AHIP

America's
Health
Insurance
Plans

SETTING A HIGHER BAR:
WE BELIEVE THERE IS MORE THE NATION CAN DO TO IMPROVE QUALITY AND SAFETY IN HEALTH CARE

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A STRATEGY TO IMPROVE HEALTH CARE QUALITY AND SAFETY

Health care reform is a huge challenge — but not an insurmountable one. Above all, it requires a commitment to act, and a determination on the part of key stakeholders to reconcile differences in pursuit of shared goals.

Acting in that spirit, America's Health Insurance Plans (AHIP) in November 2006 put forward a comprehensive proposal to extend access to health insurance coverage to all Americans. Our plan builds on private and public resources to expand access to health insurance coverage to all children within three years and to 95 percent of adults within ten years.

Expanding access is a vitally important first step. But actions to extend coverage must be accompanied by comparable initiatives to improve the quality and safety of health care. Otherwise consumers will continue to be subject to needless risks and the nation's health care system will continue to run up needless and ultimately unsustainable costs.

AHIP's Board of Directors has accordingly developed a new set of policy initiatives to achieve the twin goals of improved quality and safety. In doing so, AHIP has worked closely with clinicians and other health care stakeholders who share our commitment to creating a health care system capable of providing consistently excellent care and protecting patients against medical errors and other risks.

The policy initiatives described in the following pages are aimed at achieving three broad, interlocking goals:

- Supporting innovation by determining which procedures and technologies are most effective and safe;
- Improving clinical quality by improving dissemination and transparency of information on safety, effectiveness, and performance; and
- Better protecting patients by creating new mechanisms to resolve disputes fast, fairly, and effectively.

We propose a wide range of specific actions to achieve these goals. These include: creating a new entity with the specific mission of comparing health care services and technologies; reforming the Food and Drug Administration (FDA) to improve its ability to assess the long-term safety and effectiveness of new drugs and devices; coordinating dissemination of health services research information; setting a national health care research agenda; strengthening broad-based efforts to provide more actionable information for consumers on health care choices; developing innovative tools to help physicians and patients manage chronic conditions; promoting optimal care by emphasizing coverage of best practices; and enacting meaningful medical liability reform in order to lay the groundwork for a new, nationwide medical dispute resolution system that fairly protects patients and eliminates the runaway costs and risks of defensive medicine, suppression of information about medical errors, and litigation based more on influencing juries than advancing medical science.

We recognize the challenges inherent in building a critical mass of support for the initiatives we propose. We believe, however, that it is our responsibility as health insurance plans — and, for that matter, as health care consumers — to join with other stakeholders in advancing an agenda that will create a health care system that is not only more accessible and affordable but of consistently higher quality and safer than ever before.

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President and Chief Executive Officer, Group Health Cooperative
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President and Chief Executive Officer, AHIP

OUR VISION

In November 2006 the members of America's Health Insurance Plans (AHIP) introduced a comprehensive proposal to extend health insurance coverage to all Americans — because we believe every American should have access to affordable health care coverage.

Now, in 2007, we are proposing a framework for an equally crucial step: ensuring that any serious and sustainable effort to extend coverage is accompanied by significant improvements to the quality and safety of health care.

After several years of rapidly rising health care costs, the growth in health insurance premiums has begun to slow. According to data from the Centers for Medicare and Medicaid Services (CMS), premium growth slowed to 6.6 percent in 2005. It was the third consecutive year that health insurance premium growth has decelerated and it is the slowest rate of growth since 1997. During this same time period, there has been rapid advancement within the private sector that has resulted in new tools and techniques designed to keep health care safe, affordable and of the highest quality. Broader adoption of these private sector initiatives throughout the public sector holds promise to further slow the rise in premiums and improve the health and health status of all Americans. Additional changes must take place system-wide to meet consumer and purchaser expectations for an affordable, high-quality health care system.

This proposal presents a set of recommendations which, if fully implemented, can move the nation toward the day when health care is not only accessible to all Americans but of higher quality than ever before.

The strategies we propose are framed by three broad goals which, if achieved, will drive a transformation of our health care system. These goals are:

- Set a course that will allow our country to support innovation by determining what procedures and technologies are safe and most effective;
- Improve clinical quality through better dissemination and transparency of information on safety, effectiveness, and performance; and
- Better protect patients by resolving disputes in a way that is fair, fast, and effective.

We offer a series of recommendations to achieve these goals, and we urge policymakers and other stakeholders to consider these recommendations as a package. To bring about wholesale change the nation must pursue a comprehensive strategy. Only by addressing the entire range of issues with a coordinated approach can we hope to meet patient and purchaser expectations for a health care system that delivers consistently higher quality care, suffers from far fewer medical errors, promotes clinical practices based on sound evidence, and makes optimal use of health care resources.

OUR PROPOSALS

GOAL 1: Set a course that will allow our country to support innovation by determining what procedures and technologies are safe and most effective.

Scientific evidence – promoting it, requiring it, and relying on it — is the basis for our first goal. Although technological innovation is essential to the advancement of health care, it is also a leading driver of rising health care costs. New drugs, devices, procedures, and biologics are often widely used without sufficient medical evidence of their effectiveness, particularly as compared to other options, and existing treatments are not systematically re-evaluated. As a result, both quality and affordability have suffered. Medical care has become notorious for wide regional and even intra-regional variations in treatments, unacceptable numbers of preventable medical errors, significant underuse of recommended best-practices, and undue reliance on treatments of little or no value. Strengthening the use of scientific evidence throughout the health care system will spur efforts to improve quality and affordability. Failure to achieve this goal, on the other hand, would mean failing to maximize the value and effectiveness of the nation's investment in health care.

RECOMMENDATION: Establish a National Entity to Evaluate New and Existing Health Care Services and Technologies.

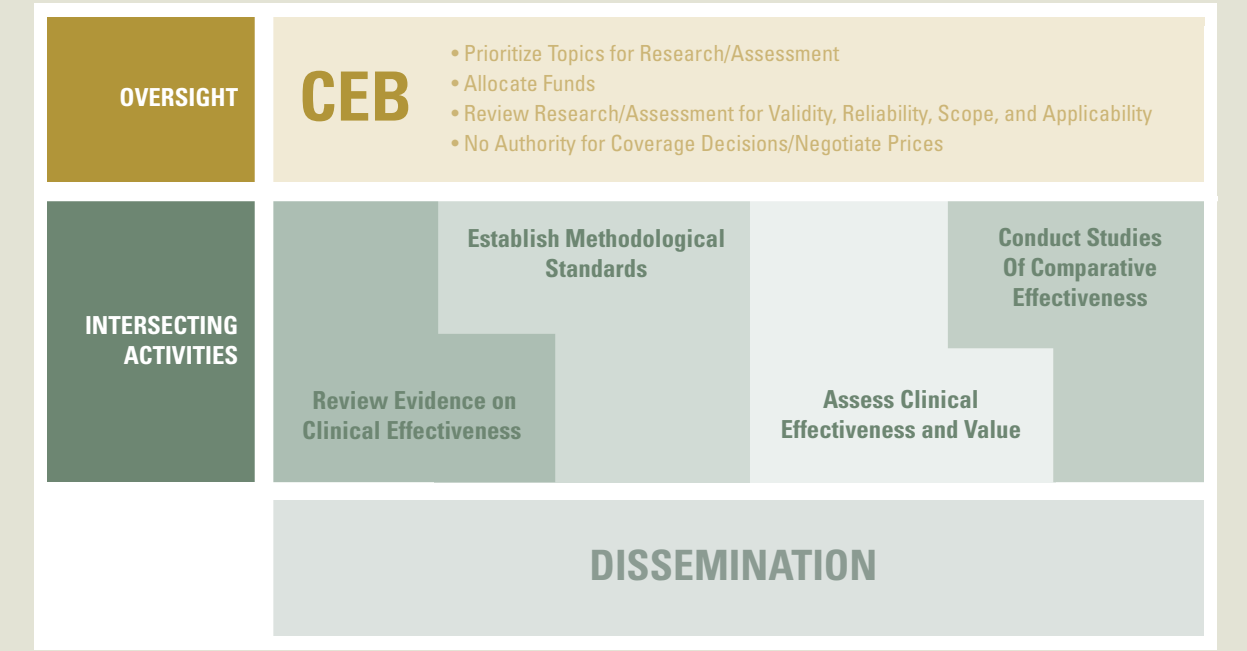
The Food and Drug Administration (FDA) evaluates only the safety and efficacy of new drugs and medical devices, and usually bases its decisions on studies of targeted patient groups. Determining the ability of new drugs and devices, not to mention medical procedures and other technologies, to improve the health of much larger and diverse populations in real-world situations and comparing their use to what is currently being used is not part of the FDA's responsibilities. As a result, there is a significant lack of reliable information about what works best — a gap that helps to raise health care costs while potentially lowering the quality of health care. Despite the clear need to address this issue, the United States is virtually alone among developed nations in not having an entity dedicated to comparing the effectiveness and value of new drugs, devices and medical procedures to those currently being used.

Americans need a trusted source from which they can get up-to-date, objective, and credible information on which health care services are most effective and provide the best value. This new entity (which could be known as a Comparative Effectiveness Board) should be responsible for (1) comparing the clinical and cost-effectiveness of new and existing drugs, devices, procedures, therapies, and other health care services; (2) assessing alternative uses of treatments currently in practice; and (3) distributing this information in a useful format so patients and clinicians can make more informed health care decisions. *See figure on page 4*.

The design of the new entity should be tailored to fit the U.S. health care system. We recommend that the new organization be a public-private partnership, endowed with the scope and credibility to lend significant authority to its findings. The scale of its efforts will require that the new entity be funded through public sources, but supplemented with support from private sources through mechanisms that will provide stability and independence from political pressures.

Patients, practitioners, employers, health plans, and others can all play an important role in supporting the activities of this new entity. They can help identify which health services should be a priority for assessment as well as help distribute and promote the results. Health plans and employers will also have an opportunity to use the information provided by this entity to create innovative ways to reward patients and practitioners for the use of high-value tests and treatments. In the end, better information on effectiveness and value will provide a new basis for a shared approach to improving the quality and affordability of American health care.

POTENTIAL DESIGN FOR A COMPARATIVE EFFECTIVENESS BOARD (CEB)



RECOMMENDATION: Reinforce FDA's Capacity to Assess Long-Term Safety and Effectiveness Of New Drugs.

As the principal federal agency with jurisdiction for approval of new drugs, devices, and biologics, the FDA has a significant role to play in assessing safety and effectiveness. Approaches for improving the FDA's review of new drugs were recently suggested by the Institute of Medicine (IOM) Committee on the Assessment of the U.S. Drug Safety System in its September 2006 report, The Future of Drug Safety: Action Steps for Congress. Our proposal is consistent with many of the IOM's recommendations and also offers new ideas for reforming the FDA to meet 21st century demands.

The law governing approval of new drugs (Prescription Drug User Fee Act) places a priority on increasing the speed of the drug approval process. We recommend that Congress enact specific, post-market safety goals to better balance the need to get new drugs to market quickly with the need for information on long-term drug safety. To further achieve this balance between speedy approvals and post-market safety a portion of the funds collected from drug user fees should be dedicated to safety and effectiveness evaluations once a new drug has been approved for use. Additionally, the FDA's enforcement abilities should be expanded to better enable the agency to require drug manufacturers to make labeling revisions and/or perform additional clinical trials to ensure post-market safety. Health plans and employers can play an important role in integrating the results of these post-market studies by regularly updating their formularies and reimbursement policies to allow for new data that may emerge as a result of these studies.

RECOMMENDATION: Strengthen FDA's Review of Certain Devices and Capacity to Track Device Safety.

The less-stringent 510(k) approval process for certain new devices only requires manufacturers to show that a new device is similar to an existing, approved device and does not raise any new concerns about safety or effectiveness. We recommend that this process be tightened by narrowing the range of medical devices that can be deemed similar and only allowing devices that represent truly insignificant changes to previously approved devices to use the 510(k) process. All other devices should be evaluated through the same rigorous process that is used for new drug approvals.

Additionally, there should be a "unique device identification system" that marks each device with its own unique identifier. Such a system would greatly improve the FDA's ability to track the safety and performance of medical devices and would make tracking far easier for devices that have been recalled.

GOAL 2: Improve clinical quality through better dissemination, transparency, and use of information on safety, effectiveness and performance.

Generating and appraising medical evidence and information on what works best will take us only part of the way toward quality improvement. We must also create better ways to put the best available information into the hands of those who need it in a way that will lead to real system and behavioral change by improving physician practices and engaging patients. We can bridge the gap between what we know works and actual medical practice by requiring and supporting a more coordinated approach — linking research on what works, what works best, and what yields the best value for patients and purchasers — and advancing explicit recommendations of best practices in caring for patients with particular conditions.

RECOMMENDATION: Coordinate Dissemination of Health Services Research Conducted Across Federal Agencies.

To highlight how to get the best outcomes from the latest medical evidence, we need to streamline the way practitioners and patients retrieve information. We recommend that a single entity be charged with coordinating and making public available information on clinical best practices. The Department of Health and Human Services (HHS) should take specific steps to promote the coordination of the health services research conducted across Agency for Healthcare Research and Quality (AHRQ), National Institutes of Health (NIH), Centers for Disease Control and Prevention (CDC), and other federal agencies. HHS should construct a web-based approach for retrieving findings from the latest medical studies, develop fact sheets for patients explaining the results and implications for patient care in easy to understand language, and suggest how physician practices can adopt these findings. Health plans can maximize this effort by helping to disseminate available information on best practices to providers through their respective websites, sending alerts or timely information to providers regarding recalls or breakthroughs through electronic health records, linking providers to the newly-created HHS website, and communicating patient-friendly information through electronic personal health records. Information provided to patients can highlight the latest improvements in care and be personalized so that patients with cardiac conditions, for example, can be made aware of the latest research on controlling cholesterol levels.

Similarly, coordination of research demonstrating the value of prevention and health improvement activities, in particular, may help patients assume greater personal responsibility for their own health. The employer community will benefit from easily accessible information on the return on investment (ROI) of these programs that address employee and community health and contribute to a more productive and satisfied workforce. Health plans can help integrate the research findings into practice by assisting with the dissemination of those strategies found to be effective to patients, practitioners, and employers.

RECOMMENDATION: Set a National Research Agenda that Addresses Known Gaps in Evidence and Make Communication Regarding Ongoing Research Studies a National Priority.

Given that gaps in evidence can lead to variations in medical practice and put patients at risk, identifying areas that need further research is as important as coordinating the dissemination of results and conducting studies on comparative effectiveness. As part of its role in coordinating health services research across the federal agencies, HHS should also prioritize a research agenda that addresses known gaps in evidence and safety. In this new role, HHS, in collaboration with the comparative effectiveness entity recommended under Goal 1, can help ensure that research is conducted in areas that currently lack sufficient research findings yet have the potential to significantly improve patient outcomes.

In addition to identifying and promoting research in these priority areas, HHS' role should include enhanced communication with the public regarding those studies underway to address these priority areas. Such public information will advise both consumers and providers of the lack of reliable evidence on these conditions or treatment protocols, and provide the ability to track this information throughout the study period.

Similar to the website created at the National Cancer Institute to highlight the current cancer clinical trials that are underway and provide information on patient eligibility, trial protocols, and the current status of the trial, HHS could, for example, coordinate the release of public information on any post-marketing approval studies — studies conducted after FDA approval of drugs, devices, and biologics — currently under-way, the goal for such studies, and expected completion dates.

RECOMMENDATION: Give Consumers Actionable Information to Make Decisions Based on Value.

In the majority of U.S. economic markets, entities compete on the basis of price and quality, and consumers make their decisions based on reliable, accurate information. For a variety of reasons, this has never been the case in the health care market. Instead, many consumers, having little other information to go on, tend to equate higher costs with higher quality — although this is often not the case. In recognition of this problem, the IOM in its 2001 report, Crossing the Quality Chasm, stressed that transparency should be a key element of any strategy to improve clinical quality and achieve better value in the health care system. A health care marketplace that empowers consumers to make informed choices based on both cost and quality will result in a health care system that offers improved value to consumers and encourages innovation and continued evolution.

The private sector has led the way in developing a uniform approach for the disclosure of relevant, useful, understandable, and actionable information to facilitate consumer decision-making. Key stakeholders across different disciplines including health plans, physicians, hospitals, consumers, and employers — have convened broad-based, national alliances (AQA and HQA) to determine a more effective strategy for measuring, reporting, and improving physician and hospital performance. In an effort to eliminate duplicative efforts to measure and report on performance, AQA has launched a pilot project in six sites across the country that would combine public and private sector data to measure and report on physician-level practice. The private sector has also begun building the capacity to analyze certain agreed-upon episodes of care (e.g., pregnancy), in addition to specific services (e.g., labor and delivery), to allow consumers to make more comprehensive and informed assessments. This comprehensive approach being undertaken by the private sector to promote better assessments of performance will make it far easier to identify opportunities for quality improvement and result in valid and consistent measures of quality and efficiency that can be used to improve care throughout the health care system.

We recommend that the federal government embark on an effort parallel to that being undertaken in the private sector to implement a uniform strategy to measure and report on physician and hospital performance within public programs. Only by improving performance assessment and making the results of those assessments available to consumers in both the private and public sectors can we achieve system-wide improvement.

RECOMMENDATION: Encourage the Development and Use of Tools to Improve Health Care Quality.

Health plans have made significant progress in managing chronic conditions to achieve better health outcomes. Moreover, because a high proportion of health care costs are incurred by a small percentage of patients with multiple chronic conditions, disease and care management programs have been successful, not only in improving patients' health, but also in significantly impacting health care costs. Health plans and employers are continually exploring opportunities to extend the range and effectiveness of disease and care management programs, so that patients, many with multiple chronic conditions, can take full advantage of the improved health and savings associated with these programs.

Health plans are uniquely positioned to identify and reach out to high risk individuals — such as those with one or more chronic conditions — through their use of a new generation of health risk assessments. Today, health risk assessments are providing patients, practitioners, and health plans with customized tools that engage consumers, help change behavior, and improve care. Not only do new health risk assessment tools provide improved methods for assessing "baseline health," but they also offer follow-up programs for consumers to address potential health problems. Particularly when used in conjunction with personal health records, these proactive programs offer information, guidance and support by encouraging patient self-management, improving provider management of chronic conditions, increasing the use of preventive care, tracking personal progress, monitoring potential medication interactions, and offering consumers financial incentives — including differential cost-sharing where co-payments may be waived for use of chronic care maintenance drugs or certain preventive care services. Moreover, giving consumers access to their personal health information can help reduce preventable medical errors, inefficient and inappropriate care, and duplication of tests and procedures, as well as result in more productive interactions between providers and patients.

Given the proven effectiveness of these tools to manage chronic conditions and improve health outcomes, we recommend not only broader adoption within the health plan community, but also enhanced use of these tools by the provider community in reaching treatment decisions at the point of care. Recognizing the benefits personal health records (PHRs) offer both to consumers and providers, the health plan community has developed a model PHR to enable individual patients and their providers secure, timely access to important health information, such as allergies, medications, and patient history. *See figure on page 8*. Health plan use of this model PHR will ensure that PHRs will be portable, enabling patients to easily transfer their PHR data when they change coverage and facilitating broader adoption among the provider community. Particularly as we move toward a health care system that will increasingly rely on electronic health records, providers will have real-time access to patient-specific information that will better enable them to make treatment decisions consistent with the latest medical evidence and the specific needs of the patient. The support for and use of these tools to manage chronic conditions and improve health outcomes at the individual provider and provider group level is essential to achieving system-wide improvement.

HEALTHTRACKS: A PARTNERSHIP FOR ELECTRONIC PERSONAL HEALTH RECORDS (*Sample*)

My Personal Health Summary: Jane Doe

Share this summary of your health with any new doctor or specialist. It can be an easy reference when you are filling out forms.

My Personal Information

Name:	Jane Doe
Address:	111 Maple St, Boston, MA 02215
Date of Birth:	6/12/57
Marital Status:	Married
Preferred Phone Number:	617-555-1934
Alternate Phone Number:	617-555-2167
E-Mail:	jane@gmail.com
Height:	5’ 2”
Weight:	130
Blood Type:	A-
Preferred Language:	English

My Emergency Information

Emergency Contact:	
Emergency Contact Name:	John Doe
Relationship:	Spouse
Emergency Contact Phone Number:	617-555-1245
Emergency Contact Alternate Phone Number:	617-555-2167
Advance Directive:	
Organ Donor:	Yes

My Insurance Information

Insurance #1:	
Insurance Name:	ABC Insurance

RECOMMENDATION: Promote the Delivery of Quality Care Through Coverage of Best Practices.

Health plans have adopted a range of strategies designed to encourage evidence-based decision-making. In addition to updating coverage policies to reflect scientific findings on effectiveness and value, health plans routinely provide information to patients encouraging them to take advantage of preventive benefits supported by medical evidence. Additionally, health plans provide feedback to individual practitioners about their performance and offer incentives for practicing medicine consistent with medical evidence.

In addition to improving the availability of best practices, a modernization of public coverage standards and reimbursement policies should be encouraged. For example, because of its tremendous influence on the adoption of health care technologies and treatments, CMS should be given explicit authority by Congress to use available data on comparative effectiveness and cost-effectiveness in determining its coverage policies. Similarly, CMS should be empowered to set its reimbursement rates for new technologies more in alignment with the added (or marginal) value of a new technology over established alternatives. Parallel efforts by other federal agencies that have a role in establishing coverage policy, such as the Department of Veterans Affairs and the Office of Personnel Management, as well as by state agencies responsible for administering state Medicaid programs, should also be considered.

In addition to a modernization of state Medicaid coverage and reimbursement policies, state enactment of coverage mandates must be addressed. A number of states have enacted laws requiring the systematic review of benefit mandates and the extent to which such mandates are consistent with medical evidence. By nature, a mandate is static and unable to reflect changes in the practice of medicine that may make the mandate obsolete or even harmful to patients. Yet, should mandates persist, we recommend continued establishment and use of independent state advisory bodies to evaluate their consistency with the latest medical evidence.

Continued health plan leadership in updating coverage policies to reflect scientific findings on effectiveness and value and designing reimbursement systems that include incentives for providers who practice in accordance with recognized best practices will improve medical practice nationwide.

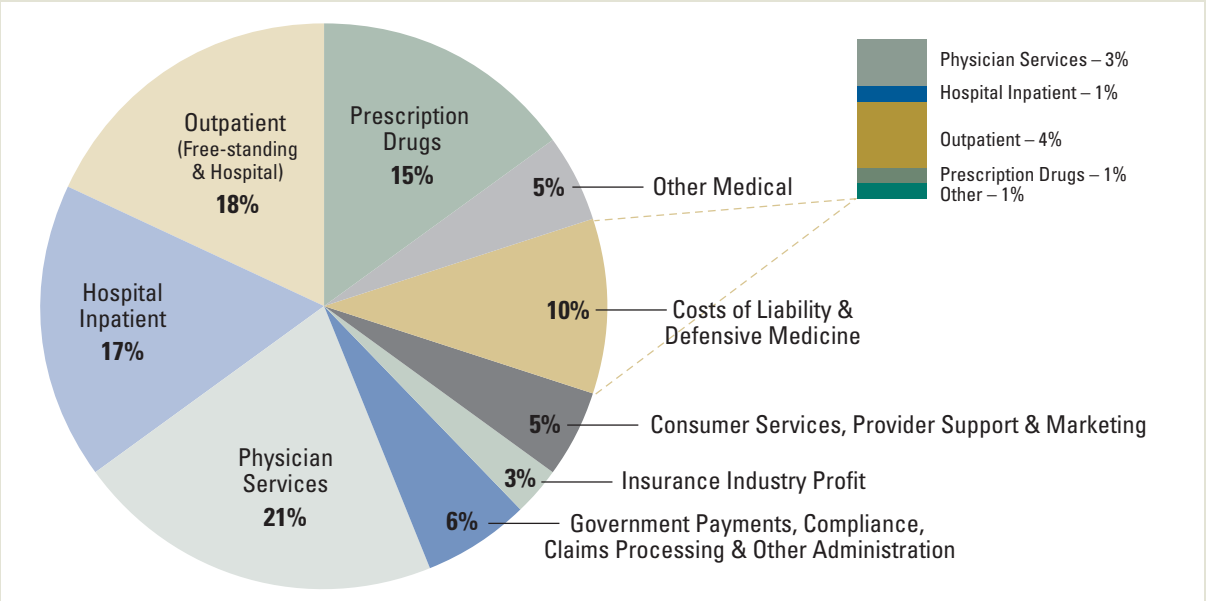
GOAL 3: Better protect patients by resolving disputes in a way that is fair, fast and effective.

The adverse impact of the legal system on the delivery of health care cannot be overstated. The current tort system is not only enormously costly, time-consuming, and ineffective for patients; more critically, it is a threat to patient safety and quality. Too often, medical practice driven by the fear of litigation is an unfortunate substitute for evidence-based medicine, resulting in billions of dollars worth of tests and procedures deemed medically unnecessary but ordered nonetheless to avert potential lawsuits. Fear of litigation also has a chilling effect on the sharing of information among health care professionals that would improve patient safety.

The costs of medical liability for patients and the overall health care system have been well-documented. A 2006 Tillinghast-Towers Perrin report found that the direct costs of the medical liability system totaled $29.4 billion in 2005, excluding the cost of defensive medicine. The HHS estimated in 2003 that the system-wide costs of defensive medicine may exceed $120 billion. These costs have a direct impact on health insurance premiums. A PricewaterhouseCoopers analysis of how health insurance premiums are spent found that a full 10 cents of every premium dollar is spent on medical liability and defensive medicine. *See figure below.*

There is a better way to resolve claims of medical negligence and to compensate patients who suffer injuries as a result of malicious or incompetent medical practice. Bold reform is needed to both undo the damage done by the current system and to advance improved health care quality and affordability.

ESTIMATED BREAKDOWN OF INSURANCE PREMIUMS WITH MEDICAL LIABILITY AND DEFENSIVE MEDICINE EXTRACTED, 2005



Source: *The Factors Fueling Rising Healthcare Costs 2006*; PricewaterhouseCoopers; January 2006

RECOMMENDATION: As a First Step, Enact Meaningful Medical Liability Reform in 50 States.

The tort system can be improved upon in the short term by enacting a series of reforms that help address the flaws of the current system. These flaws include: patients are not fairly compensated; disputes are not resolved quickly; health care quality is adversely affected; and inappropriate behavior is not deterred. We recommend a package of short-term reforms addressing four main areas of concern.

First, we recommend that the use of evidence-based medical standards should be admissible in all judicial or administrative proceedings, including medical liability cases, external review, and administrative hearings. Additionally, physicians and health insurance plans should be deemed to have acted appropriately or within the standard of care if they can demonstrate that their actions are in accordance with relevant, evidence-based medical standards.

Second, to ensure that all medical liability claims are medically-grounded and sound, new cases should be reviewed by an objective expert panel before they can be filed in court. This process — which will screen out frivolous lawsuits as well as claims which are supported by expert testimony that is only hypothetical and not based on scientific evidence — could be modeled after the independent external review process that is now used in some states to review coverage determinations.

Third, states should enact programs which promote the use of early-offer settlements granting immunity from tort liability to providers who make settlement offers acceptable to injured patients and agree to pay reasonable compensation within specified timeframes. Early-offer settlements would resolve disputes expeditiously and avoid costly trials.

And fourth, other improvements common to states that have enacted tort liability reforms — including the elimination of joint liability as well as the creation of caps on liability and/or limits on non-economic damages and attorneys' fees — should be given priority consideration in those states that have not yet enacted them. While the majority of states have enacted some form of tort reform, one-third of states have no limits on non-economic damages and even more have not capped attorneys' fees and eliminated joint liability. These reforms would reduce defensive medicine and improve patient safety by better encouraging physicians to report medical errors.

RECOMMENDATION: Replace the Current Medical Liability System With a New Approach That Would Fairly and Quickly Resolve Patient Complaints While Supporting Quality Care.

In the long term, we believe that the current medical liability system should be replaced by a new dispute resolution process which would more fairly and promptly resolve patient complaints and significantly reduce the number of lawsuits filed against physicians, other healthcare professionals, hospitals, and, in some cases, health insurance plans. An independent third-party review process would provide fair compensation and quick resolution of disputes while promoting health care quality nationwide through reliance on evidence-based medicine.

We recommend that states establish demonstration programs to test newly-created Medical Dispute Resolution Boards (MDRBs), which would review claims and compensate eligible claimants based on schedules. MDRBs would have jurisdiction over medical treatment disputes that patients have with physicians, other health professionals, and hospitals. They could also be given jurisdiction over liability claims against health plans for provider negligence and credentialing, as well as coverage disputes between patients and non-ERISA plans.

To help ensure consistency and fairness, all MDRBs should have a uniform structure and common rules. In order to receive compensation, claimants would have to demonstrate negligence on the part of a provider or plan. MDRBs would be required to use evidence-based standards to resolve clinical practice questions. Strict timeframes for completing reviews and rules for selecting members would be established as well as an appeal option for claimants w ho disagree with an MDRB's decision. In cases where compensation is awarded, limits on non-economic damages would be set by an independent body consisting of experts in the field.

MEDICAL LIABILITY REFORM

Short-Term Strategy

Enact or promote the following reforms:

- Physicians and health insurance plans are deemed to have acted appropriately if actions are in accordance with evidence-based medicine standards;
- Screening processes to eliminate frivolous lawsuits and claims not grounded in science;
- Early offer settlements granting immunity from tort liability to providers who make settlement offers acceptable to injured patients and agree to pay reasonable compensation within specified timeframes; and
- Conventional reforms, such as limits on non-economic damages and attorneys' fees.

Long-Term Strategy

Replace the current tort system with state Medical Dispute Resolution Boards:

- Independent, third party process to review claims
- Reviewers to use evidence-based medicine standards to improve quality
- Fair compensation based on scheduled damages
- Quick resolution of disputes
- Reporting to patient safety organizations, state medical boards and other agencies to improve patient safety

MDRBs would have the authority to disclose relevant information to and work with existing patient safety organizations and state medical boards and other appropriate agencies. The private sector can assist by also reporting to patient safety organizations and by educating consumers on the value of the Medical Dispute Resolution Boards. This type of collaboration among key stakeholders would create an integrated, comprehensive information system which would further the goal of reducing medical errors and adverse events.

CONCLUSION

We believe that the goals and recommendations outlined in this report are practical and realistic. We urge policymakers and other health care stakeholders to join us in advancing from vision to action and accomplishment. Working together, we can make our health care system the best in the world — at a cost we can all afford.

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