Focus		
<ul style="list-style-type: none"> Cross subsidies in current payment system – There is a lot of money moving back and forth across the public and private sector boundaries, which negates the ability to generate efficiencies longitudinally in any line of business. They create barriers to quality. U.S. health care system does not pay less, or not pay, for low-value services and waste. 	<ul style="list-style-type: none"> Expand bundles (finance related) – More likely to get government to change if work outside it (e.g., state level). Focus on Medicare Advantage plans – It was acknowledged that it will take a couple of years to play out, and that the Administration’s focus could be short-term and later moved back to a more fee-for-service focus. 	<ul style="list-style-type: none"> Reinvent capitation – In a socially responsible way; change the fee-for-service “signals”. True focus needs to be on integrated delivery systems to provide high-quality care over time. Fundamental conflict that capitation in theory is the right approach (rationalizes delivery of services); however, physicians have resisted and health plans moved away from capitation. In a capitated system, quality is tightly aligned with cost. New bundles and aligned information – Create a package that aligns quality and cost. Consider working with CMS to think about new bundles. Create something where there is good information about the outcomes and quality, which is connected to some value that measures what it is going to cost [e.g., bundle Current Procedure Terminology (CPT) with co-pays]. Pay-for-performance program that rewards longitudinal efficiency and quality. MedPAC could define bundles.

General System Dimensions (Gaps, Causes and Barriers)	Potential Approaches	Potential Action Items
Action Idea: Disruptive Innovative Insurance Product		
<ul style="list-style-type: none"> • No clear idea of what success looks like – Not clearly-articulated; limited knowledge about how to export “best practices” and how to create conditions for innovation. • No perceived crisis – While in the automobile industry, there was a clear leader to identify a crisis, there is no single actor in health care. Instead, health care is so decentralized that even if people perceive a crisis, there is no obvious actor to make a change. • We can afford to grow infinitely – While this seems to be a minority view, it was acknowledged that there are economists who think that given the growth in Gross Domestic Product (GDP) the U.S. can afford to spend more on health care than we are now spending. That conflicts with the HarrisInteractive poll numbers showing that more affluent Americans are becoming less willing to continue to pay for less affluent Americans’ health care. • No locus of system authority and accountability. 	<ul style="list-style-type: none"> • Idea of disruptive innovation – How to create conditions to encourage innovation that encourages something very different from the status quo in terms of efficiency. Message being “for what it does, it does it at least as well, and much less expensively than the rest of what we have”. • Plan for a crisis (e.g., a large employer drops coverage, hurricane or other natural disaster) – Have a product that the federal government can insure; work with a contractor to develop a plan that can be responsive to a disaster/ crisis. New insurance product or approach to deal with a sudden jump in the number of unemployed/ uninsured. • Facilitate importation of physicians via telemedicine – As a component of the disruptive innovation insurance product. 	<ul style="list-style-type: none"> • Identify organizations and partners to develop a low-cost/ high-quality disruptive insurance model/ product built around the most efficient providers in a community – Would not include “low value” services. Due to regulatory barriers, would work best with organizations with tightly linked financing and delivery models. • Create a work group to study how to develop it – Go to insurers that already have longitudinal and quality profiles on physicians and practice groups and have them develop a narrow network that only includes the most efficient physicians (within the upper half of the quality distribution in the community) and see who takes up the market. Then evaluate whether it works and how much it saves. Premise that consumers might be willing to trade off certain amount of geographic convenience for lower insurance premiums. • Couple high-cost and variation communities; create narrow networks, with caution that regional narrow networks exist and people are not buying. • Initially focus on employers with unsustainable costs and/ or those that do not provide benefits but would like to. Get “stamp of approval” from a trusted agent that could legitimize it.

A PUBLICATION OF THE NIHCM FOUNDATION

ABOUT THE NIHCM FOUNDATION

The National Institute for Health Care Management Research and Educational Foundation is a non-profit organization whose mission is to promote improvement in health care access, management and quality.

ABOUT THIS MEETING BRIEF

This Brief was prepared by Elliott Fisher, MD; John Wennberg, MD; Kathleen Eyre; and Hafiza Pirani with editorial assistance by Carolyn Myers, from a meeting hosted by NIHCM Foundation and attended by national health care leaders from both the private and public sectors on September 6, 2005 in Washington, D.C.

Resources for Consideration	
Resource	Website
Agency for Healthcare Research and Quality (AHRQ)	http://www.ahrq.gov/
American Board of Medical Specialties (ABMS)	http://www.abms.org/
Best Doctors	www.bestdoctors.com/bd/default.htm
Center for Studying Health System Change	http://www.hschange.org/
Centers for Medicare and Medicaid Services (CMS) - Quality Initiative - Medicare Advantage	http://www.cms.hhs.gov/quality/ http://www.cms.hhs.gov/medicarereform/pdbma/maplan.asp
Dartmouth University Medical School Center for Evaluative Clinical Services - <i>Dartmouth Atlas of Health Care</i>	http://www.dartmouth.edu/~cecs/ http://www.dartmouthatlas.org/
Foundation for Medical Informed Decision Making (goals include: to provide patients with the perspectives and information they need when making medical decisions, to improve the quality of decisions patients make in collaboration with their physicians and to foster research to learn how best to help patients who face health care decisions)	http://www.fimdm.org/index.html
Harvard University School of Business; Clayton Christensen, "Theory of Disruptive Technology"	http://dor.hbs.edu/fi_redirect.jhtml?facInfo=bio&facEmId=cchristensen@hbs.edu&loc=extn
Health Affairs – "Variations Revisited" Web Exclusive, 2004	www.healthaffairs.org
Institute for Clinical Systems Improvement (ICSI) – Dedicated to championing health care quality and to helping its members identify and accelerate the implementation of best clinical practices for their patients. Has four components: improvement commitment, scientific groundwork for health care, support for improvement, and the Minnesota health quality agenda.	http://www.icsi.org/index.asp
Institute of Medicine - Committee on Redesigning Health Insurance Performance Measures, Payment, and Performance Improvement Programs: Subcommittee on Pay for Performance - Report: Building a Better Delivery System: A New Engineering/Healthcare Partnership	http://www.iom.edu/topic.asp?id=3718 (main page) http://www.iom.edu/project.asp?id=25241 (co-chair Dr. Robert Reischauer) http://www.iom.edu/report.asp?id=28393
Judy Hibbard (University of Oregon)	http://www.uoregon.edu/~jhibbard/
In-store clinic examples: Take Care Health Systems MinuteClinic InterFit Health	http://www.takecarehealth.com/ http://www.minuteclinic.com/ www.interfit.com
National Institute for Health Care Management Foundation: Expert Voices – Dr. Elliot Fisher, MD, MPH	http://www.nihcm.org/expertvoices.html
Pacific Business Group on Health	http://www.pbgh.org/programs/quality_measurement.asp
The Leapfrog Group	http://www.leapfroggroup.org/
The Urban Institute	www.urban.org



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