

## Colorado Medical Society

Report of: Colorado Medical Society Physicians' Congress for Health Care Reform

Subject: Progress Report and Recommendations

Referred to: CMS Board of Directors

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1 Over the last four years the Colorado Medical Society (CMS) Physicians' Congress  
2 for Health Care Reform has engaged physicians across the state in a broad-based  
3 strategy to develop consensus on policies to provide safe, quality cost-effective care  
4 to all Coloradans. This strategy has been instrumental in keeping the profession  
5 engaged in the rapidly evolving health care reform debate at both the state and  
6 federal level.

7  
8 In 2006 the CMS House of Delegates (HOD) approved new guiding principles for  
9 health care reform. From these guiding principles, the Physicians' Congress  
10 developed and the House approved the Evaluation Matrix in 2007. The matrix is  
11 composed of 71 detailed policy criteria and serves as a policy diagnostic tool to  
12 evaluate the pros and cons of reform proposals.

13  
14 During the 2008 Annual Meeting, the CMS House of Delegates directed the  
15 Physicians' Congress to:

- 16 I. Support Governor Ritter's leadership on health care reform policy, including  
17 the Building Blocks I and II efforts as initial steps towards achieving his  
18 Colorado Promise to end the state's crisis of the uninsured and underinsured.
- 19 II. Develop a comprehensive health care plan, based upon the evaluation matrix,  
20 which can be pursued if Governor Ritter's Building Blocks for Health Care  
21 Reform falter.
- 22 III. Develop recommendations on how better to organize systems of care in  
23 Colorado in order to improve quality and reduce cost growth.

24  
25 This report is divided into three sections, which detail progress over the past year  
26 and offer recommendations that will continue to position Colorado physicians in the  
27 evolving debate. The Physicians' Congress strongly believes that health care reform  
28 remain a high priority for the Colorado Medical Society.

### 29 30 I. Building Blocks for Health Care Reform

31 Governor Ritter's Building Blocks for Health Care Reform operationalize the health  
32 care component of the his Colorado Promise. This package of initiatives builds off of  
33 the SB208 Commission recommendations in a strategy to implement comprehensive  
34 health care reform in stages rather than all at once. A complete report from Governor  
35 Ritter on progress over the past year on his Building Blocks for Health Care Reform

1 can be found on **PAGE XXX**. Governor Ritter is expected to announce plans for the  
2 next phase of his Building Blocks for Health Care Reform at the 2009 Annual  
3 Meeting of the CMS House of Delegates.

#### 4 5 **Recommendations**

- 6 1. Congratulate the Governor on his leadership on the first two phases of the  
7 Building Blocks for Health Care Reform.
- 8 2. Consider the next phase of the Building Blocks for Health Care Reform as a  
9 means to achieve comprehensive health care reform for Colorado.

#### 10 11 12 **II. Matrix reform plan**

13 The Physicians' Congress convened the Matrix Reform Plan Work Group to develop  
14 an outline of a universal health care plan based upon the Evaluation Matrix that  
15 includes a public/private mix of payers, increases regulation of the insurance  
16 industry, and is accountable to communities and patients rather than to  
17 shareholders. The work group created the superstructure assumptions of a  
18 comprehensive health care reform plan and the Physicians' Congress refined and  
19 approved it.

20  
21 The following recommendations are purposefully silent on the financing mechanism  
22 for a new system. The Physicians' Congress believes that its expertise and  
23 leadership lies in improving the delivery system. While there are likely a number of  
24 financing scenarios that are well suited for meaningful reform, the Physicians'  
25 Congress believes that the present system of financing is incompatible with either  
26 continued sustainability or affordability. The group concludes that some mix of public  
27 and private financing will be needed to achieve the goals of the proposed delivery  
28 system reform. The details of that financing system should be debated by society as  
29 a whole, with participation by physicians, as deliberated by our elected  
30 representatives. The Physicians' Congress believes that no matter the mechanism of  
31 financing, systems must be accountable, equitable, affordable and sustainable.  
32 Reform of the system should not only include delivery system redesign including  
33 accountable care organizations, but also accountable financing organizations.

#### 34 35 **Recommendation**

36 Approve the following as an outline of a basic, universal health plan that could  
37 provide medical, mental and dental care for all Coloradans that could be  
38 implemented in the event that other reform efforts fail to achieve CMS' strategic  
39 objectives for health care reform. The proposed plan for Colorado would:

- 40  
41 1. Universal health care
  - 42 • Include tiered public support for individuals based upon sliding scale income  
43 levels.

- 1 • Provide universal access to a community rated basic benefit package,  
2 provided on a guaranteed issue basis.
- 3 • Require individuals to have health insurance coverage.
- 4 • Allow consumers to purchase additional benefits above the basic package if  
5 they choose to, but everyone would have access to the basic package.
- 6 • Allow and incentivize employers to participate voluntarily by providing  
7 coverage for employees, with discounts for health maintenance and risk  
8 reduction programs.
- 9 • Provide a basic benefit plan that would be uniform and uniformly administered  
10 across all beneficiaries and payment sources.
- 11
- 12 2. Cost containment and improved outcomes
- 13 • Ensure open and transparent access to all data so that unwarranted variation  
14 in overuse, underuse and misuse of health care services can be identified and  
15 addressed.
- 16 • Provide physicians with actionable, relevant and trustworthy data to improve  
17 outcomes in health quality and costs.
- 18 • Decrease the administrative costs associated with utilization quality  
19 management.
- 20 • Explicitly monitor and evaluate conflict of interest issues related to  
21 unwarranted variation in care.
- 22
- 23 3. Payment reform
- 24 • Utilize incentives to encourage the provision of primary care and the delivery  
25 of care in underserved areas.
- 26 • Utilize alternative payment models to maximize transparency and value in the  
27 system.
- 28
- 29 4. Interoperable exchange of data that is patient centric
- 30 • Require all stakeholders to fund and participate in the development and  
31 usage of interoperable health information systems.
- 32
- 33 5. System for addressing adverse events, accountability and compensation
- 34 • Utilize non-tort based system that separates compensation for medical injury  
35 from a finding of medical negligence, thus facilitating system changes to  
36 enhance patient safety.
- 37
- 38 6. Medical education reform and financial support for students choosing health  
39 careers
- 40 • Place greater emphasis on primary care and training principles that highlight  
41 patient safety, comparative effectiveness, chronic care management, end of  
42 life care and outcomes improvement.
- 43
- 44 7. Shared accountability and personal responsibility

- 1       • Align accountability with responsibility by all stakeholders and provide  
2       incentives for healthy behaviors.  
3
- 4   8. Systems of care and patient-centered medical home
- 5       • Support the development of systems of care, specifically patient-centered  
6       medical homes, and encourage the development of organizations that are  
7       accountable to local communities for the continuum of patient care, including  
8       outcomes, quality, service and costs.  
9
- 10  9. End of life guidelines
- 11       • Incentivize and require increased utilization of hospice services, living wills,  
12       advanced directives and care guidelines.  
13
- 14  10. Oversight and Governance
- 15       • Utilize an independent governing board, appointed by the Governor and the  
16       legislature, to oversee all aspects of the universal health care plan including:  
17       ○ Creating a uniform, robust basic plan that is available to everyone and  
18       ensuring that additional coverage for non-covered benefits would be sold  
19       on a competitive basis.  
20       ○ Establishing mechanism to address adverse risk selection by plan  
21       administrators.  
22       ○ Requiring all data holders to provide cost and quality information to permit  
23       the delivery systems to measure and improve performance.  
24       ○ Designing incentives to encourage and enforce community collaboration.  
25       ○ Overseeing the mechanism to reinvest proceeds into the communities.  
26       ○ Monitoring and regulating the utilization of self-owned facilities.  
27       ○ Encouraging and incentivizing the development of community-based, not-  
28       for-profit accountable care organizations.  
29  
30

### 31 III. Systems of care

32 The Physicians' Congress agrees with leading national, state and local policymakers  
33 that health care reform and efforts to expand coverage will likely be unsuccessful  
34 and unsustainable unless the value of care is improved, with value defined as quality  
35 divided by cost over time, and with quality including outcomes, safety and service.<sup>i,ii</sup>  
36 Achieving that goal requires systemic changes in the way care is delivered through  
37 better integration and collaboration, as the SB208 Commission's Provider Task  
38 Force called it, by "creating greater systemness."<sup>iii</sup>  
39

40 The Physicians' Congress created the Systems of Care Work Group to define how  
41 the physician community can accelerate the transformation of the delivery system  
42 proactively. The work group developed a report that was refined and approved by  
43 the full Physicians' Congress. The following recommendations are the result of  
44 lengthy deliberations on the merits of comprehensive (which necessitates significant

1 disruption) versus incremental health care reform. The Physicians' Congress  
2 acknowledges that while some of the ideas contemplated here are bold, others may  
3 believe they do not go far enough. Polling of a majority Colorado physicians and the  
4 general public shows what is clear to the Physicians' Congress: the status quo is not  
5 acceptable and the profession must continue to lead efforts to reform the system.  
6

7 The following integrated set of recommendations represents changes that the  
8 Physicians' Congress believes can be acted upon immediately to improve health  
9 outcomes and value in health care. The recommendations also provide an  
10 opportunity to advance reform efforts already underway in Colorado and provide  
11 direction for long-term change.  
12

13 Since 2001 with the publication of the seminal report *Crossing the Quality Chasm*,  
14 the Institute of Medicine (IOM) has argued for system redesign on four levels: 1)  
15 aims, 2) patient care processes known as clinical "microsystems," 3) health care  
16 organizations and 4) environmental factors including payment, regulatory, legal and  
17 educational systems.<sup>iv</sup> While the Physicians' Congress recognizes that reform must  
18 occur on multiple levels given the complexity of the system, the recommendations in  
19 this report concentrate on clinical microsystems. This focus is intentional, as the  
20 group believes that physicians can play a meaningful role in advancing reform on  
21 other fronts by starting first where they live and work every day—in the exam room  
22 and at the patient's bedside. The microsystem is the ground on which physicians  
23 have the most standing in the health care reform debate.  
24

#### 25 Professionalism and the care covenant

26 Professionalism in the practice of medicine is under assault because of the current  
27 structure and incentives of the health care system. High visibility media stories like  
28 the recent *New Yorker* article by Atul Gawande, MD,<sup>v</sup> are spotlighting what some  
29 experts are calling "the battle for the soul of medicine." As health care reform  
30 advances, it is important for physicians to recommit to the patients and the society  
31 they serve in order to help lead the necessary change at the microsystem level.  
32

#### 33 **Recommendation**

34 CMS urges all physicians to adopt or reaffirm the following day-to-day operating  
35 philosophy relating to patient care:  
36

37 *The patient's needs come first and as a physician I am a member of a care*  
38 *team committed to meet those needs.*  
39

#### 40 Triple Aim

41 The CMS Evaluation Matrix provides a Colorado physician-specific approach to  
42 reorganizing the health care system. The Physicians' Congress reaffirms the criteria  
43 within the matrix and recognizes the work of the Institute for Health Care  
44 Improvement (IHI), a non-profit organization based in Massachusetts, and how it

1 supports the approach outlined in the Evaluation Matrix. The institute has created an  
2 initiative known as the Triple Aim that seeks to:

- 3 1) Improve the individual experience of care;
- 4 2) Improve the health of the population; and
- 5 3) Reduce per capita costs of care for populations.<sup>vi</sup>

6 Optimizing and balancing performance on these three dimensions requires  
7 sustained, strategic effort and movement beyond individual self interest because the  
8 current system is structured to meet perhaps one or possibly two of the aims, but not  
9 all three.<sup>vii</sup>

## 10 11 **Recommendation**

12 Embrace the IHI Triple Aim as a conceptual framework to integrate and reinforce the  
13 principles and criteria within the Evaluation Matrix.

### 14 15 Attributes of Systemness

16 The Evaluation Matrix also envisions key components or attributes of a redesigned  
17 delivery system. The Physicians' Congress believes that the following list of system  
18 attributes, refined from one created by the Commonwealth Fund Commission on  
19 High Performance Health System,<sup>viii</sup> effectively summarize key components of the  
20 Evaluation Matrix and serve as a succinct, starting point to define success for a  
21 better performing the delivery system:

- 22 1) Patients' clinically relevant information is available to all providers at the point  
23 of care and to patients through electronic information systems.
- 24 2) Patient care is coordinated among multiple providers and transitions across  
25 care settings are actively managed.
- 26 3) Providers both within and across settings have accountability to each other,  
27 review each others' work and collaborate to reliably deliver high-quality, high-  
28 value care.
- 29 4) Patients have easy access to appropriate care and information; there are  
30 multiple points of entry to the system; and patients are treated with dignity,  
31 respect and responsiveness to their needs.
- 32 5) There is clear, shared accountability across the spectrum of patient care.
- 33 6) The system is continuously innovating and learning in order to improve the  
34 safety, quality, value and patients' experiences of health care delivery.
- 35 7) Patients are supported in their ability to carry out the care plan, including  
36 actively participating in the management of their health information.

### 37 38 Integration, coordination and organization

39 Sustainable health care reform must be anchored at every level in the delivery  
40 system. The Physicians' Congress believes that physicians must focus their  
41 individual and collective leadership at the microsystem level to improve health  
42 outcomes and lower costs by driving better integration, coordination and  
43 organization. Reform at this level can be divided into three categories: 1) structural  
44 changes, 2) enabling tools and 3) payment changes.<sup>ix</sup>

1  
2 *Structural changes*

3 I. Reduce unwarranted variations in care

4 Misuse, underuse or overuse drives up unreliability and costs. Ample  
5 evidence shows that more care does not translate into better care. In fact the  
6 opposite has been shown to occur.<sup>x,xi</sup> While Colorado generally fares well in  
7 Medicare per capita spending (with parts of the state like Grand Junction  
8 serving as national models), more can be done to improve health outcomes  
9 and contain costs by reducing variations in care. Targeting overuse, or so-  
10 called “supply sensitive services,” is a priority.

11  
12 **Recommendation** – Strive to provide appropriate care for every patient every  
13 time by reducing extraneous services or treatments including: unwarranted or  
14 unnecessary procedures and consultations; inappropriate medication use;  
15 unnecessary lab and diagnostic tests; inappropriate end of life care; and  
16 potentially harmful preventive services with no plausible benefit.

17  
18 II. Strong primary care-based system

19 Evidence shows that a health care system with a strong primary care base  
20 produces better outcomes, higher quality care at a lower cost. This is  
21 enhanced when that care can be coordinated through a medical home. The  
22 CMS currently has a grant from the Colorado Health Foundation to promote  
23 and educate physicians about the medical home and other systems of care  
24 models.

25  
26 **Recommendation** – Promote the development and maintenance of a strong  
27 primary care base in the health care system to provide appropriate access to  
28 quality, safe and coordinated patient care.

29  
30 III. Improve coordination of care and teamwork

31 Poorly coordinated care creates errors, higher costs and more pain and  
32 aggravation for patients and physicians. Substantial improvement at every  
33 level of the delivery system occurs when care is consistently coordinated  
34 across conditions, service and settings over time to help patients manage  
35 their health and health care (otherwise known as patient activation).  
36 Improving communication and coaching between and among care team  
37 members is a place to start.

38  
39 **Recommendation** – Develop, promote and utilize physician-to-physician and  
40 physician-to-other provider agreements (compacts), and patient activation  
41 techniques that establish minimum guidelines for communication and  
42 coaching regarding optimal patient care transitions.

43  
44 IV. Improve patient safety

1 Despite laudable efforts on many fronts to discover processes to reduce  
2 hazards in patient care, there remain enormous opportunities to improve  
3 patient safety. This pursuit is perhaps the most critical and readily actionable  
4 challenge in health care reform.

5  
6 **Recommendations –**

- 7 1) Establish leadership structures and systems to ensure that there is  
8 organization-wide accountability for gaps in safety.<sup>xii</sup>  
9 2) Embed safety into Colorado's health care culture by addressing the  
10 following:  
11 a) The education of both consumers and providers of health care  
12 regarding the importance of efforts to assure patient safety;  
13 b) The identification of and access to specific patient safety tools that are  
14 appropriately tailored to each participant in the health care system; and  
15 c) The removal of legal, regulatory and procedural impediments to the  
16 use of patient safety tools.  
17 3) Establish mechanisms for community-wide coordination of care when  
18 patients are transitioned between providers of care.  
19 4) Foster the creation and maintenance of patient safety organization(s).  
20 5) Explore alternatives to the current medical liability system that foster  
21 transparency and accountability.

22  
23 **V. Patient engagement**

24 The patient is the key stakeholder in the health care system and can be a  
25 powerful driver of cost-effective, quality health care. Informed patient choice  
26 models using decision aids (e.g. booklets, web applications, videos, audio-  
27 guided workbooks) that allow the patient and physician to make decisions  
28 together about care options, values and patient preferences have been shown  
29 to be effective.<sup>xiii</sup> Improving value in health care requires committed action to  
30 produce informed, activated patients who will understand, demand and  
31 choose higher quality health care.<sup>xiv</sup>

32  
33 **Recommendations –**

- 34 1) Facilitate shared-decision making with patients by utilizing patient decision  
35 aids and advocating for policy changes to utilize informed patient decision-  
36 making models.  
37 2) Incorporate patients within the administrative and management functions  
38 throughout the care system.  
39 3) Facilitate patient management of their health information.  
40 4) Facilitate health literacy.  
41 5) Facilitate healthy behaviors.

42  
43 **VI. Redesigned approach to end of life**

44 Thirty percent of Medicare expenditures are attributable to 5% of beneficiaries

1 who die each year.<sup>xv</sup> Most of these costs result from life-prolonging care (e.g.  
2 mechanical ventilator use and resuscitation attempts), with acute care in the  
3 final 30 days of life accounting for 78% of costs incurred in the final year of  
4 life. These costs are substantially higher for racial and ethnic minorities.<sup>xvi</sup>  
5 Unwarranted life-prolonging care at end of life results in both patient and  
6 family suffering. Evidence-based palliative care must be more fully integrated  
7 into the delivery system.

8  
9

**Recommendations –**

- 10 1) Facilitate close coordination and partnerships between palliative care and  
11 hospice programs from diagnosis to the end stages of an illness across  
12 the continuum of care settings and living situations.
- 13 2) Ensure that palliative care is provided in a culturally sensitive, appropriate,  
14 and understandable manner to facilitate the comprehension of the  
15 condition and realistic potential of treatment options.
- 16 3) Ensure that palliative care is available at the same time as disease-  
17 modifying therapy in acute care, ambulatory care and community-based  
18 settings.
- 19 4) Support legislative efforts that will provide adequate protections for  
20 providers for following patient wishes. (MOLST – Medical Orders for Life-  
21 Sustaining Treatment)
- 22 5) Ensure that health care providers throughout the state have adequate  
23 generalist-level palliative care knowledge and have access to specialist-  
24 level palliative care expertise.

25

26 VII. Accountable care organizations

27

Fragmentation and misaligned incentives in the current system stymie  
28 accountability for the overall quality and cost of care in communities.

29

Increasing integration and reducing unwarranted variation within care systems  
30 is essential, whether it is through virtually integrated physician practices  
31 (using health information technology), or through structurally integrated  
32 practices (like large multispecialty groups). Because health care  
33 microsystems are local, diverse models of organization should be  
34 encouraged; one size does not fit all.

35

**Recommendation –** Actively work to develop organizations that are  
36 accountable to local communities for the continuum of patient care, including  
37 outcomes, quality, service and costs. Key attributes of such organizations  
38 should include:

39

- 40 • Improving care delivery by spreading and integrating systems of care  
41 models;
- 42 • Aligning payment incentives;
- 43 • Coordinating ancillary supportive services;
- 44 • Using data to improve performance; and

- Collaborating among multiple stakeholders (payers, purchasers, patients, providers and government).

*Enabling tools*

I. Outcome measurement and public reporting

Continuous health care quality improvement should be based on measurement of outcomes against planned thresholds of success. Despite efforts on many fronts to define and measure quality of care, many current measures are widely believed to be inappropriate or untrustworthy. Yet, without a suite of generally accepted, scientifically and intuitively plausible parameters—reliably collected and reported in a timely fashion—there are no objective grounds for comparing information on best practices.

**Recommendations –**

- 1) Support the development and use of appropriate measures to document progress on patient health goals.
- 2) Support policies that aggregate data across all payers with a sufficient level of detail to be actionable for outcomes improvement.
- 3) Support public reporting that drives accountability and continuous improvement.

II. Health information technology/health information exchange

Implementing electronic clinical information systems and sharing their content in the service of patient care can produce significant value across the care system.

**Recommendation –** Use health information technology (HIT) and health information exchange (HIE) to improve health outcomes and reduce costs by:

- 1) Presenting best evidence, consensus recommendations and prompts for both physicians and patients at the point of care;
- 2) Collecting data on treatments, practices, outcomes, diseases, needs and performance across the spectrum of care;
- 3) Conducting quality improvement projects;
- 4) Improving the performance of HIT and HIE designs and processes; and
- 5) Fostering the adoption of HIE tools in the community, as well as agreements among providers regarding appropriate data exchange.

III. Comparative effectiveness research

Changes at the microsystem level require concerted, sustained and rigorous efforts to evaluate the effectiveness of clinical processes. Ensuring that such efforts are independent, objective and transparent is essential for developing appropriate clinical and health policy.

**Recommendations –**

- 1) Advocate for benefit design changes that use clinical information to show whether new health technologies/services are reasonable and necessary;
- 2) Support efforts to advance the evidence base and facilitate rapid diffusion of appropriate new services, while curbing the use of unwarranted services; and
- 3) Maintain an awareness of warranted variation to protect patients with atypical conditions or needs.

*Payment reform*

I. Value not volume

The current health care payment system is structured with a bias toward often rewarding providers for the quantity of care delivered, rather than for the quality of that care. In many settings, it can discourage collaboration among providers, encourage unwarranted services, and frustrate the provision of appropriate care. More is not necessarily better; in fact in health care more is often worse.

**Recommendation** – Support policies that disconnect physician incomes from volume and intensity; align physician compensation with appropriate measures and goals.

II. Develop and adopt new payment models

Aligning incentives to drive better value in health care requires changing payment models in many settings. Options include recalibrating fee-for-service, pay for performance, creating episode-based or bundled payments, global payments or salaried positions. No one form may be best; payment models must work within local systems to drive system aims.

**Recommendation** – Promote payment reform that appropriately aligns compensation with both individual and system performance.

Respectfully submitted on behalf of the members of the Physicians' Congress for Health Care Reform,

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