Thought Leadership

Health Care Reform: The Impact on Academic Health Centers

Joe Robertson, MD

Currently, health care reform generally is focused on expanding access to primary care and promoting wellness and prevention. Oregon Health & Science University (OHSU), operating as a major, comprehensive academic health center, embraces the reform. However, OHSU faces the challenge of continuing to deliver high-level health education and biomedical research while health reform measures threaten to shift funding toward primary care and prevention. Society depends on the ability of academic health centers (1) to innovate and disseminate new knowledge and (2) to intervene effectively with regard to treating and curing complex and debilitating medical conditions. Because the objectives of health reform are consistent with the mission and values of academic medicine, OHSU recognizes, particularly in the face of declining resources, that it has a special obligation to lead change. OHSU leads change by developing new systems of care, new methods of training for providers, and more rapid ways to apply science.

Introduction

Oregon Health & Science University (OHSU) is Oregon's major comprehensive academic health center (AHC). The OHSU four-part mission is education, research, patient care, and community outreach. Like many of our peer AHCs, we are a unique health care resource in our communities and regions, and active in state and federal health policy debates.

OHSU supports the effort to reform our health care system generally and to offer universal access to health care specifically. We adopted eight essential principles for health reform in 2008,[1] principles that continue to be relevant today as much work remains to be done at both the state and federal levels. Given the unique mission and funding model of academic medicine, elements of health reform offer both opportunities and challenges.

The focus of reform efforts to date has been on expanding access to primary care and promoting wellness and prevention. Coverage for all Americans not only improves outcomes for individuals and populations, it's absolutely vital to address the growing cost of health care. Policymakers often cite the triple aim as a guiding light of reform: (1) improving the patient experience, (2) improving population health, and (3) reducing the per capita cost of care.

For an AHC that specializes in high-acuity care and provides public goods like education and biomedical research, there are significant risks of being able to adequately fund our missions as resources are prioritized for primary care and prevention.

As a nation, we should be sure to protect the ability of AHCs to innovate and disseminate new knowledge—as well as our ability to effectively intervene in complex and debilitating conditions such as cancer, cardiac disease, and neurological disorders.

At the same time, AHCs should make themselves relevant to the changing health care delivery system in this country. Understanding how that is possible—and indeed essential for reform to be fully successful—requires some background about the

unique aggregation of programs and services known as academic health care.

What Is an Academic Health Center?

There are more than 100 academic health centers nationwide, each with significant regional and sometimes national impact. Not every AHC is the same, but the term typically refers to a university that contains the following:

1. A medical school plus additional health professions schools or programs such as dentistry, nursing, pharmacy, public health, and allied health
2. Extensive biomedical research programs
3. One or more affiliated hospitals or health systems.

AHCs educate tomorrow's health care providers and leaders. They are vital providers of patient care, from basic to advanced care, and they offer comprehensive primary care as well as cutting-edge specialty treatment. OHSU hospitals and clinics tend to handle a disproportionate share of safety net care and provide complex tertiary and quaternary care available nowhere else in the state or region. OHSU revenue sources for the fiscal year ended June 30, 2012, are summarized in Figure 1.

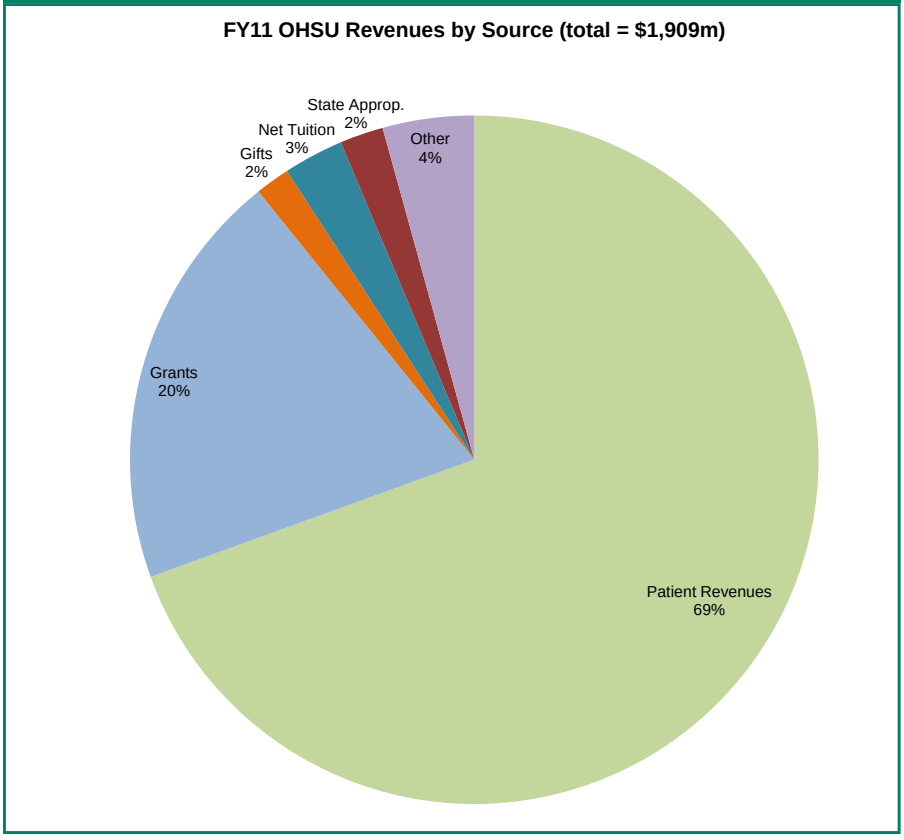
AHC research portfolios generate new ideas, leading to new treatments, therapies, and cures. AHCs also tend to have a significant local and regional economic impact, and are often the biggest employer in a community (e.g., Johns Hopkins is the largest employer in Baltimore, and OHSU is the largest employer in Portland).

Many staples of high-quality clinical care were developed and perfected in academic health centers, including intensive care units for newborns; new and better treatments for diabetes, cancer, and heart disease; new technologies, such as joint replacements, that improve quality of life; and organ and bone marrow transplantation. Academic centers are where breakthroughs are assimilated into the practice of health care: new medications are tested and new procedures are perfected, taught and disseminated.

With the most highly trained health care providers and research scientists, and the best facilities in the world, AHCs serve as hubs of innovation that have transformed the delivery of health care and dramatically improved its quality. Advancing the frontiers of science for the benefit of patients is one of the great calling cards of academic medicine.

What most distinguishes AHCs is their multi-talented faculty, many of whom choose to work for less salary for the chance to be in an academic, mission-driven environment. At OHSU, each of our faculty members is a teacher, a health care provider, a researcher, and often a thought leader in their field. Only in academic health care does the best education, research, and care come together this way.

Figure 1
OHSU Revenue Sources



Defining the AHC Operating Model

As the mission of academic health centers differs from community hospitals and other health systems, so does the operating model. AHCs have one foot in academia and the other in the highly competitive world of health care delivery.

This relationship is unique in graduate and professional education. Business schools do not manage large corporations. Law schools do not manage comprehensive law firms. But academic health centers include the largest, most complex medical centers in the world.

The prevailing model for funding academic health centers is one in which the clinical system significantly cross-subsidizes the education, research, and community outreach missions. As a result, AHCs typically have lower margins than community hospitals. In recent years, for example, OHSU has transferred more than $100 million annually from the clinical enterprise to support other mission activities—making OHSU's clinical enterprise a larger source of funding for the OHSU School of Medicine than the State of Oregon.

Unfortunately, over-reliance on the patient care enterprise to fund other missions has often come at the cost of hindering adequate investment in clinical facilities and equipment. With cost containment one of the primary drivers of reform efforts, academic health centers should find new sources of revenue to support education and research as well as re-investment in the clinical enterprise. In short, the prevailing model for funding academic health care is under heavy duress.

The paradox of our era is that we are moving into a golden age for biomedicine, in which all the missions and activities of academic health centers are in greater demand than ever before, precisely at the very moment that many of the traditional funding sources for these activities are facing greater constraints than ever.

AHCs are preparing for lower federal and state appropriations for education, lower Medicaid and Medicare reimbursements, and flat or declining research budgets at the National Institutes of Health.

In addition, as of this writing, the President and Congress are preparing for a lame duck session to deal with the so-called "fiscal cliff." Sequestration and other debt reduction proposals potentially could place aspects of OHSU's patient care, research, and health care workforce education missions at risk.

Should sequestration be implemented, OHSU has estimated that our federal funding will be cut by $27 million in 2013 alone. The two largest impacts would be reduced funding from the NIH and reduced Medicare reimbursement. Other potential impacts of sequestration or other deficit reduction initiatives include: payments for medical education, payments for bad debt (care provided that goes unpaid), and disproportionate share payments (to hospitals that serve low-income or otherwise underserved patients).

In short, academic health centers like OHSU are often far more reliant on public sources of funding than their community hospital peers (see Figure 2), making them more vulnerable in an era of budget austerity.

As governments at all levels reduce spending, OHSU is planning to systematically adjust its funding split from 52-48 to 60-40 in favor of private sources, if not higher, over the next 10 years (see Figure 2). This, of course, is easier said than done. While government resources tighten dramatically, we have seen evidence that the commercial health care market may be shrinking as well.

In the past few years, consumers deferred health care spending as never before—a trend that began in the Great Recession but which has yet to correct and may in fact reflect a new, lower-demand reality.

These figures are Oregon-specific and reflect merely one aspect of consumer health spending—

Figure 2
OHSU Funding, Public vs. Private

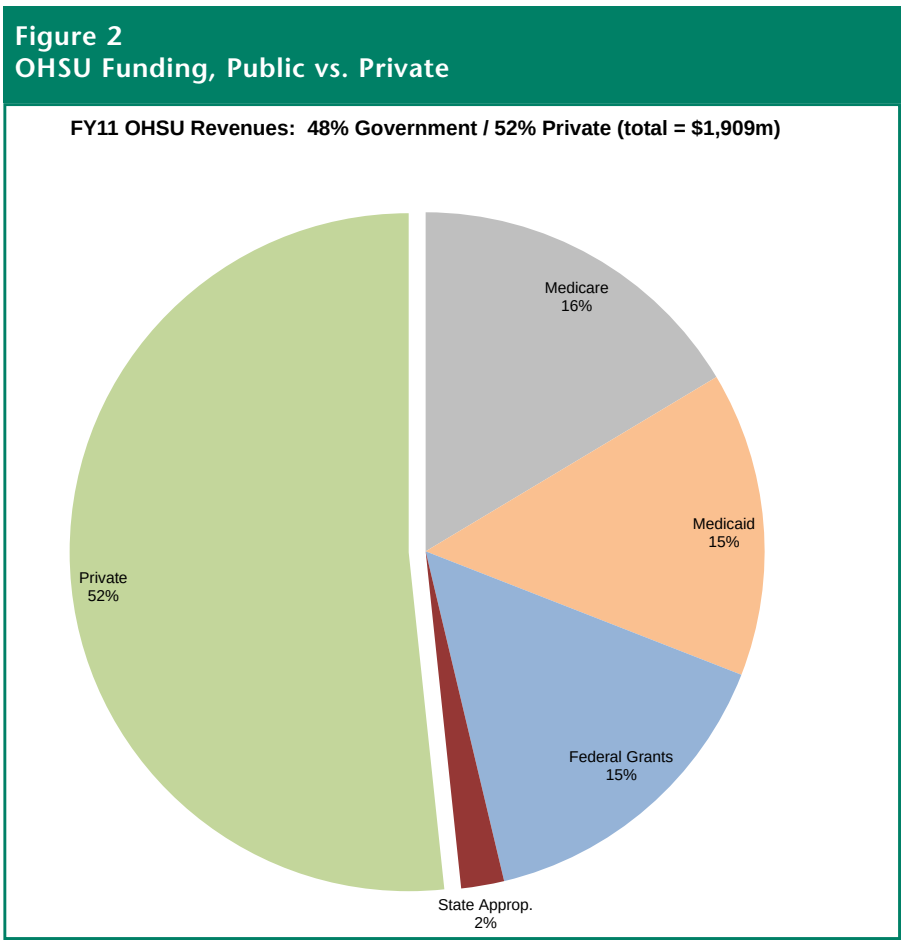


Table 1
Commercial Inpatient Admissions by Region

Region	FY07	FY11	FY07 to FY11 % Change
Portland Metro	97,961	71,890	-27%
Nonmetro	98,218	88,589	-10%
Total	196,179	160,479	-18%
Case Mix[a] Index Over 2.0	26,297	29,735	13%
Case Mix Index Under 2.0	169,739	131,473	-23%

[a] Case mix index is a measure of overall patient complexity.

inpatient care—but as the trend seems tied to confidence in the national economy, these figures are likely emblematic of other markets. The case mix index suggests that consumers were far less willing to defer or skip care that was more complex in nature (see Table 1).

It's difficult to escape the conclusion that consumers are simply spending less on health care, and prioritizing by severity. On its face, this might seem like a positive development—reducing the overall national spend on health care—but it's also possible that patients are deferring the very types of primary and preventative care that might forestall more complex and expensive care later. We simply don't know yet.

All of this means that AHCs such as OHSU will have to operate more efficiently, compete more effectively in the local health care marketplace, and diversify their activities to generate more revenue.

AHCs will have to become more entrepreneurial, to find additional economic value in things they already do while developing new lines of service to meet changing demands. They will have to translate new knowledge to the bedside and to the commercial marketplace more rapidly than ever before. They will also have to collaborate with community partners—across all missions—to better leverage scarce resources.

The challenge for academic health centers is that they still don't fully know the nature of the environment in which they will operate. At this stage, health reform offers more questions than answers. What should we expect?

Reform: What's Different This Time?

For years, health care reform has been a political football. Many in the industry are understandably wondering whether this latest iteration of reform isn't destined to fade away as so many efforts have before. Doubts persist even after President Obama's recent re-election and the Supreme Court decision earlier in the year upholding the Affordable Care Act (ACA). After all, the ACA is really just a framework for reform. Universal coverage is the beginning of the process, not the end, and many states have done little, if anything, to prepare.

What makes further change inevitable, in my view, is the looming shortfall in funding for Medicare and Medicaid (see Figure 3) that threatens to squeeze out future federal spending. In short, reform has less to do with politics than economics—and the laws of economics are as immutable as the laws of physics.

Health care is the primary driver of future federal spending, and it is rapidly headed towards unsustainable levels. To paraphrase Don Berwick, former Administrator of the Centers for Medicare and Medicaid Services (CMS), there are basically two options: cutting care or improving care.

Rather than sit back and wait for cuts, Oregon has set out to transform care, through the leadership of Governor John Kitzhaber (a former emergency room physician, and a 1973 graduate of OHSU). As a state senator in the late 1980s and early 1990s, Kitzhaber garnered national recognition for driving the creation of the Oregon Health Plan, a visionary effort to reshape Medicaid care in the state.

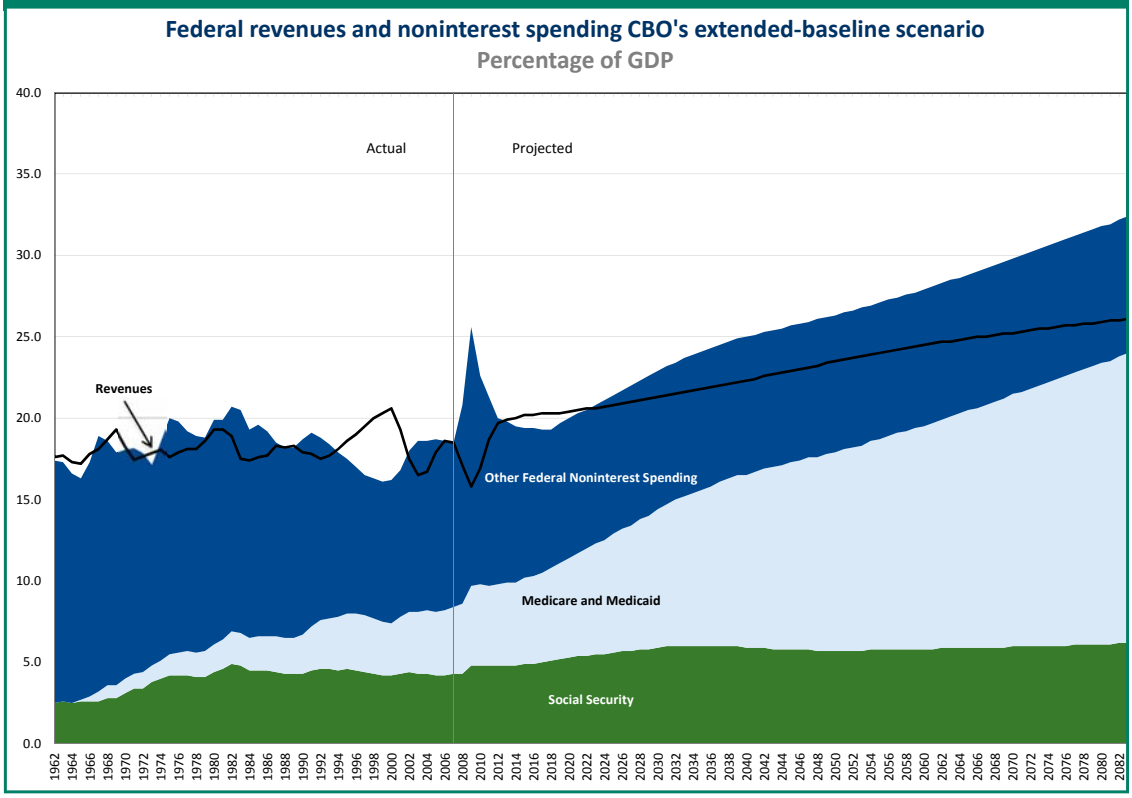
More recently, the Governor's "Health Care Transformation" initiative, passed by large bipartisan majorities through the legislature in 2009 and 2011, lays the groundwork for integrated, coordinated care for the Oregon Health Plan population, as well as those jointly eligible for Medicare, the combination of which includes some of the most vulnerable Oregonians.

The new law provides for "Coordinated Care Organizations," or CCOs, to provide services that focus on prevention for the Medicaid population

in a given geographic catchment area. They will use new delivery models, evidence-based practices and technology to improve health.

Each CCO will manage and provide mental and physical health care for its "members," managed within a global budget. Each will be accountable for health outcomes of the population they serve. During the early phases of implementation, special emphasis will be placed on managing complex disease and chronic conditions to reduce inpatient admissions.

Figure 3
Federal Spending on Health Care



For years, services such as mental and physical health care typically have been offered separately, in fragmented and uncoordinated ways. Providers were paid for treating illness, not for preventing them. There was little incentive to get patients with chronic conditions services that kept them healthy and avoided unnecessary hospitalizations or emergency care. CCOs are meant to change all that—and, in the process, to reduce the cost of care.

CCOs will bring forward new models of care that are patient-centered and team-focused. They will have flexibility within the budget to deliver defined outcomes. They will be governed by a partnership among health care providers, community members, and stakeholders in the health systems that have financial responsibility and risk. The global budget will grow at a fixed rate for mental, physical and, ultimately, dental care.

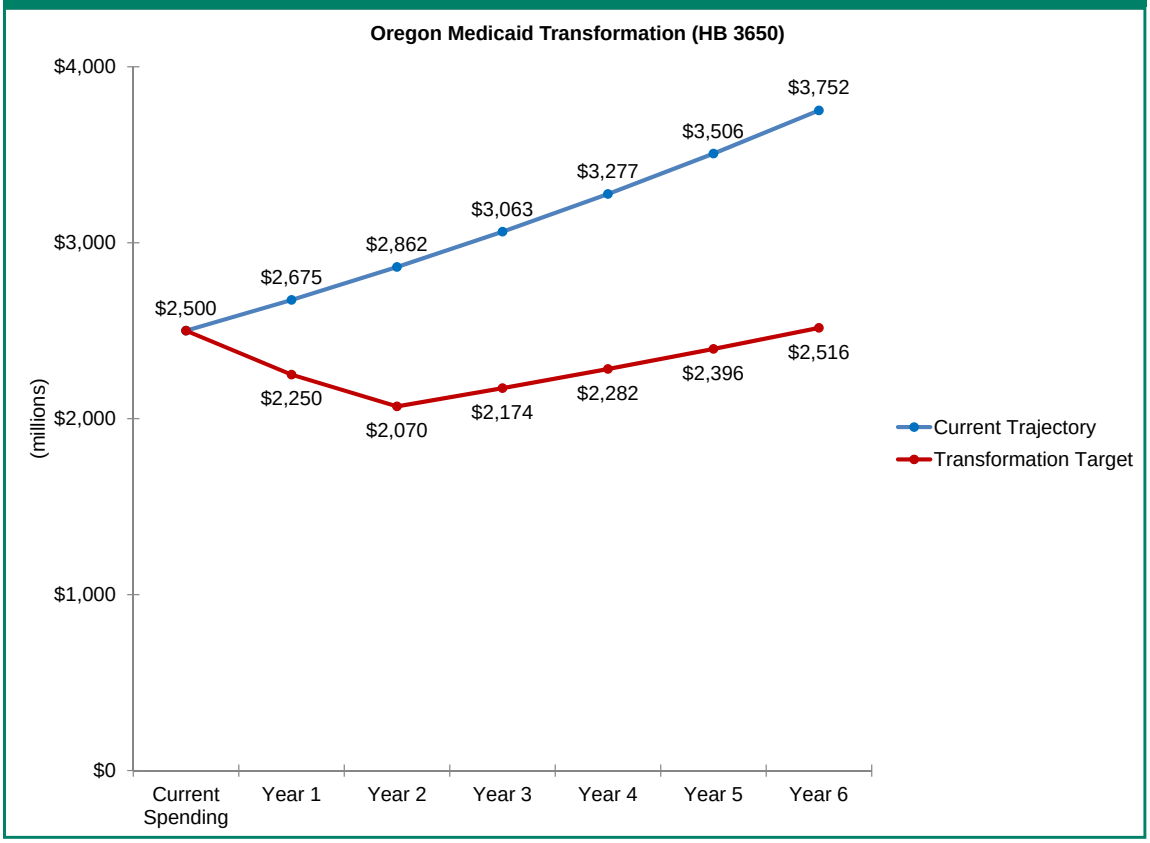
The Obama Administration recognized the good work being done in Oregon through a $1.9 billion agreement with Governor Kitzhaber to invest federal dollars in Health Care Transformation. In exchange, Oregon should stem the growth of Medicaid spending from its current 5.4 percent annual growth rate to 3.4 percent on a per member per month basis (see Figure 4). The overall spend will continue to increase, in large part as the covered population increases from 600,000 to nearly 1 million over the next decade.

This is a true partnership between Oregon and the federal government, with both sides deeply committed to seeing Health Care Transformation succeed. As the Governor himself has frequently observed, if Oregon is successful and the approach is replicated by all 50 states, it will save the federal government $1.5 trillion, an amount greater than what is being sought through sequestration and other deficit reduction initiatives.

The eyes of the nation will be on Oregon to see if we can take the next step in health reform—improve community health and quality of care while reducing costs. There is hard work ahead, but we are cautiously optimistic. Across Oregon, local stakeholders have pulled together to transform care in their communities.

Already, more than 15 CCOs are certified and active in Oregon, serving more than 80 percent of the state's Medicaid population. OHSU is part of Health Share of Oregon (HSO), a collection of public and private entities comprising the CCO for the three counties of the Portland metropolitan area—representing by far the largest Medicaid

Figure 4
Bending the Cost Curve in Oregon



population in the state. HSO began serving patients on September 1, 2012.

This will be an evolutionary process, with plenty of mistakes and ample opportunity to learn. But the commitment to change is unwavering, as is the expectation that innovations modeled through the CCO process eventually will be adopted by the commercial market, further bending down the cost curve.

In addition to participating in local efforts to better coordinate care, AHCs can help lead reform in two additional vital ways:

1. By addressing health care workforce shortages through innovative, collaborative approaches, as well as the development of new types of health professionals
2. By helping to reduce the cost of care through the rapid application of research, including new treatments and cures

One of the best hopes for improving outcomes at lower cost is to study the health care system analytically and apply what we learn. This may be described as either delivery system science or process engineering for the health care industry. Neither term sounds glamorous, but the impact could be profound.

Workforce Shortages: Trading One Access Problem for Another

With more than 30 million newly insured Americans about to enter the health care system, addressing the nation's provider workforce shortages takes on greater significance than ever. The demand for health care is growing but the supply of care is essentially fixed, at least in the short term (given the lead time for educating more health care professionals). Access to coverage is not the same as access to care.

Let's consider the Massachusetts example: In the 12-month period after the state of Massachusetts passed a landmark law providing universal coverage, about 340,000 of the state's estimated 600,000 uninsured citizens were able to gain coverage. With no corresponding increase in the population of health care providers, however, waiting times doubled for routine procedures like a general physical.[2]

Insufficient new providers are being produced to replace the current provider population for the following reasons:

1. The production of new health care providers has been relatively constant over several decades.
2. The population is growing.
3. The population is aging.
4. Health care providers are aging.
5. The educational model has historically been inefficient and relatively inelastic.

According to the Association of American Medical Colleges (AAMC), the physician shortage alone could reach 130,000 by 2025.

OHSU has sought innovative ways to expand the workforce pipeline. We have long wanted to expand classes for all our health professions programs, but historically lacked the physical space to do so. We knew we needed a new, collaborative approach that could leverage scarce resources to meet the state's needs.

Back in 2007, after looking out over the horizon, we adopted collaboration as a key plank in our strategic vision: "OHSU will partner to make Oregon a national leader in health and science innovation for the purpose of improving the health and well-being of all Oregonians."

Figure 5
Rendering of Collaborative Life Sciences Building

OHSU reached out to potential partners at the State of Oregon, the Oregon University System (OUS), Oregon State University (OSU), and Portland State University (PSU)—as well as Tri-Met, the transit agency for the Portland metropolitan area—to see if we could jointly expand the infrastructure for life sciences education and research.

After two years of planning, and a significant philanthropic campaign, we broke ground together last October on the Collaborative Life Sciences Building (see Figure 5) on the OHSU new campus along the Willamette River, close to nearby PSU and connected to several transit connections, including the Portland Aerial Tram, the Portland Streetcar, and MAX (Metropolitan Area Express), and the regional light rail line.

The Collaborative Life Sciences Building (CLSB) will place elements of OHSU, OSU, and PSU together under one roof, sharing resources to increase class sizes, create additional opportunities for inter-professional education and simulation training, and provide space for cutting-edge research and research collaborations, while continuing the OHSU commitment to green building practices.

The 498,642-square-foot building will include lecture halls, classrooms, labs, specialty research centers, offices and a state-of-the-art facility for the OHSU School of Dentistry.

The CLSB will foster collaboration in undergraduate and graduate education among students and instructors from multiple institutions. It will also enable OHSU to accomplish the following goals:

1. Increase the medical school class size from 120 to 160 students
2. Increase the dental school class size from 75 to 90 students
3. Increase the physician assistant program class size from 40 to 50 students
4. Increase the pharmacy program jointly run by OHSU and OSU from 90 to 115 students

While the production of more health care professionals in raw numbers is needed, this is also an opportunity to re-think the way we provide and organize health care education. The health care delivery system of the future is expected to feature an integrated primary care team comprised of different provider types (physician, nurse, nurse practitioner, physician assistant, dietician, and health coach, for example).

Allowing and even encouraging team-based systems would support an increase in the physician-patient ratio without a decline in quality by allowing all primary care providers to work at the top of their license. In this vision, the "team-patient" relationship supplants the current "physician-patient" relationship.

Unfortunately, current reimbursement regulations tend to discourage the role of nonphysicians by reimbursing less for the same procedure. Studies show that aspects of primary care can be provided by nurse practitioners and physician assistants, with more complicated conditions referred to the physician.

In addition to the policy changes required, the educational model must shift. Most nursing students today never interact with medical students until they encounter each other for the first time as professionals on a hospital ward or in a clinic. New, inter-professional educational models are needed that include physicians, nurse practitioners, midwives, physician assistants, and other providers learning side-by-side.

"Research ultimately holds the greatest promise through finding less expensive treatments, discovering more efficient systems, and applying discoveries in new ways that prevent disease."

In this way, they will learn to better understand, respect, and rely on each other's role in successful patient outcomes, and they will naturally align in health care teams. The CLSB will be the vehicle for that, particularly in that it will create the vehicle to implement inter-professional education.

This inter-professional education must include both classroom work as well as clinical training. Technology centers that simulate the patient care environment—also part of the CLSB—are one essential part of this strategy. OHSU is testing another method through the Inter-professional Care Access Network (I-CAN) grant, funded by the federal Health Resources and Services Administration (HRSA).

I-CAN uses a collaborative model for clinical practice and education with goals to enhance the health care experience, improve population health outcomes, and reduce health care costs for disadvantaged and underserved patients, families, and populations in selected neighborhoods.

The OHSU School of Nursing (SON) in collaboration with the OHSU School of Medicine (SOM) and the OHSU Global Health Center will build upon existing Portland community partnerships such as Central City Concern, Neighborhood House, and Macdonald Center.

Working together across disciplines, students can help patients access available resources in the neighborhood that help support primary care and improve the social determinants of health, which include socioeconomic background, access to health care, and environmental factors.

The SOM also is embracing a curriculum transformation project to prepare students for the changing health care delivery and discovery environments, and to do so in ways that continue the emphasis on self-directed learning and lifelong attainment.

Our teaching environment should evolve to embrace the abilities and learning preferences of today's students through the creative application of technology: podcasts, web- and app-based tools, distance learning, virtual reality, and simulation centers, to name just a few. We also need to explore sharing resources with other medical schools nationally and with our different health professions programs at OHSU.

In addition to enhancing educational quality and outcomes, some of these ideas may help reduce the costs of education. Tuition is rising everywhere, not just at OHSU, and our students increasingly leave school with staggering debt burdens that may influence their career choices towards the specialties. We have been aggressive in raising scholarship funds through philanthropy, but our best chance at reducing the tuition burden in a meaningful way is to partner with the State of Oregon. In a rural state like ours, debt loads can impact another important public policy goal—the rational geographic distribution of providers.

As we work to educate larger numbers of health professionals in a more efficient and effective manner, we should also recognize that we cannot educate enough physicians or nurses to fill the expected need. We will need new kinds of health professions to fill gaps in our delivery system. Examples include: anesthesia technicians, dental therapists, community health workers, patient navigators and/or care coordinators, and home care providers.

We also will need clinically focused public health professionals who know how to work with communities and implement an intervention to improve the health of a community.

One part of the new reality for tomorrow's providers is a patient population with access to previously unfathomable levels of information. The rate of expansion for new knowledge has become exponentially higher in the current environment than even in the recent past, and that information is increasingly available to the public.

Future providers will increasingly need to rely on four important attributes: critical thinking, the ability to use data, understanding complex systems, and leading through effective communication.

While it will be a challenge to learn how to manage all this new information, the rapid application of new knowledge will ultimately be a vital part of an improved health delivery system.

Role of the AHC in Bending the Cost Curve

To reiterate, one of the driving motivations of health reform, as embodied by the triple aim, has been cost containment.

Coordinating care and adapting the education model are necessary but not sufficient. Research ultimately holds the greatest promise through

Table 2
Delivery System Science at OHSU

	Center for Health Systems Effectiveness	Center for Evidence-Based Policy	Oregon Evidence-Based Practice Center
Overview:	The Center for Health Systems Effectiveness drives health systems research collaborations while pursuing innovative models of research, evaluation, implementation, and organizational change. Research focuses on data-driven analysis of the factors that influence healthcare cost, quality, and access.	The Center for Evidence-based Policy gathers, appraises for quality, and synthesizes research to inform policymaking in health. The Center also organizes and supports multi-state and stakeholder collaborations to reduce redundancy and cost. The Center specializes in outreach and communications with broad varieties, constituencies and stakeholders.	The Oregon Evidence-based Practice Center conducts systematic reviews of healthcare topics for federal and state agencies, private foundations, professional societies, and consumer groups. These reviews report the evidence from clinical research studies and the quality of that evidence for use by policymakers in decisions on guidelines and coverage issues.
Expertise:	• Health economics • Analysis of large data sets • Healthcare quality improvement through analysis of data	• Policy analysis • Application of evidence to policy • Stakeholder engagement • Multi-state collaborations to create evidence-based policy	• Clinical practice guidelines • Systematic reviews • Consumer-oriented evidence reviews • Clinical evidence gap analyses • Patient-centered outcomes research • Evidence-based informatics • Critical appraisal of cost-effectiveness analysis and decision analysis

finding less expensive treatments, discovering more efficient systems, and applying discoveries in new ways that prevent disease. Outcomes research will help maximize population health by rationalizing the type of care provided.

Today, we face the need to bridge a knowledge gap identified by health reform—namely, understanding and dismantling the barriers to implementing research findings in clinical practice. OHSU has significant resources to bring to bear on this problem—resources in translational research, health systems effectiveness, evidence to inform clinical practice, and evidence to inform policy discussions (see Table 2).

Among the strengths of AHCs are data collection and research. They are poised to lead in this effort, but it does require a shift in their thinking. Rapid deployment of science into the clinic will require new partnerships among schools, institutes, and centers, and hospitals and clinics. The AHC component parts—and their overall culture—will need to become more connected and team-oriented to meet these goals.

Certainly AHCs should educate tomorrow's providers in the use of information tools that will help them better document, retrieve, and analyze information about their patients and the populations they serve as well as apply evidence-based practices.

Summary and Conclusion

Health reform offers opportunities and challenges for academic health centers. As the process moves forward, we want to protect our ability to serve the public but we also want to contribute meaningfully to the process.

As community, regional, and sometimes national leaders, academic health centers are purposefully engaging in a fundamental re-design of our health care system. They are doing this, despite the fact that AHCs have been quite successful in the current system, because leadership in both health policy and practice is consistent with the mission and values of academic medicine. I believe we have a special obligation to lead change—developing new systems of care, new methods of training for providers, and more rapid ways to apply science.

As a nation, we are entering a moment in which far-reaching public sector imperatives are matched by grass roots efforts to improve care and outcomes. How exactly this all plays out has yet to be decided, but rest assured that academic health centers will continue to play a leading role.

Notes:

1. See Appendix 1.
2. "In Massachusetts, Universal Coverage Strains Care," *New York Times* (April 5, 2008).

Joe Robertson, M.D., M.B.A., is president of Oregon Health & Science University, the state's only comprehensive academic health center with a four-part mission of patient care, education, research and outreach and programs that touch all 36 Oregon counties. He is a member of the Oregon Health Policy Board, the policy-making and oversight board for the Oregon Health Authority, which operates most of the State of Oregon's health care programs. Dr. Robertson also serves on two other boards: Heath Share of Oregon, the new metropolitan Portland coordinated care organization, and the Portland Branch of the Federal Reserve Bank of San Francisco. Previously, he was a practicing ophthalmologist with a specialization in vitreo-retinal surgery. He can be reached at robertjo@ohsu.edu.

Appendix 1
Eight Principles for Health Reform at OHSU

1. Support universal access to a defined set of health care services for all children and adults that is paid for in ways that are not exclusively linked to employment.
2. Believe that a defined set of health care services in a universal access framework should include all health services that are demonstrably beneficial, including tertiary and quaternary health care, in order to guarantee equal access to care and to prevent continuation of inequities in the current system which ties care delivery to economic status.
3. Believe that a geographically well-distributed health care workforce, accurately mirroring in capacity and diversity the population it serves, is critical to ensuring long-term quality and access in Oregon. Funding for recruiting, educating and keeping workforce skills current is also critical. Further, health care reform should find ways to utilize all providers to the full benefit/extent of their education and training.
4. Support an aggressive focus on preventive health care to both improve quality and reduce costs, including promotion of and reward for healthy lifestyles.
5. Believe that the long-term viability of universal access will depend on the full and equitable participation of all health care providers and systems (the opting out by a provider or health care system should not disadvantage those electing to participate).
6. Support a compassionate evaluation of end-of-life care and the adoption of health care delivery models that support end-of-life decision making and options for patients and families.
7. Believe that quality health care is linked to outcomes transparency and that incremental improvements in standards of care require support for both evidence-based practices and mechanisms to incorporate real-time outcomes feedback in quality initiatives. However, leaps in health care quality and outcomes are also a result of discovery and innovation, and a reform proposal must find ways to reward and adopt innovations and discoveries.
8. Support more effective deployment of information technology, including but not limited to portable electronic health care records.

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