Good afternoon. My name is Mary Wakefield and I am the Associate Dean for Rural Health at the University of North Dakota, School of Medicine and Health Sciences.

I was asked to comment on some of the national and state level challenges facing health care and identify potential solutions to those challenges. The challenges I'll be talking about stand in the way of creating a health care system that consistently delivers high quality care, every day, to every person, every where. This goal sounds simple, but as we know, the strategies to achieve it are quite complex. Achieving a high quality, safe system for everyone in this country has been the concern of a number of different organizations, including one on which I serve, the Commonwealth Fund's Commission to create a High Performance Health Care System.

Across our nation, we have some of the most advanced technology and best educated health care providers in the world. Yet the U.S. performs worse than other industrialized nations in a number of important areas, including lack of consistent preventive care, poorer health outcomes on some key measures, fragmented care for individuals with chronic health care problems and large pockets of people without health insurance; all of this, at considerably greater expense.

To illustrate how we compare on just a few measures, this slide shows US average spending on health per capita, which clearly far outstrips the next nearest countries, and total expenditures on health care as a percent of Gross Domestic Product. Additionally, expenditures for some of our largest programs, Medicare for example, are not projected to level off any time soon. You can see from the 2007 Medicare Trustees' Report that expenditures are projected to continue to steeply rise and Medicare program insolvency is projected to occur 12 years from now if we continue down this path.

This slide shows you how well the U.S. does in terms of deaths from causes that are considered amenable to health care, that is, deaths that, with appropriate medical care, would likely be preventable. This is just one indicator of what we're getting for some of the money that we're spending. Here, the US is 15th out of 19 countries in terms of deaths per 100,000. Of these 19 countries, only four do more poorly than we do. Additionally, not only do we have troubling differences between the US and other countries, we also have troubling variation within the United States. On the right side of this slide you see data that indicates some states do extremely well on this measure and others do quite poorly. And, on this slide you see how North Dakota compares to other states-quite well. Overall though, what these first few slides tell us is that we spend more on health care than any other country and within the United States, we get some exceptional care, but we also get tremendous variability that comes at significant cost.

To change these characteristics and achieve a high performing health care system, the Commonwealth Commission's framework is a useful place to begin. The Commission advocates focusing efforts in four core areas: 1) delivering high quality care, 2) ensuring access to care for all people, 3) providing care that is efficient and of high value, and 4)

reengineering the health care system so that it has capacity to improve. I'll make a few comments about these areas from both a national and a state perspective.

Delivering high quality care. Let's look at a few international comparisons first and then look across the states. When care is well coordinated, with information readily available to clinicians and patients, care quality is better. In terms of coordinated care, this slide indicates that, when compared to 4 other countries, the US consistently performs more poorly on care coordination measures such as test results and patient records being unavailable at the time of appointment. This slide indicates that we have more adults reporting medical errors than in five other comparable countries. And this slide indicates that when you have more doctors treating you, in the US as elsewhere, the likelihood of medical error increases. Patient reported errors however, are highest again for the United States. While seeing four patients over two years may seem like a lot, 20% of Medicare beneficiaries in the US, with five or more conditions receive services from an average of almost 14 physicians per year. Given the tools and structures available in our current system, that is a recipe for fragmented care. In spite of these findings, we have some evidence that certain care coordination efforts underway in the United States markedly improve patient outcomes and care quality.

A recently released report from Stanford University shows how a number of coordinating strategies do improve patient outcomes. Cost-effectiveness is associated with care coordination for patients with depression and care coordination for elderly patients with congestive heart failure. Coordinated care is a fundamental underpinning of a concept gaining a lot of attention-medical homes. In North Dakota, we have an award winning example of a collaboration between two key stakeholders, a provider and a payer; MeritCare in Fargo and Blue Cross Blue Shield of North Dakota. This example of a medical home built on care coordination for patients with diabetes is now serving as a model for other entities, including national associations of physicians and payers. The model has at its core, chronic disease management, engages patients through improved knowledge and self management skill development, and uses electronic medical records, measurement and physician and patient feedback and data. The results of a study of this model show improved health outcomes, improved clinician and patient satisfaction with care, and decreases in costly interventions such as emergency room visits. This program is now being expanded, and both the payer and provider are sharing in the savings.

In addition to testing new models, delivering high quality care is also evident in measures of quality that help us to see how we're doing in North Dakota. Here are just a few. This slide provides one example of the variation in quality-readmission rates to hospitals. North Dakota does better than the national average, although not the very best.

Using data reported to CMS, we can see how our hospitals do on a different set of measures, those that focus on care for specific conditions. This one is a measure of care for heart failure patients, a costly disease. On this measure, on average, North Dakota hospitals do better than the national average. On the next slide, care for pneumonia patients, one rural hospital in North Dakota does exceptionally well and well above the national average.

Related to measures of care for heart failure, pneumonia and heart attacks, less than a month ago, an article in the journal Health Affairs published findings indicating that high performance on three common medical conditions- heart attack, congestive heart failure and pneumonia, found that high performance in hospitals on these measures was consistently and significantly associated with fewer patient deaths in those same hospitals. The point is, across the United States, when it comes to quality of care, there is significant variation in performance; variation that has associated costs in both lives and financial resources.

Ensuring Access to Care

The national numbers on uninsured across the U.S. general population are, while disconcerting, well known, and so I won't spend time on those. However, I do want to comment on two special populations, children and farm families. Regarding children, your work on the Budget and Finance Committees was critical to the recent Senate passage of the State Children's Health Insurance Program reauthorization. This program expansion is extremely important for all American children, but particularly for rural children. National studies tell us that more rural than urban children live in economically vulnerable families, and a majority of uninsured children in rural America, 54% of them, live in families where the head of the household works full-time, year-round. In fact, over 1.3 million rural children are uninsured.

Compared to other states, North Dakota does well on health insurance coverage, with about 85% of our state insured. However, that 15% uninsured includes about 11,000 children.

In terms of coverage for another important population, farm and ranch families, the Center for Rural Health at UND, in conjunction with the Access Project in Boston recently undertook a survey of non-corporate farmers and ranchers in seven states, including North Dakota, to get a better sense of affordability of medical bills and medical debt in this population. While these findings will be released fully in just a few weeks, what is interesting to note is that almost all of the respondents across the 7 states had some health insurance coverage and more than a quarter reported having to pay out of pocket for health care. Almost one in four farmers indicated that health care expenses contribute to their financial problems including difficulty paying other bills, paying the mortgage, needing to take off farm or off ranch employment and delaying making investments in the farm or ranch. About 27% of respondents with debt owed money to hospitals and almost half had debts to individual providers, such as physicians and dentists.

Affordable health care coverage is essential for all Americans. As long as we have large numbers of uninsured or underinsured, where people aren't getting care when they need it and, when they do receive it, are unable to pay for it, achieving high performance health care systems will be unattainable.

Efficient, high value care. I'm going to briefly comment on three dimensions of high performing systems that contribute to efficient, high value care; primary care, health information technology and comparative effectiveness research.
Primary Care. The Medicare program gets a very good deal in terms of value in North Dakota. ND ranks second across all states in Medicare reimbursement per enrollee. North Dakota has the lowest average number of days spent in ICU across all states. Part of what is going on in North Dakota is this graph that shows ND in the top 15 or so states that has a higher proportion of primary care inputs and associated higher quality of care. There are a lot of reasons for this finding but it's worth noting that ND is higher than the national average in the number of primary care providers to population, and primary care is key to managing many things well, including chronic conditions like diabetes and asthma. Managing chronic conditions well has significant implications. Twenty per cent of Medicare beneficiaries with five or more chronic conditions account for about 66% of all Medicare spending.

We know from international data and from the Dartmouth data, that countries, and states that rely more on primary care to manage chronic illness tend to have lower Medicare spending and use fewer hospital beds. We also know that the amount and quality of care chronically ill Medicare beneficiaries receive varies extensively across the country, by region and by health care provider. People who live in areas with higher per capita resources receive more interventions, such as hospitalizations, physician visits and diagnostic testing. Yet according to the Dartmouth Atlas data, there is no evidence that people who receive more supply sensitive care have better health care outcomes. In fact, there is evidence that more tests, hospitalizations, intensive care admissions and physician visits lead to worse outcomes for patients and lower patient satisfaction. This is an important piece of information in terms of helping us direct our attention- whether you're talking about clinical care or public policy. However, there tend to be greater rewards for providing specialty care than for primary care and there is no incentive to establish medical homes that have at their core primary care and the coordination of specialty care.

Health Information Technology. The use of Health information Technology –HIT- is another important contributor to efficient, high value care. At the national level, we've seen some progress in encouraging standard electronic transactions in health care. However, health care in the US still lags behind other industries in use of information technology. As is clear from this slide, compared to other countries, primary care and other providers in the US don't have the tools they need to help make their practices efficient. One might think that HIT in small practice settings is inordinately difficult to do. However, while it is a challenge, it can be done. In Denmark for example, the medical association and their national government got behind electronic medical records, and now virtually all health care practices in the country are linked. Important to note is that 80% of those practices are solo or 2 person practices. Electronic medical records and information systems help to reduce duplicate tests, provide decision support for clinicians and patients, reduce medical errors, promote better management of chronic conditions and care coordination and increases efficiency. In terms of health care claims, some

sources indicate that the average cost per claim, if handled electronically, is 85 cents compared to $1.58 if submitted on paper.

In North Dakota, as you will recall, you spearheaded a focus on strengthening Health Information Technology through an HIT summit you sponsored last year. That Summit catalyzed the creation of a HIT steering committee that has been meeting monthly since then—with a focus on facilitating the adoption and use of HIT to improve health care quality, and efficiency in North Dakota. It's critically important that in this state, we don't lose any ground in adopting technology that will enhance efficiency and care quality. At regional levels in North Dakota, new partnerships are being formed around building HIT infrastructure, many of these with support from federal programs. HIT linkages moves us from the concept of Centers of Excellence often associated with urban areas, to networks of excellence, that help to connect and integrate health care across regions in new ways.

Comparative effectiveness research. We noted in the landmark IOM report, Crossing the Quality Chasm that our current approaches to organizing and delivering care just can't meet expectations. The science and technologies involved in health care drugs, devices, and procedures, have advanced more rapidly than the health care system's ability to deliver them safely and efficiently. One of the reasons that health care in this country falls short of its potential and costs so much is because we don't have a very good idea about which drugs, devices and procedures used to treat the same conditions are most effective, safe and efficient. Other countries have well developed comparative effectiveness research processes that produce objective information. In this country, we need to ensure that payers, providers and patients have timely information to evaluate which treatment options will achieve better outcomes while lowering health care costs. Senator Conrad, you wisely recognized the need to shore up this function when as Chairman of the Budget Committee, you included a place in the budget for this important research.

Building system capacity to improve. In rural North Dakota, as in other rural areas across the country, necessity is the mother of invention and capacity for innovation while challenging, is often led by rural administrators and care providers. The nature of rural health care lends itself to creativity, collaboration and regional coordination. Rural health care is typically nimble and new interventions can be adopted in a matter of hours or days when it can take that same intervention months to be adopted in a large facility. Rural facilities, with tools and expertise can be rapid learning organizations that test and model efforts for the rest of the country. Encouraging networks and partnerships through financial and other incentives are important in order to get economies of scale, and cast regional solutions. Strong national policies that support local players to develop common agendas and pool resources are important. From a rural perspective, I can tell you that Quality Improvement Organizations, like the one in Minot that services the entire state, play a pivotal role in working with all types of providers to help them measure and institute appropriate improvements and innovations in the way care is delivered.

In summary, not only do we see variation among countries, we also see considerable variation within our own country; variation that costs money, days lost from work and even lives. We find large gaps in quality of care, access to care, avoidable hospitalizations and healthy lives across our states. We also find that there is no systematic connection between high spending and high quality health care.
What is needed is a coherent set of expectations, tools, and rewards for measuring and improving dimensions of health care that are essential to high performance. That means having metrics for health outcomes, access to care, efficiency and care quality.

It means realigning payment to pay more for value and pay less for valueless care. We need comparative effectiveness research, information technology, and we need to work to make sure that all Americans have health insurance. Using these approaches to create high performance health care is a big part of the answer. Asking health care providers and administrators to simply work harder, doing a lot more of the same isn't. All of this is hard work but at the end of the day, when we invest wisely in good health care, we get healthy productive people, a strong vibrant economy and healthy communities in return
Thank you Senator Conrad, for your commitment on so many of these critical fronts, all of which taken together, can help us create high performance health care.