

## Campaign for Effective Patient Care

September 2, 2009

10:00AM PT

**Maryann O'Sullivan:** Hi everyone. Thank you for joining us. I am Maryann O'Sullivan. I am the Executive Director of the Campaign for Effective Patient Care. I want to ask you to go to our website now, if you are not there already. It is [www.campaignforeffectivepatientcare.org](http://www.campaignforeffectivepatientcare.org). If you go to the tab that says, "Opinion Research Results", you will see that the first tab under that is the new report that we are releasing today which is called Perception vs. Reality: Evidence-Based Medicine, California Voters, and the Implications for Health Care Reform. We are hoping you'll take a look at that. But, for right now, I want you to go down to the third tab, Lake Research Partners, and select the presentation. That is the first thing we are going to hear today. It is a PowerPoint presentation. Celinda Lake will name the pages as she goes through the presentation so that you can pay attention to the right pages. Now, at the bottom of the webpage, there is a list of the speakers with their titles and bios. So, you should have everything you need for later. There is also contact information in a separate document. The Campaign for Effective Patient Care is a new California organization. It's an education and advocacy organization that will be working for more and better use of evidence-based medicine in California. The public policies we will be supporting include, development of more scientific evidence around healthcare and then its translation and dissemination into systems that have infrastructures and incentives in place that encourage documentation to use evidence-based medicines in making informed healthcare decisions about the individual situations of each patient. We commissioned this survey of California voters this summer because we wanted to understand better how California voters think about scientific evidence in their own healthcare. There were a few things that struck us in the findings. One was the level of importance that California voters -- and California generally I would assume -- place on the use of scientific

evidence in their healthcare. And also, the extent to which they are very highly supportive of reform, commonsense reform, which would move us more in the direction of evidence-based medicine in healthcare. However, we were surprised to see the level to which Californians already think they are getting evidence-based medicine. In fact, most voters think that most or all of the healthcare that they are receiving now is evidence-based. We know that, from the Institute of Medicine, in fact half or less of the healthcare that we are receiving is based on scientific evidence. That leads us to wonder whether perhaps the lack of human cry we are hearing in the national debate around quality has to do with the fact that the voters think that they have an underlying confidence that the healthcare that they are receiving is already steeped in evidence. The speakers that we are going to hear from today are as follows -- we will take about 30 minutes to hear from them and then we will open up for questions and answers. Celinda Lake is the President of Lake Research Partners. Stephen Shortell is the Dean of the School of Public Health at UC Berkeley. Wells Shoemaker is the Medical Director for the California Association of Physician Groups and is a pediatrician who has worked for decades in California's agricultural communities. Shannon Brownlee is the author of our new report and also the author of Overtreated. JoAnn Lamphere is with AARP and she is the Director of State Government Relations there for health and long-term care. Betsy Imholz is the Special Projects Director at Consumer's Union. Anthony Wright is executive director of Health Access. And last but not least, Peter Lee is the Executive Director for National Health Policy at the Pacific Business Group on Health. With that, we will turn things over to Celinda.

**Celinda Lake:** Thank you very much. I want to thank this new and very exciting organization for commencing this survey and really asking tough questions. I want to thank everyone who is here also because it is a very auspicious coalition and fascinating polling results. I think some of these results really are of great interest to the public because they are different than conventional wisdom, which is one of the reasons we love polling. Conventional wisdom is usually about 85% wrong -- plus or minus 3%. So, we love doing polls like this. I also

want to thank you on behalf of David Mermin who is not here today. He is the head of our California office and the head of this project. I would also like to thank you on behalf of Chip McGlover [spelling] who was really the [inaudible] on the project. If you look at the handout from the website -- if you're not the website it's fine, you won't need to be on there to understand what we're presenting -- on slide to you will see that this is data hot off the presses. We didn't pull in some benign period. We pulled when everybody was big on healthcare reform and there was some controversy going on. It was definitely the eye of the storm. Very hot off the press is this data. We polled 800 registered voters in California who voted in the 2008 election -- with an error of plus or minus 3%. On slide five we found, as Maryann introduced it, that many of the reforms that we tested, and we're going to focus in on a couple, people were very much in favor of and they saw them as commonsense reforms. But they also tended to think that the quality of their care is very high. People were very very positive about their doctor. They also think that the quality of the care that they get is based on scientific evidence. Now, this is a very interesting case of, "Yes to the world, but not me." So, we saw a very interesting drop off between people thinking that the care they were getting was based on scientific evidence. But, a sizable portion of the public did not think that the care that most people get is based on scientific evidence. So, the people did see more of a problem there. People also thought very important that both patients and doctors have access to the most, the newest and most comprehensive findings. As much as they were positive about their doctors, they also thought there was no problem with requiring we used the dreaded "R" word "require". So, people thought there was no problem requiring that people be told what was the scientific evidence behind treatment and if they were being recommended some kind of treatment that wasn't based on scientific evidence that they be told that as well. 39% of the public thought they placed more stock on their doctor's experience than they did on scientific evidence while 29% said more on scientific evidence. What was most interesting is that a whopping 28% of the public volunteered -- we did not offer this category -- that they want both. People really see scientific

evidence as a tool -- not as a counterpoint to their doctor, but as a tool for their doctor. They think it is very very important that their doctor be provided with that new evidence. Overtreatment and undertreatment, people thought these were serious problems. People did not particularly except that their doctors had incentives for overtreatment. There is kind of a basic connect around payment reform that is missing for people. People really don't envision their doctor being paid more recommending things because they are paid more for them. In fact, people think of treatment really being driven less by their doctor and more by their insurance company. They think their insurance company -- that their doctor is often acting in anticipation of their insurance company and that their doctor is not recommending something that their insurance company will not cover. So, they tend not to think of doctors having major incentives to provide too much coverage or too much treatment. People have a very interesting attitude about the newest and finest. People are much more tempered. We think of conventional wisdom as that Americans always like the newest, shiniest, and most expensive objects out there but there is a far more tempered judgment. People do not think that the newest or most expensive pharmaceutical would necessarily be the best. People responded very strongly to messaging and facts. Two areas that people really have in their heads that are problems that they connected these issues to are number one, medical errors. People thought that scientific evidence could really help reduce medical errors. People definitely have the stories -- often provided to them by their local news -- of medical errors. Secondly, people thought infectious diseases, particularly in hospitals. There is an increasing awareness of infections in hospitals and people thought again that the scientific protocol could help prevent that. So, that is an overview. If you turn to page six, in general, people think that the quality of their care and quality of their own health is pretty good. 80% of likely voters say that the quality of care that they get is excellent or good. 82% say that their own health is excellent or good. On page seven. Probably the most interesting data -- one of the more interesting and intriguing pieces of data that we will present. 51% -- well, 55% -- of people at the bottom said that most are nearly all of the

treatment that I get, that my doctor recommends, is based on scientific evidence. But, only 51% thought that all or most of the care that most people receive is based on scientific evidence. Only 11% thought that nearly all was based on scientific evidence. So, people tend to think, "What my doctor is recommending to me is based on scientific evidence but what everybody else is getting may not be." People have a much more conflicted concept about that. I'm in a skip ahead a little bit. We can discuss any of these slides in question. But, turning to slide ten, we asked the question about over and undertreatment. A majority of voters think that both over and undertreatment are problems, serious problems. Only less than 20% think that they are not a problem. But again, people do not tend to particularly attribute over or undertreatment to their doctor's behavior or any kind of incentive structure for their doctor. They tend to think that these are due to issues of insurance companies or things like that. On page 11 we posed the dilemma, "When doctors are paid for each service provided by the patient they have an incentive to sometimes provide more medical treatment that is really necessary versus doctors know how much medical treatment their patients need and regardless of how they are paid, they try to provide them with the proper amount of treatment." By 53 to 39 people said, "No, doctors try to provide people with the proper amount of treatment." People were much more convinced of that view than the reverse. Now, there were some groups of the public that thought a little bit more that the doctors were likely to respond to payment incentives -- they tended to be men and independents, both of whom are very suspicious in this state. And also, younger voters, who do not tend to have as firm a relationship with their own doctor. But, you still had the majority or plurality still saying, "No, I think the doctor is providing what is necessary and I don't think they have incentives to provide more." On slide 12 people were quite confident that the information they received from their doctor enabled them to make an important decision about their care. They have slightly less confidence in information gleaned from the Internet, combined with their doctor. But, 84% -- 67% strongly said, "Yes, I feel that I got the information I needed about what works from my doctor so that I could make an informed decision for myself and my family." We

have high levels who still agree with that when we said, “The doctor or the Internet.” Actually, people are suspicious of the Internet and it reduced their confidence in the information they were receiving. On slide 13 we see overwhelming support for the reforms. So, even though the premise exists that people think the doctors are providing care, “at least for me”, based on scientific evidence people think that doctor should be required to let patients know about their treatment options if their strong scientific evidence for it. This is at the level of what we would call a core value, this isn't even a policy in the public's mind. We have 92% of the public agreeing, 83% strongly. That's what we call a valence issue. It's not a policy conversation. It skipped over to a core value for people. People also were willing to go a step further and say that the doctor should be required to take the information into account. Now, they don't want the doctor to ignore what they are to know about the patient, but they definitely want to scientific information in the room as well. 87% said it should be required and 71% said strongly. Slide 14 - - this is a more interesting one I think. 91% said the doctor should be required to tell their patients if there is no scientific evidence that a particular treatment works. This does not mean that they would not necessarily take their doctor's advice, but they thought very strongly that these information requirements should be on the table. That's with people thinking they are getting treatments based on science and feeling overwhelmingly positive about their doctor. Slide 16. We looked at how important people feel certain things are and also what made people more supportive of these reforms. First of all you see, at the top of the list of importance, people feeling overwhelmingly that doctors have to have access to the scientific evidence and that they should be required to share that with their patient. So, there is a triangle here. They believe the doctor absolutely have to have access. I believe it should be shared with the patient. And, I believe that there should be requirements about associating or not associating a recommendation with it. That is all very robust and all frankly at the level of core values of people. People are, frankly, quite a bit surprised that that was not happening already. In fact, when we were listening to the interviews, people were saying things like, “I thought this

happened already.” A little less support in intensity for payment reform mainly because they just thought people were a little confused about the dynamics. But still, 72% saying that it is important that doctors are paid based on the number of services they provide and a third of the voters saying that that is very important to them. Finally, where do people make the connection themselves between these reforms and problems that they see out there in the real world? There are very very strong connections for people, particularly around medical errors. People are well aware of medical errors and thinking that they are increasing, thinking that they have very bad impacts on patients, and 80% said they are more likely to support these reforms when reminded of the medical errors while 45% much more likely. People also are very aware of the story of increasingly virulent infections in hospitals. They connected that storyline in their head as well to these reforms and you saw 77% more likely than 42% much more likely. I would add as a closing remark, these were not particular reforms that needed messages. These were core values for people already. The only thing that is inhibiting them from being at the barricades now advocating for these reforms is they assume they exist already. People strongly and intensely are supportive of these reforms as core values and attaching it readily to problems that they see out there. Thank you. I will take questions at the end, but let me turn back to Maryann.

**Maryann O'Sullivan:** Great. Thank you Celinda, that was a great presentation. I just want to take the opportunity to say to you that working with Lake Research Partners is also a great experience. Thank you. We'll move over now to Dr. Stephen Shortell. I do want to say that if you look online there are statements there -- just call your attention to this -- from the governor and from a bipartisan set of California legislators. They are there online.

**Stephen Shortell:** Thank you Maryann very much. Can you hear me okay there?

**Peter Lee:** Yes, we can hear you clearly.

**Stephen Shortell:** Good. I'm going to make three points in three minutes. We will move this along. It is very much surrounding what Celinda has said regarding the results of the survey. The first point is something we can all relate to. We all want the best care possible for

ourselves and our families and our neighbors and friends and it's pretty clear in this country, and in this state, that we are not getting that currently. Not only are the perceptions of what Celinda's survey has indicated, but the actual data from studies done by RAND [spelling] and others indicate that we get recommended care that is already evidence-based only about half the time on average. That's true not only for adults, but for our children as well. They have done that same study through children with essentially the same results. Some of that is due to the fact that we are getting a lot of care that does us no good whatsoever. And this is the point about half the treatments having no evidence-base for what we are getting. Some simple examples are things like antibiotics for colds or back pain surgery -- as the evidence now has come out about that -- and often, MRIs that are done for a variety of reasons that have no real rationality evidence-base. The other part of that is we are not getting, in some cases, care that we should be getting. That's the undertreatment phenomenon or underuse -- preventive measures, for example. So, that's the first point. The second point I want to make is to think about what's happening in the future -- new technologies, new devices, new procedures that are coming down the pipe, the advancement coming out the biological and life sciences. We are very ill-prepared in terms of the delivery system. As consumers working with our doctors to incorporate those new advances and new information, we do not have ways of sorting that out. What is the evidence-base? What can we trust? We need some mechanism by which -- whether it's the center or a unit for comparative effectiveness. But, the basic issue is how is that going to filter down to us as consumers and patients... to our doctors, to our nurse practitioners, to our physician's assistants, and to all clinicians? As an example, prostate cancer, there are a variety of different ways of dealing with that from watchful waiting -- or I think the new term is "vigilant surveillance"-- or use medication and so on. Breast cancer is a huge issue in which the evidence now suggests that we are actually over treating a lot of women that have very low stage, mild symptoms, and undertreating those that are very severe stage IV and beyond. That is beginning to change because we now have biological markers and molecules that are

beginning to be able to diagnose more specific and sensitively the stage of breast cancer that then leads to different treatment branches. This is all new information. How do we incorporate that? A little back pain is another example. That is the second point. The third point, building on the second point, is that we need a package of -- if you will -- incentives and tools for healthcare system, for the clinicians that operate in it, that work in our medical groups across the state and across the country, to be able to use this information to benefit us as patients. That gets us into issues of paying for desired outcomes, paying for results, payment reform, payment that encourages our hospitals and doctors to work together rather than have separate financial incentives, and giving them the tools to use the information which has to do with the electronic health records and things of that sort. There are a number of things nationally in proposals around IT, around developing accountable care organizations, around developing patient-centered medical homes that are going to be needed in order to take advantage of some of these advances in the evidence-base. So, let me conclude there.

**Maryann O'Sullivan:** Thanks a lot. Next we will hear from Wells Shoemaker, who we introduced earlier as the Medical Director of the California Association of Physician Groups and a practicing pediatrician for decades; and much of that, with the agricultural community along the California coast.

**Wells Shoemaker:** Thank you. I'm privileged to be in a room with Stephen. What an elegant condensation of what healthcare reform promises if we do it right. There are a number of comments about evidence-based medicine from the perspective of California's -- at least in CAPG, 150 medical groups caring for approximately 13 million people on HMO contracts of care and another five or six million on a fee-for-service care -- so, roughly half the people in the state. It's interesting when you talk to medical directors in these groups; they all consider themselves to be quality crusaders. We want to pursue a goal of having the right care done at the right place at the right time and the right hands as the first gesture. So, the caricature that managed care exists to deny appropriate care and stand in the way of appropriateness is categorically not

even on the mindset of the physicians that are actually making these decisions. Our greatest tool, and the tool that we use to try and make those decisions is to try and sort out clinical evidence and apply that to the individual circumstances of our patients, all of whom are different from each other in important ways. That is easier said than done. One of the problems that we have had is that medical information comes to us in a scattered format and like millions of windows with light coming in, it does not all shine on the same place. We also know that there is no individual study details the whole truth in healthcare. We are studying human beings of which there are six billion varieties on the surface and we are finding out just how important some of those differences are as we dig in. The history of medicine is full of examples of situations where we thought we were on the right track and we thought we knew enough to say, "This is the right way to go." That turns out to be uprooted. The hormone replacement therapy is a good example, but there are dozens and dozens of surgical procedures and so-called standards of practice that have now been discarded. These medical directors are trying to interpret an incomplete body of knowledge and take incomplete knowledge about the individuals and try to arrive at the best decision for the best care in the best place. That is a hard job. We certainly abundantly welcome any clarification of that and the idea of having a third-party combination of academic and practice brainpower applied to looking at new evidence and trying to see if what we are doing now is indeed the smartest and best. We welcome that like we welcome an April sunshine. The two enemies that we have, where evidence makes medicine led us down -- Stephen mentioned earlier -- clearly under use of services that we know are effective is a problem. Among our medical groups using advanced registries we actually are getting, steadily every year, stronger handles on connecting people who are late or who are missing a service or who are falling outside of targets and connecting them with a physician who is responsible for their care and then closing the loop and making sure that something gets done. Using evidence of what really does work in making sure it gets to people is one of the most powerful tools we have. I think we are making fairly decent progress there. We are aware of our flaws. The other

area, the one where the healthcare reform debate puts a lot of ideology in this, is the whole concept of overuse. A lot of people think that doing care which is ineffective or inappropriate is bad economics, and it certainly is if you look at the amount of waste of precious resources in this country. But, inappropriate care hurts people. These are people's mothers and fathers and children that are injured by care which maybe was not necessary in the first place or was not the right thing. We are eager not to deprive anyone of something that works or something that is effective, but we want to know what we are doing. We do not want to be guided politically. We do not want to be guided by review systems, which are inherently adversarial where there is supposed to be a winner and a loser. We would love to be guided by true knowledge with full humility that that knowledge is constantly changing, which means there needs to be an informed system to constantly re-evaluate that. So, the fact that the consumers are expecting this and they want it definitely puts air in our balloon and we are looking forward to the next step.

**Maryann O'Sullivan:** Thank you very much Dr. Shoemaker. Next, Shannon Brownlee.

**Shannon Brownlee:** Thank you very much Maryann for having me as part of this group and giving me the opportunity to work on this very very interesting project. As we grope our way towards healthcare reform, promoting effective and evidence-based care, it is one of the most important steps that we need to take. But our health care system is broken in ways that I think not everybody acknowledges. We know it is too expensive and we know it is not covering everyone, but it is also hugely wasteful and inefficient and often harmful. It's not because we have physicians and nurses to our lazy or do not care, but because they are working within a broken system. I want to echo some of Dr. Shoemaker's comments because we know have very harmful the system can be with more than 90,000 medical deaths from errors and more than 90,000 medical deaths from infections acquired in hospital. We also are spending an enormous amount of money and putting patients into harm's way with a tremendous amount of unnecessary care, which is where I focus most of my work. We think there is somewhere in the order of \$.20 to \$.30 on every healthcare dollar spent on unnecessary care. This does not just

drive costs, it does put patients in harm's way of being affected by errors and infections. Part of what drives that unnecessary care is that physicians do not know what works and what does not. So, one of the crucial building blocks of building a better healthcare system is better medical evidence. There is this old joke in medical school, and I don't know if any Dean of any medical school has actually said this to a graduating class, but supposedly Dean's have been known to stand up and say, "Half of what you just learned is wrong. The problem is, we do not know which half." It is funny, but it should concern every patient because physicians are struggling with this lack of evidence and because the patients are not always aware of it. It is a real problem and it is not just problem of not getting minor care, it can be a real problem of putting patients into harm's way. As a writer of this report I was really immersed in the polling data in one of the things I found most interesting is that kind of solved an abiding mystery about why voters are so easily misled during these healthcare debates by misinformation. One of the biggest pieces of misinformation that is being passed around right now is that any kind of comparative effectiveness research where you compare treatments, to different treatments or three different treatments for the same condition, like those treatments for prostate cancer, if you compare those treatments the only thing that will come out of that is rationing, that the government or insurance companies will use that information to deny people access to the most expensive treatment and force them into inferior treatments. The reality is that we need this kind of research so doctors know what actually works, what does not work, and what works for which patients. One of the eye openers from this poll was the fact that most voters think that doctors already know what works. This may explain why they have been so vulnerable to this kind of misinformation about the kind of comparative effectiveness research that we may need.

**Maryann O'Sullivan:** Great Shannon, thank you very much. Thank you for your wonderful work on this report. JoAnn Lamphere is here from AARP will speak to us next.

**JoAnn Lamphere:** AARP is delighted for effective patient care. Through education and advocacy that focuses on the use of scientifically based information, we believe that our unique collaboration with Blue Shield of California and the California Association of Physician Groups holds great promise to help improve the quality of care for people in California. AARP embraces the idea that doctors and patients together should be making important healthcare decisions based on the best information. Evidence-based medicine is an issue whose time has come. It is a commonsense idea that can improve patient outcomes by ensuring that consumers receive effective and appropriate care. Much attention is now focused on generating independent reliable comparative effectiveness research at the national level. AARP though, is now seeking to highlight the importance of applying this evolving healthcare knowledge does become available. How can information best be summarized and made available to busy physicians? How will this research be translated so that it is usable for consumers? These are just a few of the many issues that the Campaign for Effective Patient Care will be undertaking in the next few years. As with all new groundbreaking work in complex fields, this will be exciting and challenging. AARP believes that California provides the campaign with the professional expertise and dynamic environment to make great things happen. We look forward to working with Maryann O'Sullivan of the campaign, our Blue Shield and CAPG organizations, and the many other stakeholders that can make better, more informed medical decision making a reality. As a national organization that represents consumers' interests, AARP is pleased that this first activity of the campaign focuses on what the consumer thinks and understands about evidence-based medicine. As far as we know, the first effort of its kind in the country. Since we are all healthcare consumers can have a stake in improving how our health system works, we encourage everyone in California to support the work of the Campaign for Effective Patient Care.

**Maryann O'Sullivan:** Thank you JoAnn. Next we will hear from Betsy Imholz.

**Betsy Imholz:** Thank you Maryann. From the consumer side, I can see that there is nothing more frightening and frustrating than facing a major medical decision or new diagnosis and trying to figure out what the right step is, feeling that maybe you don't have the right answer, maybe you don't have the most accurate information on the various risks and options before you. I think this hole demonstrates that consumers want and need that unbiased scientific information. An interesting finding to me was that people thought that they had already gotten it on previous occasions when they have had medical decisions and that even more strongly they said, "We want it going forward." That may be a case of not wanting to think that you did not make the right decision in the past. I'm not so sure about that, but it's an extremely strong showing of need from the consumer side going forward. Strong majorities want their doctors to tell them the evidence of what works for their condition or if there is no evidence as well. They want to be informed about that. They emphatically want their doctors to have that comparative information as well. They want it to be easy to understand scientific information themselves. Consumer's Union has done focus groups. I think the findings from the campaign, many of them, confirm what we found before in the Consumer's Union focus groups about people thinking that they are already getting the best scientific information from their doctors and that their decisions are based on the best science. To me, that speaks to a positive thing, which is trust -- trust in physicians. We can build on that when we get this new comparative effectiveness information. Arming consumers with it, arming doctors with it, it will give them a basis for dialogue that can only benefit medical outcomes. Consumer's Union tackled this with an ongoing project, a free public education project on prescription drugs. Our Best Buy drugs project that takes the scientific research done by the drug effectiveness research project and translates that into plain language for consumers but slightly more detailed reports for doctors as well on different categories of drugs. It has been a very interesting and challenging project. The translation is not what is so hard, although that is challenging in itself, but changing behavior, [inaudible] the detailing that goes on with doctors and the public with direct to

consumer advertising. It is a very challenging project. But, we've done some pilots -- in fact, in Wisconsin we did one -- where we have seen that by targeting specific populations with specific drug information it has changed behavior and has saved millions and millions of dollars, in that case, for the Public Teacher's Union in Wisconsin. Often it's a generic drug that comes out and is seen as being the most effective, the safest, but not always. But, sometimes it is another kind of lower-class drug. We have seen some changes there and we are hopeful that that push will continue on our side as well on the drug front. The IOM, the stimulus bill, and the health care reform proposals have, of course, all recognized the needs for significant effort on comparative effectiveness research. I will just highlight consumer input on the research priorities, on the translation and compliant language, and then the dissemination. I think that's critically important because for the research to be relevant to consumers they have to address topics that we care about, that they care about, then all of us care about. To put them into action will require buy-in from the public and input from consumers. I think for some folks there is a sense of, "Well gosh, why would everyday people be involved in complicated medical analysis?" But, I think there is now a public recognition, a recognition on the part of policymakers that consumers must be at the table and must be part of it in order to get an effective outcome and the kind of buy-in we want. I would also note that one thing I found really interesting in the survey was the very strong recognition of the seriousness of overtreatment as an issue. Consumer Reports did an article -- last summer, I think it was -- on overtreatment. They took the Limburg [spelling] data on variations in care and trying to explain in plain language -- in fact their editor said it was the toughest article they ever did, they ever edited, because it is not intuitive for most lay folks to think that less can be more, that less care can actually be better and safer. I was really struck by that finding and heartened by it to think that California voters understand that overtreatment is a high risk and that that risk from infection and other medical errors and just extra expense can be harmful. Congratulations for this work and thanks Celinda for your always great work.

**Maryann O'Sullivan:** Next will be Anthony Wright of Health Access.

**Anthony Wright:** This is Anthony Wright, the Executive Director of Health Access of California, the statewide healthcare consumer advocacy coalition. Among the things we've done over our 20 years is actively work with coalition partners like AARP and Consumer's Union to make sure that the path to HMO patient's Bill of Rights here in California. In various venues we have actively worked to make sure that people have access to the care that they need. That is our main mission and our cause. That does not mean that people want -- that people should get all treatment. In fact -- I think people recognize that -- consumers don't want to spend time in the hospital unnecessarily, that is not where they want to hang out for most of their time [laughing].

**Participants:** [laughing]

**Anthony Wright:** People don't necessarily want to take the fifth or sixth drug in a regimen. This is not where they want to spend their money or their co-pay, this is not what they want to be doing with their time. They want what is effective and that's why they want this information. They want this information to be scientifically based. I think that consumers want to make sure that the care that they are provided is based on scientific evidence rather than industry marketing. That is a lot of the work that we have to do. I know that these poll results get to sort of like the, "Mom and apple pie" levels when you are talking about 70, 80, 90% here. But, this is an active debate in policy circles at the state and federal levels. Here in California, we have had very tough debates in the legislature around transparency of just trying to get some of this data, this information about what is the best quality and what is the most effective treatments and procedures. This has obviously been a huge debate at the federal level in the stimulus package with the comparative effectiveness research and HR3200, the current health reform proposals. Consumers need to be vocal about these efforts because otherwise the institutional prerogatives and inertia of the healthcare system will take over. It is good to get this data that shows strong consumer support for comparative effectiveness and for getting the right information. But, we need that to translate into political action in order for this to actually be part

of the health reform that we need. We are excited about the potential this year at the federal level and the state level.

**Maryann O'Sullivan:** Finally, and last but not least, Peter Lee from the Pacific Business Group on Health.

**Peter Lee:** Maryann, thank you very much. In the past month, much of the debate about health reform has not been evidence-based, it has been, sadly, evidence free. These survey results underscore that we need to reform health care to be more evidence-based, but it also raises the level of the debate. So, we are actually talking about the real issues of high costs, very inconsistent quality, that will only be addressed if we change how we engage doctors and patients with better information and change how we pay for care. I want to applaud AARP, CAPG, and Blue Shield for starting the Campaign for Effective Patient Care. I think it is a newsworthy event unto itself to have some of the leading consumer organizations of the country coming together with physicians and a major health plan to anchor our debates in evidence that employers want reform that will change how care is delivered. To do that, we need better information, which is going to rest on better comparative effectiveness research. It also means we need to change how we pay for care -- as you heard from Stephen Shortell. We welcome the results of the survey which will hopefully shift our discussions and health reform to themselves to be more evidence-based as we try to get the reform that all Americans need. Thank you.

**Maryann O'Sullivan:** Okay, thank you everyone for really thoughtful comments. We really appreciate it. People on the line have questions they would like to ask. The operator will tell us how. What do they press operator?

**Operator:** If you would like to ask a question press "star one" on your touchtone phone. Our first question comes from Nate Johnson from freelance journalist. Go ahead.

**Nate Johnson:** Hi, this is Nate Johnson in San Francisco. How big is this in the healthcare debate? Peter Lee said that the debate has been mostly evidence free. We've heard

a lot about who pays, but not a lot of talk about what the payment would be for or how good that treatment would be. How should this be entering the debate and how the debate be changing it before talking about evidence-based care?

**Anthony Wright:** This is Anthony Wright for Health Access California. It is discouraging that some of the more innocuous provisions of the bill, like comparative effectiveness research and getting information, for political purposes, get tagged with conversation about rationing and death panels. At some level the debate is so disconnected from the substance of the proposal, the policy proposal, that there is no way to respond. I think the key thing is that at the end of the day, when you actually look at what reformers are trying to do, consumers support it -- whether that's how the bill is being characterized is an entirely different discussion. I think the point is that if the question is, "Should we have proposals as part of health reform so people can get the information about effective treatment and what is both effective in terms of both health outcomes and best cost?" People overwhelmingly support that. That is the major takeaway of this proposal as it affects the health reform in my view.

**JoAnn Lamphere:** There are definitely pieces of the health bill, for example, have comparative effectiveness centered in them and their stimulus money therefore it. The House bill, as well, as a health choices commission charged with coming up with quality information and make it public. How you drive performance in medical decisions is kind of a separate question that we have all mentioned, but the baseline is getting the comparative research done and then from there the decision has to be made by providers and consumers together.

**Shannon Brownlee:** This is Shannon Brownlee. Much of this debate has been, to some degree, subterranean. The information that comes out of this kind of research could have really important economic consequences for many medical manufacturers, drug companies, for example, medical device manufacturers, and also providers, hospitals and physicians. It's tremendously important economically for them and so they are keenly interested in this from a policy perspective. At the same time, we had the Institute of Medicine, which is this very

prestigious body that has been spending an enormous amount of time convening groups to define what the priorities are for the huge amount of research that we need to do to be able to get medicine onto firmer scientific footing. So, those two things may be talked about in a peripheral way when we talk about health care reform because mostly were talking about covering anybody and everybody, but they are tremendously important in the debate.

**Stephen Shortell:** I would just add to that -- this is Stephen Shortell -- that one of the keys is the notion of value and increasingly questioning, "Are we getting our money's worth?" As a country, we know we are spending 17% of our GDP, 2.7 trillion dollars, and we know on most of logistics and so forth we are doing very well at all I think what we are going to begin to see in the next eight weeks is more of this issue of, "If this is going to cost us 1 trillion dollars" -- which are some of the estimates currently -- we're going to asking the question of, "What are we getting in return for that and how are we going to pay for it?" That will then begin to build more to the forefront this center for comparative effectiveness to make sure that the incrimination that our doctors and other clinicians and our patients and our consumers have is going to optimize the use of that insurance dollar and the other kinds of dollars that we are going to be investing to make sure that all Americans are covered. I think there are people in Washington that will be working to bring that more into the forefront of some of the discussion has been truth so far.

**Maryann O'Sullivan:** Another question?

**Operator:** Once again, ladies and gentlemen, if you would like to ask a question press the "star" key followed by the "one" key on your touchtone phone now.

[Silence]

**Operator:** It looks like at this time we have no further questions.

**Maryann O'Sullivan:** Okay, great. At 11:30 today we will be having a longer briefing in the capital with Celinda, Dr. Shortell, and Dr. Shoemaker making presentations. That presentation has been moved to room 126. Thank you everyone for joining us.

**Operator:** Thank you Maryann. As we now conclude today's teleconference, you may disconnect.

###