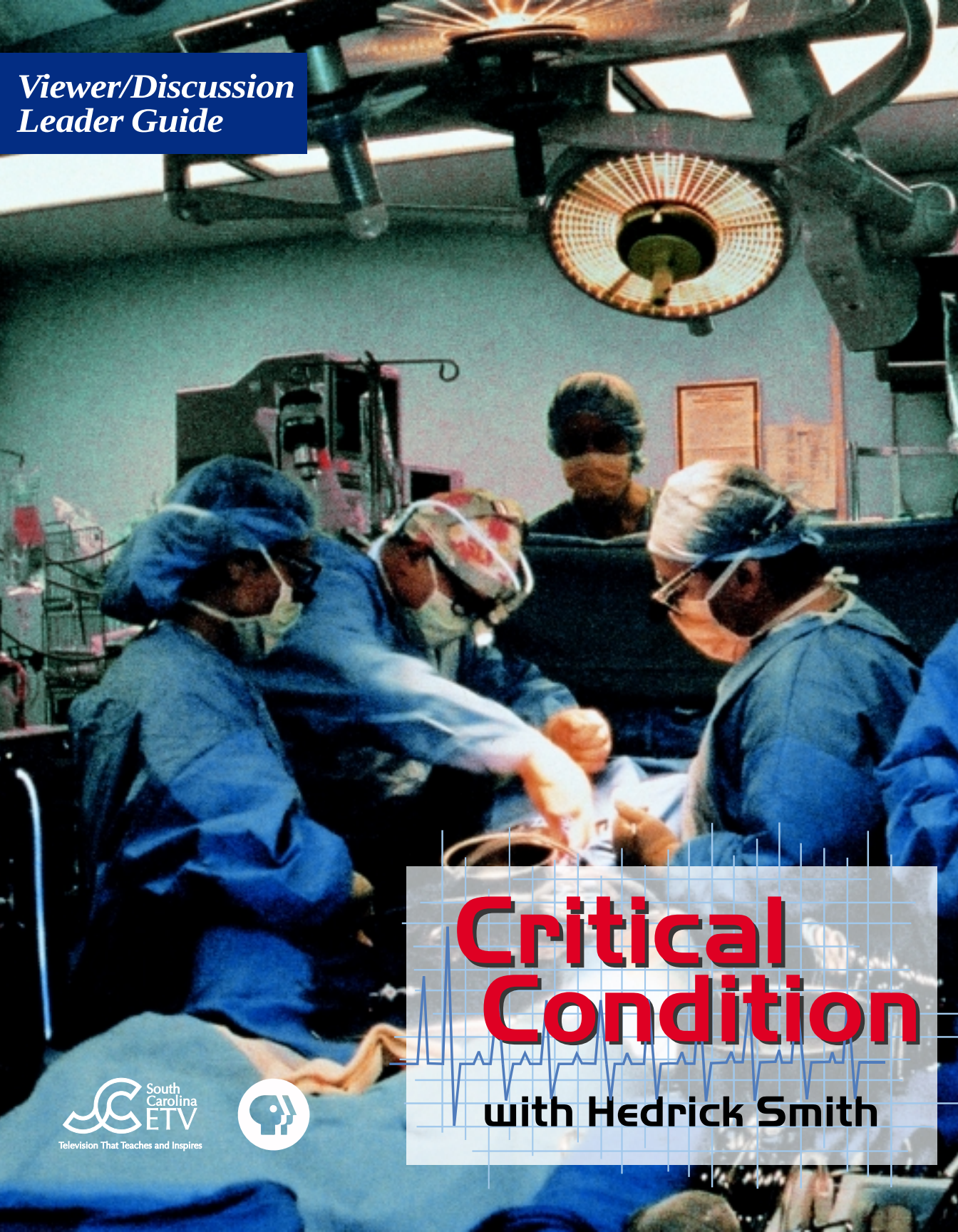


Viewer/Discussion Leader Guide

Critical Condition

with Hedrick Smith

South Carolina ETV

Television That Teaches and Inspires

Dear Viewer:

What happens when your mother suffers a stroke…your child comes down with diabetes…you get cancer…or your employer unexpectedly cuts your health coverage? Suddenly, you realize how vulnerable you are. And you face the all-consuming question… Will the proper health care be there for me and my family when we need it most?

(Photo credit: Susan Zox)

After the revolution of managed care, health care weighs on the minds of Americans more than ever before. In fact, coming into the 2000 elections, one in four Americans identified health care as the most important issue in deciding their votes for President and Congress.

In a health care marketplace that is in constant flux, people are uncertain about how to gain access to care and assure high quality care. They are uneasy that 44 million Americans have no health insurance at all, with that total rising by one million every year despite steady economic growth. And they are deeply worried about what might happen if a medical disaster strikes their families or they find themselves facing a chronic illness.

Our special PBS broadcast, **CRITICAL CONDITION with Hedrick Smith**, takes a penetrating look at why—despite the most enormous health expenditures in the world—does our country still suffer tens of thousands of deaths from medical errors? Why are we so poorly informed as consumers on quality of care? How well do we do caring for the chronically ill? How large is the quality gap in U.S. medicine?

By providing case studies, expert advice and patient experiences, **CRITICAL CONDITION** seeks to help American patients and their families learn how to find better health care and to become powerful advocates for gaining the care they need. For as we crisscrossed America, we found that people who were passive, tended to get shunted toward second-class care, and were less likely to get the treatments that experts recommend. Those who were well informed and assertive in demanding the best quality care generally received better care.

Because it touches all Americans, this broadcast may be the most important that I have undertaken over the past decade. It is no mere journalistic homily to say that we hope **CRITICAL CONDITION** will inform, educate and empower average Americans. For in health care, ignorance can be fatal. Good information can often save a life. Our program is designed to give you insights and experience that will enable you to enjoy the good health that should be the birthright of all Americans.

Hedrick Smith
Correspondent and Executive Producer

(Cover photo credit: Susan Zox)

How to Use This Guide

This viewer/discussion leader guide is designed to show people how to become their own best advocates when navigating their way through the complicated world of health care and health insurance. Today, you need to be assertive and ask questions when dealing with your family doctor, the specialists taking care of your loved one, or your health plan representative. This guide to **CRITICAL CONDITION with Hedrick Smith** is designed to be used with VHS cassettes of the three-hour PBS special or with the video clip reel of excerpts from the special provided in the Patient Advocacy Kit, or by itself.

The guide is broken into several sections. It opens with an essay that provides the user with background on how health care has changed in the United States over the last 25 years. Following this essay are detailed descriptions of the four segments that make up the three-hour PBS special **CRITICAL CONDITION** and another program Hedrick Smith Productions produced last spring for the PBS series FRONTLINE entitled **DR. SOLOMON'S DILEMMA**. These descriptions are:

- THE QUALITY GAP – *Medicine's Secret Killer*
- THE CHRONICALLY ILL – *Pain, Profit and Managed Care*
- THE IDEALISTIC HMO – *Can Good Care Survive the Market?*
- THE UNINSURED – *44 Million Forgotten Americans*
- DR. SOLOMON'S DILEMMA – *Cost vs. Care*

The next section of the guide is made up of nine case studies, which examine the challenges facing those dealing with serious illness and health insurance plans. Each case study is taken from the three-hour special or **DR. SOLOMON'S DILEMMA** and focuses on a particular topic—stroke, diabetes, the uninsured, etc. Look at the different case studies and select the ones that you think your group would like to discuss.

Use the VHS cassette from the Patient Advocacy Kit, or an appropriate video sequence from **CRITICAL CONDITION with Hedrick Smith**, or **DR. SOLOMON'S DILEMMA**, to show the group the case study and then begin a discussion using the questions in the guide. If you don't have access to the video, each case study is described in enough detail in the guide to set the scene for the discussion. Share the case study description with the group and then proceed to the questions.

If the group wants more information on a particular topic, the resource list beginning on page 20 and the **CRITICAL CONDITION** Web site www.pbs.org/criticalcondition are excellent sources for further information.

And, finally, to help members of the group know the type of questions to ask when considering health plans, give them copies of "Ten Questions to Consider Before Choosing a Health Plan," found on page 17. Even if you already have a health plan, this is an excellent tool to use to determine whether your current health plan does all that you want it to do. Immediately following these questions are "Ten Questions to Ask Your Doctor about Financial Risk." Share these with the group, too.

America's Health Care Dilemma
By Hedrick Smith

The New England Journal of Medicine recently labeled the U.S. health care system "the most expensive and most inadequate in the developed world." Harsh language from a sober institution devoted to repairing a system that has spun out of control. Over the past decade, few American institutions have been more dramatically transformed than the nation's $1 trillion health care system. Yet despite revolutionary change, or perhaps because of it, most Americans are unhappy with the state of health care.

In a *New York Times/CBS News* survey, 55 percent believed that "fundamental changes are needed in our health care system," and another 30 percent made the sweeping judgment, "We need to completely rebuild it." One in four Americans told a poll, done for this project by Princeton Survey Associates, that health care would be the most important issue in deciding their votes in November 2000.

Over the past decade our health care system has changed with lightning speed, leaving ordinary citizens uncertain, worried and frustrated. Most people don't understand how health insurance plans work or how they influence health providers. Managed care remains a mystery. Critical questions go unanswered: What motivates hospitals and doctors in the new health market environment? How do people with chronic illnesses and conditions fare under various health plans? How good is the quality of care that most Americans receive? How well does America care for the needy?

Whose Point of View?

The answers to many health questions depend on who is speaking and where they stand in the landscape of the U.S. health care system. Different groups judge health care by different yardsticks. The experience of the hard-working poor is radically different from people who are employed by corporations that offer a choice of health plans at subsidized costs. Likewise, the experience of chronic patients differs from people who are generally healthy.

To the institutions that foot most of the health care bill—corporations, the federal government and commercial health plans—cost is and has been the paramount issue. For the payers, the past decade of expanding managed care has brought relief from the spiraling health care costs of the 1980s. Fifteen years ago, leading corporations such as General Motors and Xerox protested that they could not compete in the global economy carrying the burden of skyrocketing health costs. They demanded an overhaul of America's "unmanaged" health care system. Corporate America championed HMOs and promoted strategies to cut waste, push standardization, force hospital mergers, eliminate excess capacity, and impose cost restrictions on doctors and patients. Managed care advocates claimed they could improve quality by cutting waste and offering preventive care that would save money in the long run.

Without doubt, the new, more efficient, market-driven system has profoundly affected health spending. Health inflation slowed down dramatically in the 1990s as our health system trimmed away excess costs and capacity. The average daily occupancy in America's hospitals dropped from 763,000 in 1981 to 531,000 in 1996. Between 1990 and 1996, health plans claimed up to $181 billion in national health savings—savings that corporate America claimed helped restore its global competitiveness and allowed some small and mid-sized employers to continue offering health benefits. But now, once again, health costs are on the rise.

The Chronically Ill and Uninsured

But many health consumers have a radically different view, especially those who are heavy users of health care either for serious emergency care or for long-term care for chronic illnesses. With chronic patients now amounting to roughly 100 million people, or more than one-third of all Americans, their plight and the cost of their care—$760 billion a year—has become a central issue in any debate about our health care system.

Many of the chronically ill and other heavy health consumers complain that while businesses and commercial health plans save money, they find themselves in a "health care strait-jacket," constantly fighting to obtain needed care and often forced to carry more of their own health care burden. In a 1998 Kaiser Family Foundation survey, two-thirds of respondents reported some problems with the health care system—56 percent worried about not being able to keep their current doctor, 58 percent feared denial of some medical procedure, and 70 percent dreaded benefit reductions.

The American public has become so disgruntled that four out of five Americans now support the passage of a comprehensive Patients Bill of Rights to help ensure access to quality care, according to an opinion poll conducted for this project by Princeton Survey Research Associates in the spring of 2000. The survey found that only 33 percent were "very satisfied" with the quality of their medical care—down from 55 percent a decade earlier. Nearly three out of four people expressed the fear that the drive by managed care companies and health insurers to save money threaten the quality of their health care.

Doctors at northern New England's Dartmouth Hitchcock Medical Center prepare for rounds. (Photo credit: Susan Zox)

Another public concern is the mounting millions of uninsured. Despite nine years of economic growth, employers are cutting back in providing health care, increasing the number of uninsured. Census data shows that roughly 85 percent of America's 44 million uninsured come from working families. Nearly one in three adults reports being uninsured during the past 12 months. So concerned is the general public about this problem that a surprising 53 percent of Americans questioned by Princeton Survey Research Associates said they were willing to pay at least $360 more in annual federal taxes to help insure all Americans.

New Role for Doctors

For most medical providers, the central issue in the upheaval in American health care is regaining the power of decision over what treatments are medically necessary for their patients. Many providers chafe at seeing their role usurped by health plan administrators. But as they fight to regain control over health decision-making, many doctors and hospitals are being forced to take on the financial responsibility to control and cut costs. To their great discomfort, they see their own earnings coming into conflict with the amount and quality of care they order for their patients.

Quality Care

In opinion surveys, the public sees quality as the #1 health care issue and a growing body of health experts asserts that the quality gap is the most serious problem in the American health system. In late 1999, the Institute of Medicine stunned the nation with its report that up to 98,000 Americans die unnecessarily each year in U.S. hospitals because of medical errors—mistaken procedures, wrong drug doses, fatal infections and the like. Dr. Robert Brook, head of the Rand Health Study Group, bluntly asserted that "as many as twenty-five percent of hospital deaths from pneumonia, heart attack and stroke could be prevented by better inpatient hospital quality of care."

A small body of quality crusaders have mounted what some call "a holy war" to radically improve the actual performance of health care—not just access to doctors and regular checkups and mammograms but to lower death rates. They point to New York state's dramatic improvement in the survival rates from open-heart surgery after publishing the actual records of individual hospitals and heart surgeons over the past decade and a similarly effective campaign in northern New England where six hospitals shared experiences as a way to save the lives of heart patients. Despite these impressive achievements, most of the medical profession still staunchly resists publishing quality report cards on actual operations and treatments, leaving health consumers knowing less about health safety than

about their safety on airplanes, in cars or on trains.

One thing is clear. In today's confusing, fragmented, and often adversarial health care system, patients must become far more activist. Patients and their families must understand the system well and demand to know much more about how to find and judge the quality of care. For it is true that ignorance about health plans, the performance of health providers, and issues of patient rights, can quite literally stop a beating heart.

The Quality Gap – Medicine's Secret Killer

By Marc Shaffer

Is the trillion-dollar American health care system the best money can buy? Most Americans assume it is and that they are getting the finest care possible. The painful truth is the system is plagued with an alarming number of failures. Last year the national Institute of Medicine reported that up to 98,000 Americans die each year as a result of medical errors. They are America's eighth leading cause of death, ahead of car accidents, breast cancer and AIDS. There is also the subtler and still lethal problem of varying quality of care, because most medical practice does not match the best practice.

However, a new movement of quality crusaders aims to cure these ills and improve the quality of American health care.

In 1990, New York became the first state in the nation to rate the medical performance of hospitals and doctors. When it released a "report card" showing patients' chances of surviving heart surgery differed dramatically from hospital to hospital, and doctor to doctor, it caused shockwaves. Publicly humiliated, hospitals that performed poorly worked to lower their death rates by improving teamwork, hiring better surgeons, offering more training and upgrading equipment. New York's death rate for heart surgery fell 41 percent between 1989 and 1992.

Equally impressive gains were made, without public disclosure, with a breakthrough collaboration among six hospitals in northern New England. After an internal study revealed dramatically different heart surgery outcomes, the hospitals began to work together. They shared information and replaced their surgeon-centered, top-down culture with a more cooperative team approach. The result: a 24 percent mortality drop between 1990 and 1992.

Quality efforts are springing up outside the Northeast, too. At Intermountain Health Care (IHC), a network of 122 hospitals and clinics in Utah, dozens of innovations developed by front-line doctors have resulted in better quality care and lives saved. One such innovation was a protocol for treating pneumonia developed by IHC Doctor Kim Bateman. After surveying doctors in 10 rural hospitals, Bateman found chaos—dozens of different treatments and a wide variation in how patients fared. Bateman convinced his peers to simplify their choice of antibiotics and streamline care. His protocol saved as many as 50 lives a year at Intermountain Health Care.

Utah physician Kim Bateman (left) with Hedrick Smith.
(Photo credit: Susan Zox)

That still leaves the vexing problem of medical errors: a bungled prescription, the slip of a scalpel, a botched lab test, or a missed diagnosis. When such sensational errors are publicized, they grab headlines and drive debate. The threat of malpractice lawsuits only reinforces the instinct among doctors and hospitals to hide their errors.

But in one hospital, the

veil of secrecy has lifted. The Lexington, Kentucky, Veterans Affairs Medical Center has instituted a policy that when errors occur, the hospital comes clean to the victims and their families. So, when Claudie Holbrook died in 1997 after receiving the wrong strength of blood thinning medication, the hospital's attorney openly confessed that the hospital had caused Holbrook's death. Hospital attorney Ginny Hamm told Holbrook's family: "We were the ones that killed your dad." With honesty, staff say, patients and their families are far less angry and less in the mood for high-priced malpractice suits. And the hospital can correct the wrong procedures.

Other places have adopted quality reforms like New York's public report cards, New England's collaborative improvements, Utah's new health protocols, and the Lexington VA hospital's open admission of errors. Quality crusaders believe such steps are the wave of the future—especially if the public demands higher quality care.

The Chronically Ill – Pain, Profit and Managed Care

By Ariadne Allan

In today's cost-driven health care market, caring for the chronically ill poses special challenges. Today, people with chronic conditions such as cancer, heart disease, diabetes, stroke or cerebral palsy number over 100 million Americans—or someone in your home or right next door. Their care costs $760 billion a year, or roughly three-fourths of all U.S. health care dollars. With people living longer, these numbers are rising.

In Tampa, Florida, this program sees Mike and Criss McConnell fighting to hang on to home nursing care coverage for their son Hart. Born with a hole in his diaphragm, Hart needed a machine to breathe, and 24-hour nursing care for almost two years. When the family's HMO, Humana, suddenly withdrew all nursing care, despite a doctor's orders for 16 hours of care daily, the family had to take on the care burden. Criss McConnell admits, "I was beyond terrified." Humana later offered eight hours of nursing care.

Caitlyn Chipps. (Photo credit: Bob Eyres)

The McConnell's story reveals the tension between commercial insurers like Humana and chronic patients. As University of California health economist Hal Luft notes: "If you enroll a lot of people who are very high cost, you can end up spending more than what you bring in … and you won't be able to stay in business very long."

In a drive to cut costs for other chronic patients, Humana has turned to a strategy called disease management for its congestive heart failure patients. This program, using nurses to keep track of patients' daily regimens, significantly reduces mortality, hospital visits, and costs.

But dealing with some other patients, certain children with chronic conditions, Humana at one point dropped their special treatment coverage. In Palm Beach, sheriff deputy Mark Chipps, whose daughter Caitlyn suffers from cerebral palsy, lost extended benefits covering her special therapies. Humana's action prompted Chipps to charge that a trade-off was being made. "You can't get rid of these kids and just weed them out so that you save money," he complains, "at the same time centering all your attention on these other folks." Chipps filed suit against Humana and won. Humana is appealing.

In another interesting story, two Fort Myers area seniors suffered strokes and followed two different paths to recovery and rehabilitation as they sought to overcome paralyzing disabilities. The program follows Marijane Schacherer, who entered an acute inpatient rehabilitation hospital, and Anthony

Oczkowski, whose Medicare HMO, Humana, overruled his doctor and instead sent him to a less expensive skilled nursing facility. Dr. Andy Kramer of the University of Colorado Center on Aging, who has studied stroke treatment methods, explains that inpatient rehabilitation has a much better improvement rate than skilled nursing facilities.

Helen Boone (right) with her daughter Betsy Willard. (Photo credit: David Brown)

Finally, this program addresses treatment for breast cancer. In this case, two women are diagnosed with breast cancer—37-year-old Valerie Kennedy, a runner and vegetarian, and Helen Boone, a 75-year-old grandmother. Both quickly learned the importance of access to high quality specialty care. Each wanted treatment at Tampa, Florida's H. Lee Moffitt Cancer Center and Research Institute, the state's only National Cancer Institute designated cancer center. Kennedy, who has a special health plan from Humana, which is her employer, was treated at Moffitt. Humana, however, would not cover Moffitt care for Boone because Moffitt was not included in her Humana Medicare HMO.

From chronically ill kids to cancer patients, the financial objectives of commercial health insurers like Humana sometimes put them at odds with the people who need them most. When cost and quality of care collide, for-profit health plans can block doctors' orders and deny certain kinds of care, leaving patients scrambling for other ways to obtain and pay for the care their doctors prescribe.

The Idealistic HMO – Can Good Care Survive the Market?

By Marc Shaffer

Most managed care companies like Humana sell insurance. They don't actually provide health care. That's a far cry from the original non-profit HMOs like Kaiser Permanente, launched more than 50 years ago. Kaiser still takes a pioneering approach to health care, combining doctors, hospitals and insurance in one plan with a social mission of lifetime care.

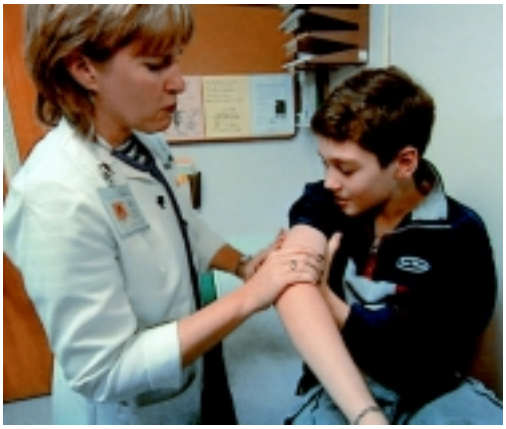
Our program focuses on the original home to Kaiser Permanente, the Northern California region, where in 1995 activists protested Kaiser's approach to treating AIDS patients. Kaiser boldly made its harshest critics the leaders of its unique HIV advisory board. Despite the fact that people with HIV and AIDS are very costly patients, Kaiser launched a public ad campaign for its HIV program. "Most health plans would never do an advertisement saying, 'We take good care of HIV,' because they would then get HIV patients who are expensive and they'd lose money on them," says health care analyst Dr. Tom Bodenheimer, an independent San Francisco physician.

Kaiser member Vivian Hannawalt. (Photo credit: John Van Amburg)

On another front, Kaiser's long-term mentality may save 68-year-old Vivian Hannawalt's life. Since 1994 Kaiser has been giving expensive colon cancer screening exams to low-risk patients over 50, once every ten years. Hannawalt, a 15-year member of Kaiser, had no symptoms. But the exam revealed she had cancer and that it had spread. If she had

waited for symptoms to appear, as many Americans do, her chances of survival would be dramatically worse. But for Kaiser, the high cost of the exams won't pay off for 15 years.

Kaiser's commitment to long-term care and its integrated structure give the HMO a big advantage in helping members manage chronic illnesses—people like 12-year-old diabetic Dillon Moore. At Kaiser, Dillon sees a regular team of providers every three months for as long as an hour or two. It's a welcome change from the care he received at a clinic in Cleveland, where his mother said the care was more hurried and impersonal. "In Cleveland we'd see a different resident every time we went in," says Debby Lyttle. "There wasn't the continuity of care that there is here."



Diabetes patient Dillon Moore with his pediatric diabetes specialist Dr. Catherine Egli. (Photo credit: Bill McMillin)

Forty-one-year-old Kaiser diabetic Roberta Kuhlman shares Lyttle's enthusiasm. A life-long Kaiser member, Kuhlman worked for seven years with a special team of Kaiser care providers to become pregnant. She stopped working to take care of her child full time and became a self-insured individual. She kept Kaiser as her health plan, even though she lost many benefits. Kuhlman must pay for all her drugs and pharmacy benefits out of pocket. When her doctor recommended that she try an insulin pump to manage her diabetes, a device that was fully covered for Dillon Moore, Kuhlman learned that as a self-insured individual the pump wasn't covered and the $5,000 price tag put it out of reach.

Kuhlman's dilemma is what Kaiser CEO David Lawrence says is the fundamental problem in American health insurance coverage—the cost of health care rises while employers and the government fight to pay less and less of those expenses.

In the early 1990s Lawrence turned to high-priced business consultants to reshape the HMO into a tough market player. Kaiser cut rates and sometimes abandoned its time-tested formula of integrated one-stop health care services. The strategy was a bust. The HMO lost more than half a billion dollars in 1997 and 1998. Now, Kaiser has dropped efforts to be the low-cost HMO and is counting instead on beating other health plans by emphasizing quality care. As Kaiser's price keeps rising, its strengths as an integrated, coordinated, community HMO with long-term goals may prove insignificant to health care consumers looking for lower cost plans.

The Uninsured – 44 Million Forgotten Americans

At last count, 44 million Americans had no health insurance. About 85 percent of these came from working families. In most cases, their employers didn't provide health insurance.

A typical story can be found in the West Texas city of Abilene. Its once mighty oil industry has hit hard times and now the economy depends on the service sector. Service jobs don't pay well and often don't provide health insurance. Twenty-five percent of Abilene's population of 110,000 is uninsured. One of these uninsured is Jody Beal, who spent a lifetime as a logging engineer for oil wells. When times got tough, Beal had to jump from job to job. He gambled that he'd make it without insurance until he retired at 65 and qualified for Medicare. At 62, he had a heart attack and now faces $125,000 in medical debts. His case epitomizes the plight of many "near elderly" people—too young for Medicare, but too old or too sick to work, and uninsured when they need care most.

Across town, 42-year-old Tom Phillips drives a truck in a stone quarry and makes $265 a week. With three children, Phillips can't afford insurance even though he had a heart attack and bypass surgery in 1997. Doctors told him to take regular medications and have regular checkups. But fearing big medical bills, he did not get the care he needed. This year he was back in the hospital being treated for chest pains. Doctors say his case is not unusual for the uninsured. They put off care until an emergency hits, and then the costs and the risks are steep.

States like Tennessee have tried to cover some of the working poor (eg., a family of four with an income up to $30,000) by expanding their Medicaid programs (which cover families with incomes at or below poverty). For children with chronic conditions, like nine-year-old Joshua Mitchell, the TennCare program has been crucial. It pays for Joshua's care at Vanderbilt University Hospital which treats his painful attacks of sickle cell anemia. Usually, he is admitted for several days. Although once, when his TennCare coverage lapsed briefly, Vanderbilt was less welcoming. At the ER, he was given morphine and Gatorade and turned away. "With TennCare, you can get the care you need," says his mother. "Without it, you're out of luck."

Sickle cell patient Joshua Mitchell. (Photo credit: Susan Zox)

But TennCare is in constant financial trouble and has had to put severe limits on taking in new people. Also, Dr. John Morris, chief of Vanderbilt's trauma center, reports that TennCare often cannot pay for proper rehabilitation for accident victims, leaving them disabled.

In 1996, to try to cover three million of the nation's 10 million uninsured children, Congress passed the Child Health Insurance Program (CHIP). In many states, however, CHIP has been slowed by red tape and difficulty getting the word out. In southern California, where many Latinos are uninsured, an anti-immigrant political climate deters people from signing up. Those who use CHIP (known in California as Healthy Families) report it has changed their children's lives.

Thirty-four-year-old Maria Gumaer is a single mother of two daughters, one of which, Denica, 14, has severe asthma. Mrs. Gumaer makes $26,000 a year working in the accounts department at a flooring distributor. She can't afford a $400 monthly family insurance policy; so she paid Denica's medical bills from paycheck to paycheck. She did not even know how seriously ill Denica was because she could not afford sufficient medical tests. Insufficient medical attention meant Denica's asthma periodically was severely out of control.

Under Healthy Families (CHIP), Maria's low co-payments enabled her to afford the low cost of a battery of tests. The doctor was shocked by the seriousness of Denica's asthma. He gave her strong treatment and her condition improved dramatically. "It hurt me so much to know that my poor child had to struggle for six years not being able to breathe correctly," said Maria Gumaer. "But now I feel so blessed."

Dr. Solomon's Dilemma – Cost vs. Care

In the 1990s, as America's HMOs cut costs by controlling patients' care, they were reviled as the enemy of doctors and patients. Now, after fighting to regain control of the medical process, doctors are once again assuming responsibility for treatment decisions and for controlling costs.

For people like Dr. Martin Solomon, this presents a problem. A respected Boston physician with more than 20 years experience, Solomon is now wrestling with more than just medical treatment for his patients—he is also worried about finances. Caring for some of his patients has become a threat to his medical practice and his own pocketbook.

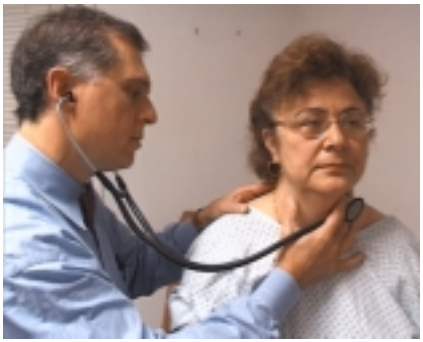
Dr. Martin Solomon. *(Photo credit: Steven McCarthy)*

Solomon has learned that taking control means financial risk. The more care doctors give, the more it can cost them directly. So the sickest patients can become money losers for doctors like Solomon, who is a respected primary care physician

In **DR. SOLOMON'S DILEMMA** correspondent Hedrick Smith goes behind the scenes for a candid examination of this new frontier in managed care. The cameras follow Dr. Solomon and his colleagues as they are forced to weigh cost vs. care, patient by patient. That's because these patients are in what's called a capitated plan with a lid—each doctor gets just so much compensation per year per patient, regardless of the amount of treatment provided. As a result, the physicians' own salaries are at stake if a patient's treatment exceeds the set limit. This report looks at how thousands of doctors are part of this new trend in managed care.

In 1998, Dr. Solomon sold his practice to a company called CareGroup, a network of seven hospitals, 3,000 doctors and 400,000 patients. In 1999, CareGroup lost $100 million.

In an effort to change that, CareGroup's doctors, working under these capitated plans, have been made responsible for containing treatment costs and turning their practices into profit centers. CareGroup and other national health care systems have organized doctors into small mutual-review groups known as "Pods." Each Pod must balance its own books.



Dr. Martin Solomon worries that the need to balance cost with care will damage the doctor-patient relationship. *(Photo credit: David Murdock)*

We follow Dr. Solomon into one of his Pod meetings where the doctors are shown cost charts itemizing how much each spends on everything from X-rays to prescriptions to surgery. The doctors see which members of their Pod are spending more on patient care; thereby decreasing the group's profits.

DR. SOLOMON'S DILEMMA also interviews corporate cost cutters who argue that doctors should have a more direct role in monitoring costs; hospital administrators who are fighting red ink every year; and patients who, in this new culture of medicine, are called "units."

Several stories of patients are interwoven throughout the report: an open-heart surgery patient, a Medicare HMO patient, a young diabetic mother, all of whom have become money losers for CareGroup, and even the doctors who care for them. So their hospital stays are being shortened or they are being told that they must get their care from within CareGroup's network of doctors and facilities, even though some outside doctor may have more experience in treating their specific condition or illness.

As Dr. Solomon confesses, this new cost consciousness not only affects a doctor's decisions in treating his own patients, it also ultimately tears apart the trust between doctors and patients. He admits point blank that he is troubled that cost cutting now affects quality of care.

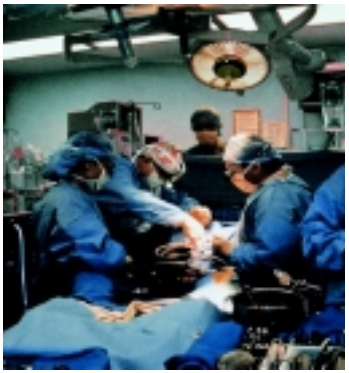
Solomon recounts an exchange with a longtime patient diagnosed with a gynecological malignancy. Solomon refused to authorize her request to see a doctor outside CareGroup. "The patient said to me, 'So, you're not letting me do this because of money?'" Solomon tells Hedrick Smith his response was "Of course—if it were just medical care, I'd let you go wherever you want. But this is a contract. I'm not in the business of subsidizing your care."

CASE STUDIES

Open-heart Surgery – Tracking Doctors' Batting Averages

Most Americans assume that our trillion dollar health care system is the best in the world and that patients can assume they are receiving the highest quality of care. Medical studies and a few specific reports, however, reveal a serious shortfall between best practice and what most people get from their own doctors and hospitals.

In 1990 New York became the first state in the nation to rate actual medical performance of hospitals and doctors. Following a successful lawsuit by the newspaper *Newsday*, the state released risk-adjusted mortality rates after heart by-pass surgery for each New York hospital and cardiac surgeon. For the first time, patients could see real data on the performance of their surgeon and their hospital, and the numbers were deeply disturbing. The chance of surviving heart surgery differed dramatically from hospital to hospital, and doctor to doctor.



A heart by-pass operation at Winthrop University Hospital in Mineola, NY.
(Photo credit: Susan Zox)

The debate rages to this day as to whether the public release of data is good for patients, or has backfired by intimidating physicians into avoiding tough cases. The proponents of openness can point to one very compelling argument: Between 1989 and 1992 the death rate from heart surgery in New York fell 41 percent.

Even so, some doctors dispute the value of publishing report cards. Dr. Josh Burack speaks for many New York surgeons when he complains that the data isn't good enough to be trusted.

"Medicine doesn't lend itself to measurement as easy as appliances do," says Burack. "I mean it's much easier to turn on a washing machine for a thousand hours and see which one breaks than it is to evaluate how good a doctor is at treating pneumonia."

For Luca Fresiello, one New Yorker who came through open-heart surgery well, the report cards could very well have made the difference. The hospital where he had his surgery, Winthrop University Hospital on Long Island, has cut the death rate by 400 percent in the last decade.

Discussion Questions

1. Should patients have access to information about how their doctors and hospitals measure up? Would you be likely to expect this data if you had a health care crisis?

2. How can the public learn more about quality efforts in general?

3. Would you change your doctor if you found out he didn't perform as well as his colleagues?

The High Cost of Medical Errors

Last year the Institute of Medicine shook the nation with the news that up to 98,000 Americans die each year as a result of medical mistakes. That's more than AIDS, breast cancer, or even car accidents. Outright errors in medical care include: giving the wrong medication to a patient; failing to follow up with a patient about a problem lab test; cutting off the wrong limb or removing the wrong kidney. These

types of errors grab newspaper headlines and drive debate.

Health providers react defensively, and the threat of malpractice lawsuits only reinforces the instinct among doctors and hospitals to hide their errors from patients or surviving family members.

A few hospitals are trying a new approach of openness. In February 1997, Korean War veteran Claudie Holbrook entered the Lexington, Kentucky, Veterans Administration Medical Center for the last time. He died days later of a blood clot in his lung. Although Holbrook was quite ill, he did not have to die. His death was caused by a medical error, when the VA pharmacy began sending home the wrong strength of blood thinning medication.

Hedrick Smith with Lexington VA attorney Ginny Hamm. (Photo credit: Susan Zox)

Instead of waiting for the Holbrook family to file a claim, as is the customary practice in medical error cases, the VA took a proactive approach. After an internal investigation, VA Hospital attorney Ginny Hamm met with the Holbrook family. She told Holbrook's daughter, "We were the ones that killed your dad." According to Hamm and Steve Kraman, the hospital's chief of staff, once the evasion and hostility so typical of hospitals facing errors disappears, patients are far less angry and punitive.

A recent paper by Kraman and Hamm published in *The Annals of Internal Medicine* showed that the Lexington VA, even with its policy of full disclosure, had the seventh lowest malpractice payouts of 36 VA hospitals east of the Mississippi River.

Discussion Questions

1. Is the Lexington, Kentucky, VA hospital's approach to dealing with medical mistakes by acknowledging its errors the right way to go? Is it a model for other hospitals to follow?

2. How can Americans get information about who is making medical mistakes, and who is working to fix them? Do you think the public should have access to this information?

3. What do you think accounts for the medical community's reluctance to be candid about errors and problems with quality of care? Is the high number of lawsuits in the U.S. today part of the problem?

Protecting Children with Special Health Needs

Born with cerebral palsy, Caitlyn Chipps needs specialists, intensive therapies, and customized foot braces to function independently. When Caitlyn's dad, Mark Chipps, enrolled his family in a Humana health plan through his employer, he was promised enrollment for his daughter in a special program with extended benefits.

Caitlyn received appropriate therapy through Humana for two years before being cut off from these special benefits. Facing bills of about $18,000 per year, the financially-strapped Chipps had to reduce Caitlyn's therapies. Her parents said this set Caitlyn back. "She was having a lot of problems just walking. She was constantly holding on to things for balance, falling into walls, falling down," said Mark Chipps. "We noticed her starting to crawl a lot more."

Mark Chipps' attorney Ted Leopold (left) with Hedrick Smith. (Photo credit: Susan Zox)

Frustrated by repeated failures to get Humana to pay for his daughter's treatment, Chipps filed suit against Humana. His action led to a startling discovery—the health plan's reductions in coverage that happened to Caitlyn had happened to 14 other children.

The Chipps' attorney, Ted Leopold, says that "Humana has very specific guidelines to keep these children in the medical case management programs. The guidelines, the policies and procedures were not followed. They weren't even reviewed." Mark Chipps' strongly held opinion was that "It's money. It's cost over care."

Although Humana denied it was reducing coverage for children to spend money on other programs, a Palm Beach jury awarded Chipps and his family a record $78 million verdict against Humana. Humana is appealing.

Discussion Questions

1. Discuss how chronically ill patients are affected by the fact that commercial insurers make a profit when members stay healthy but lose money when patients need a lot of care.

2. Mark Chipps asked about coverage for Caitlyn's needs when he enrolled in Humana's plan. Do most parents understand or ask about complex coverage issues such as comprehensive therapy or durable medical equipment?

3. How can parents of children with special health care needs ensure that a health plan will meet the needs of their child?

Saving Lives through Disease Management

Congestive heart failure costs more than $17 billion annually, making it the most common diagnosis for Medicare patients. Through a program called Disease Management, Humana has found an inexpensive way to improve health and cut emergency room visits and hospitalizations for heart patients like Florida's Jeanne Lange.

Under this approach, a disease manager calls Mrs. Lange regularly, keeping track of her six medications, providing life-saving guidance on nutrition and weight management, and monitoring Mrs. Lange's mood and energy level. The nurses at Disease Management encourage patients like Mrs. Lange to seek care before a crisis erupts.

Jeanne Lange. *(Photo credit: Dennis Dillon)*

This innovative program has reduced emergency room visits and cut hospital costs by 60 percent. Humana's Dr. Jerry Reeves says, "If we can make these people well, and they don't need as much services, they are happy and we are happy."

Normally one in five congestive heart failure patients dies within a year of diagnosis. With Disease Management, Humana has cut their mortality rate in half to one in ten.

Discussion Questions

1. How did Disease Management improve Mrs. Lange's life? What is the essence of Disease Management?
2. Why don't more health plans offer innovative programs such as Disease Management?
3. Which kind of health plans work best for patients with chronic conditions such as congestive heart failure? How does Medicare compare to other health plans?
4. How will America's aging population affect coverage for chronic conditions?

Stroke – Comparing Two Paths to Recovery

The quality of treatment and rehabilitation patients receive right after a stroke is critical. This case study of two elderly stroke victims in Florida demonstrates how acute rehabilitation services can dramatically shorten the road to recovery.

Stroke victim Marijane Schacherer was immediately sent to a well-respected acute rehabilitation facility. Thanks to extensive, high-quality therapy, she was home and living independently just 12 weeks after her devastating stroke. She is optimistic about her future, stating with a smile, "I've come a long way."

Stroke victim Marijane Schacherer with her neurologist Dr. Chris Marino. (Photo credit: David Brown)

Like Mrs. Schacherer, Anthony Oczkowski also suffered a stroke. But his road to recovery took a very different path. Mr. Oczkowski's doctor recommended an acute rehabilitation facility. His HMO, Humana, denied coverage for acute care and he was sent instead to a skilled nursing facility. The HMO's position? That a less expensive nursing home facility offered appropriate care for Mr. Oczkowski. His wife, Sarah, complained that his therapy was limited and that he found the setting depressing and poorly suited to his needs. Unlike Mrs. Schacherer, he has progressed slowly.

Dr. Andy Kramer of the University of Colorado Center on Aging has studied stroke and treatment outcomes. His findings are that the inpatient rehabilitation centers offer more intense environment for rehabilitation. "As a result," Kramer asserts, "during that very crucial interval where people are trying to recover from the acute event, they have a much better improvement rate."

Discussion Questions

1. How well do stroke patients and their families understand the difference in care between an acute rehabilitation facility and a sub-acute nursing home facility?
2. What questions should stroke patients ask to ensure quality care? How can they advocate for better care?
3. How can consumers ensure that specialty care will be available to them when they need it? What questions should they ask when considering a health plan?
4. How does coverage by an HMO differ from traditional Medicare coverage in treating strokes?

Getting Special Care for Cancer

Patients like 37-year-old Valerie Kennedy, a runner and vegetarian, and Helen Boone, a 75-year-old grandmother quickly learned how important access to specialty care is after being diagnosed with breast cancer.

As a Humana employee in Tampa, Ms. Kennedy was covered by a comprehensive employee plan. Her research on available treatment led her to Tampa's H. Lee Moffitt Cancer Center and Research Institute, Florida's only National Cancer Institute designated cancer center. There, she underwent two lumpectomies and sophisticated lymphatic mapping of her stage two cancer before starting chemotherapy and radiation treatments. Virtually all her expenses were covered by Humana's special employee plan.

Breast cancer patient Valerie Kennedy with Hedrick Smith. (Photo credit: Aaron Britton)

Because they lived on a fixed-income, Mrs. Boone and her husband had decided against a costly Medicare supplement and instead chose Humana's less expensive Medicare HMO. Under this plan, Humana denied Mrs. Boone access to Moffitt and coverage for the lymphatic mapping Ms. Kennedy had received.

In fact Humana's HMOs, covering most of Humana's patients in the Tampa-St. Petersburg area, did not list the Moffitt Cancer Center among Humana's available network of health providers.

Mrs. Boone's family decided not to appeal Humana's denial, fearing that any delay might result in the spread of her stage one cancer. Instead, they began a frantic search that ended when they found AV-MED, a non-profit Florida-based HMO willing to pay for Helen Boone's cancer care at Moffitt.

Discussion Questions

1. What are the most common coverage options people want when "shopping" for a health care plan? Do most people ask about specialty care for chronic illness when they are choosing an insurance plan? Why or why not?
2. What kind of health care plans are best for people with chronic ailments? How does traditional Medicare compare to care offered by an HMO? Should plans offer access to the best quality providers?
3. How will America's aging population affect coverage for chronic conditions?
4. Where can families find dependable information about care for loved ones with chronic conditions?

Diabetes – Group Plans vs. Individual Plans

Diabetes is a chronic illness that consumes 10 percent of all U.S. health care dollars and plagues 16 million Americans. One of them is 12-year-old Dillon Moore, diagnosed four years ago with Type One diabetes. Dillon's family joined the HMO Kaiser Permanente after moving to the San Francisco area from Ohio.

At Kaiser, Dillon sees a set team of a physician, nurse and nutritionist, for as long as an hour or two every three months. This careful attention to continuity of care was a welcome change from his clinic in Ohio, where Dillon's mother says "we would see a

different resident every time we went in."

Forty-one year old diabetic Roberta Kuhlman, a lifelong Kaiser member, shares the Moores' enthusiasm. Kuhlman enjoyed excellent coverage through her employer that paid for seven years of treatment to help her become pregnant. After her daughter was born, Kuhlman chose to care for her daughter full-time, leaving behind her employer's coverage to become a self-insured individual with Kaiser.

Roberta Kuhlman (right) with her diabetes specialist Dr. Anne Regenstein. (Photo credit: Susan Zox)

Now, Kuhlman must pay for drugs and pharmacy benefits averaging $5,000 a year. And, even though her physician recommended it, she has been denied coverage for the insulin pump that is paid for by Dillon's parents' group health plan. Nonetheless, Kuhlman chooses to remain with Kaiser.

Kaiser CEO David Lawrence calls Kuhlman's dilemma "the fundamental problem right now in American health insurance coverage." He says that with the cost of care rising and employers and the government fighting to pay less of those expenses, it is becoming impossible for Kaiser to cover the costs of individuals with income from large group plans.

Discussion Questions

1. The long-term complications of diabetes can be devastating. Is an insurer being short sighted to deny full coverage of comprehensive treatment for individual members or responding responsibly to business pressures and challenges beyond the insurer's control?

2. What are possible solutions to the problems that self-insured individuals face? Does an insurer have a responsibility to offer similar benefits to all members, regardless of employment status?

The Uninsured – One Mother's Story

Maria Gumaer is one of the 44 million Americans who don't have health insurance. A single mother with two daughters, Maria works in the accounts department of a flooring distributor but doesn't make enough money to pay for insurance. Already suffering from too little income and too many expenses, Maria struggled to pay medical costs for her 14-year old daughter, Denica, who has asthma. Insufficient medical care meant Denica's asthma sometimes surged out of control.

Concerned about children like Denica, Congress passed the Child Health Insurance Program (CHIP), in an effort to insure at least three million of the nation's 10 million plus children without insurance.

When Maria learned about CHIP, she signed up her daughter for coverage. When Denica was finally able to access quality care through CHIP, her doctor was shocked at her condition and immediately provided comprehensive treatment that dramatically improved her health.

Her mother was pleased but felt guilty. "It hurt me so much to know that my poor child had to struggle for six years not being able to breath correctly."

Discussion Questions

1. Maria was able to access CHIP coverage for Denica. In many states, families who qualify for CHIP

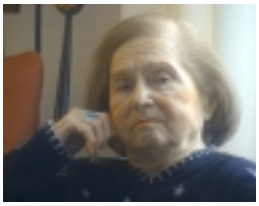
coverage may find it difficult to access care. Discuss existing roadblocks to coverage that may include red tape, language and literacy barriers, and complex eligibility requirements. How should these be addressed?

2. Some eligible families complain that information about programs such as CHIP isn't always easy to get. Discuss communication barriers and solutions that will help ensure target families get the information necessary to access care through CHIP.

3. Many providers will treat young patients covered by programs such as CHIP. Some providers, however, complain that reimbursement rates are too low and that paper work requirements are too complicated. Is this true in your state? If so, how can you work to ensure more providers will treat CHIP patients?

A Medicare HMO – Pros and Cons

Like many seniors, 84 year-old Lillian Humphrys suffered from several conditions: colon cancer, heart disease and mild dementia. When her daughter, Beverly, signed her up for a Medicare HMO called Secure Horizons, neither woman understood how the plan worked financially. Under the plan's global capitation, Mrs. Humphrys' doctors receive $5,000 a year for her total—or global—care plus another $5,000 for her hospitalization costs. Beyond this amount, they were responsible for all costs of her care. In and out of the hospital three times in six months, Mrs. Humphrys quickly exceeded her cap, or payment total.



Lillian Humphrys. *(Photo credit: Brian Dowley)*

Her physician, Dr. Martin Solomon, wrestled with the dilemma of cost versus care. He kept trying to avoid or minimize Mrs. Humphrys' hospitalizations, by trying to get her shifted to a rehabilitation program or an assisted living center. The bottom line? Dr. Solomon's physician group winds up paying for additional care for seniors like Lillian Humphrys, literally writing their health plan a check for their care above the allocated reimbursements. As a result, these doctors fear that they may soon have to give up covering the entire group of seniors in this Medicare HMO.

Trained to care for patients no matter what the cost, doctors like Martin Solomon are now being told they have to watch the bottom line in ways that can affect care negatively and shift costs to the physician.

Discussion Questions

1. Managed care reduces costs by tracking health expenditures. Every day in the hospital, every pill or test, every shot is transformed into a dollar figure and used to encourage doctors to minimize costs to the insurer. What do you think of this approach? Is it necessary to control spiraling health care costs?

2. Do you think Dr. Solomon's practice has a moral obligation to continue treating patients such as Mrs. Humphrys when costs for her care far outweigh her insurance reimbursement? Why or why not?

3. How will America's aging population affect the health care system? How can seniors ensure that life-saving care will be there when they need it most?

4. How can older Americans get the information necessary to choose the best health plans for their needs? Why did Mrs. Humphrys and her daughter choose a plan that was ultimately not well-suited to her needs?

ADVOCACY SECTION

Ten Questions to Consider Before Choosing a Health Plan

By Marc Shaffer

Choosing a health plan is simple if your employer offers just one option. Or, you may have to choose from many options. Because people are different, there is no single, best choice for everyone. Your health, personal tastes and priorities, and your ability to pay, all affect your selection. Here are some basic questions you should ask when choosing a plan and points to consider.

1. **How important is access to special care?**
   - If you are diabetic, have cancer or asthma, will your preferred medications and medical supplies be covered?
   - Are pre-existing conditions covered? How about experimental treatments?
   - Is there a lifetime cap for expenditures for all your treatments?
   - Are you guaranteed access to the best doctors and hospitals or does the health plan have a limited choice of providers?
   - How are mental health services covered?
   - How about things such as eye care or dentistry?
2. **How important is the quality of a particular plan?**

   Quality is the fact most cited by Americans when choosing a health plan. Ask about the following three components:
   - Patient Service (convenience, access)
   - Care Inputs (preventive measures such as annual physicals and mammograms)
   - Patient Outcomes (medical performance measures such as number of patients who survive certain surgeries)
3. **How important are convenience and service?**
   - Are doctors and hospitals conveniently located?
   - Can you get appointments quickly?
   - Can you get through on the telephone?
   - Are providers open after-hours or on weekends?
4. **How accessible is care?**
   - Must the HMO pre-approve your request to see a specialist? Must your primary care provider make these referrals?
   - Is your primary care provider's income increased or decreased by the amount of care he or she provides to you? By the number of specialists you see or the number of tests you have?

5. **How important is choice of provider?**

   - If you have a personal physician you want to continue seeing, does the plan provide access to him or her?
   - Do you feel strongly that you must have a very wide selection of physicians to choose from?
   - Are well-respected providers available to you?
   - Do you understand the difference between “choice” and “quality”? Remember, some health plans that get the highest quality ratings are those that limit your choice of providers to their pre-screened, pre-selected panels of physicians and facilities.

6. **How important is short-term and long-term cost?**

   - Does a low premium plan limit or deny you some of the most important coverage you will need if you become seriously ill or injured?
   - How can you balance a low monthly premium with high-deductible, high co-pay costs?

7. **How reliable is the health plan?**

   - Has the plan been around for a long time?
   - Does it rate high marks from doctors? Patients?
   - Is there a large turnover among the plan’s membership, especially patients who need costly, long-term care?

8. **How good is the appeals process in a plan?**

   - If there is a dispute over coverage or access, are there good avenues of recourse?
   - Is there a clear time limit within which the health plan must respond to appeals?
   - Does your state provide public oversight and review of health plan performance?
   - Is there a consumer hotline or service to which you can make appeals if you have a dispute with your health plan or medical provider?

9. **What are the emergency care provisions of the plan?**

   - Does the health plan permit you to be taken to any emergency room in any hospital or clinic in your area?
   - Is the hospital nearest you or the one you prefer on the approved list of facilities for the plan?
   - Does the plan require prior approval before the emergency room provides you with specific emergency services? Before emergency room doctors admit you to the hospital?

10. **How do you get care when you are traveling?**

    - Does the health plan cover your treatment in distant locations? If so, does it limit the care that you receive?
    - Does the health plan require you to obtain pre-approval before getting care when you are traveling outside of your home area?

Ten Questions to Ask Your Doctor about Financial Risk
By David Murdock

It is very difficult to raise financial questions with our doctors. Such questions have often been considered rude and challenging. But all of the doctors we spoke with in researching **CRITICAL CONDITION** and **DR. SOLOMON'S DILEMMA** stressed the importance of patients understanding the financial incentives at work in their care. Here are some basic questions you might raise with your physician.

1. **Are you "at risk" financially for my care?**
2. **Do you get paid a bonus based on performance measures?**
3. **Are you penalized financially if your costs are too high?**
4. **Does your practice follow a drug formulary? (A drug formulary is a chart developed by a practice or a health plan that encourages physicians to prescribe less expensive drugs.)**
5. **Is your practice owned by a larger conglomerate?**
6. **What specialists are you able to refer me to? (Often the answer will involve certain medical centers or clinics with which the physician has a contractual relationship.)**
7. **Are you restricted in any way from referring me to someone I want to go visit? (If your physician is and your specialist is important to you, you may want to consider choosing a primary care physician who is not restricted from referring you to your specialist of choice.)**
8. **Does the cost of the care you give affect your colleagues' income?**
9. **What emergency rooms can I go to without question?**
10. **Which rehabilitation/skilled nursing/hospice centers do you refer patients to?**

RESOURCES

General Consumer Public Policy and Patient Advocacy Groups

AARP
601 E Street NW
Washington, DC 20049
1-800-424-3410
www.aarp.org
provides information, education, advocacy and community services for people age 50 and over

Alpha Center
1801 K Street NW
Suite 701-L
Washington, DC 20006
1-202-292-6700
Fax 1-202-292-6800
www.ac.org
non-profit health policy center which helps public and private clients respond to health care challenges by providing objective information and insightful analysis

American Medical Rehabilitation Providers Association
1606 20th Street NW, Suite 300
Washington, DC 20009
1-888-346-4624
Fax 1-202-833-9168
www.amrpa.org
advocates for what people with disabilities need in their medical rehabilitation recovery

Asian and Pacific Islander American Health Forum
942 Market Street, Suite 200
San Francisco, CA 94102
1-415-954-9988
Fax 1-415-954-9999
www.apiahf.org
promotes improvement of the health status of Asian and Pacific Islanders in the U.S.; offers extensive health links

Center for Health Care Rights
520 S. Lafayette Park Place, Suite 214
Los Angeles, CA 90057
1-213-383-4519
Fax 1-213-383-4598
www.healthcarerights.org
a consumer advocacy organization which conducts research and analysis to increase consumer health care protections

Center for Health Care Strategies, Inc.
353 Nassau Street
Princeton, NJ 08540
1-609-279-0700
Fax 1-609-279-0956
www.chcs.org
non-profit, non-partisan policy resource center which promotes the development and implementation of effective health and social policy for all Americans

Center on Budget and Policy Priorities
820 First Street NE, Suite 510
Washington, DC 20002
1-202-408-1080
Fax 1-202-408-1056
www.cbpp.org
non-partisan research organization and policy institute that conducts research and analysis on a range of government policies and programs, especially those affecting low and moderate income people

The Center for Patient Advocacy
1350 Beverly Road, Suite 108
McLean, VA 22101
1-800-846-7444
www.patientadvocacy.org
non-profit grassroots organization which represents the interests of patients nationwide

FACCT (The Foundation for Accountability)
520 SW Sixth Avenue, Suite 700
Portland, OR 97204
1-503-223-2228
Fax 1-503-223-4336
www.facct.org
non-profit organization dedicated to helping Americans make better health care decisions

Families USA
1334 G Street NW
Washington, DC 20005
1-202-628-3030
www.familiesusa.org
non-profit organization dedicated to achievement of high quality, affordable health and long term care for all Americans

Health Care Financing Administration Information Clearinghouse
1-800-MEDICARE (633-4227)
www.hcfa.gov
provides information on Medicare, Medicaid, and Child Health insurance programs

Medicare Rights Center
1460 Broadway, 11th Floor
New York, NY 10036
1-212-869-3850
Fax 1-212-869-3532
www.medicarerights.org
non-profit organization devoted to insuring that seniors and people with disabilities on Medicare have acess to quality, affordable health care

National Aging Information Center
U.S. Administration on Aging
330 Independence Ave. SW
Washington, DC 20201
1-202-619-0724
1-800-677-1116
www.aoa.dhhs.gov
an elder care locator

National Association of Children's Hospitals and Related Institutions
401 Wythe Street
Alexandria, VA 22314
1-703-684-1355
Fax 1-703-684-1589
www.childrenshospitals.net/nachri/
not-for-profit organization of over 100 children's hospitals, pediatric centers and other related health systems working to ensure children's access to health care and the continuing ability of children's hospitals to provide services needed by children

National Health Council
1730 M Street NW, Suite 500
Washington, DC 20036-4505
1-202-785-3910
Fax 1-202-785-5923
www.nhcouncil.org
referrals to voluntary health agencies, patient rights and responsibilities

National Coalition on Health Care
1200 G Street NW, Suite 750
Washington, DC 20005
1-202-638-7151
Fax 1-202-638-7166
www.nchc.org
non-partisan coalition of businesses, labor unions, consumer and religious groups, and primary care providers committed to improving health care by helping the public, opinion leaders and policymakers understand the possibilities for improving our health care system

NHeLP (National Health Law Program)
2639 S. La Cienega Boulevard
Los Angeles, CA 90034
1-310-204-6010
Fax 1-310-204-0891
www.nhelp@healthlaw.org
national public interest law firm seeking to improve health care for America's working and unemployed poor, minorities, the elderly and people with disabilities by serving legal services programs, community-based organizations, the private bar, providers and groups who work to preserve a health care safety net for the uninsured and underinsured low-income population

National Latina Health Organization
PO Box 7567
Oakland, CA 94601
1-510-534-1362
http://clnet.ucr.edu/women/nlho
raises consciousness about Latina women's health and health problems

Society for Health Care Consumer Advocacy of the American Hospital Association
1 N. Franklin, 31st Floor
Chicago, Il 60606
1-312-422-3774
www.shca-aha.org
works with those health care professionals who ensure that patients and consumers receive the high-quality health care they deserve

Disease Organizations

Alzheimer's Association
919 N. Michigan Avenue, Suite 1100
Chicago, IL 60611-1676
1-800-272-3900
www.alz.org
Alzheimer's disease information and support

American Cancer Society: Colorectal and Breast Cancer Information
1-800-ACS-2345
www3.cancer.org/cancerinfo
disease information—causes, risk factors, prevention, new diagnostic techniques and treatment

American Cancer Society Online Resource Center
www2.cancer.org/medical_resources/index.cfm

American Diabetes Association
1701 N. Beauregard Street
Alexandria, VA 22311
1-800-342-2383
www.diabetes.org
information about diabetes, who's at risk, complications or warning signs of diabetes

American Heart Association National Center
7272 Greenville Avenue
Dallas, TX 75231-4596
1-800-AHA-USA1
www.americanheart.org
information about heart/stroke: disease, prevention, treatment, recovery

American Lung Association
1740 Broadway
New York, NY 10019
1-212-315-8700
1-800-LUNG-USA
www.lungusa.org
information about programs and strategies for fighting all types of lung diseases

American Medical Association
515 N. State Street
Chicago, IL 60610
1-312-464-5000
Fax 1-312-464-4184
www.ama-assn.org
information about health and fitness, journals/publications, Doctor Finder

Centers for Disease Control and Prevention
National AIDS Hotline
1-800-342-AIDS
www.cdc.gov/hiv
confidential, clear information and education; referrals; written free materials relating to HIV/AIDS, CDC also offers extensive information on other health issues

Juvenile Diabetes Foundation International
120 Wall Street, 19th Floor
New York, NY 10005
1-212-785-9500
www.jdf.org
non-profit, non-governmental funder of diabetes research; mission is to find a cure for diabetes and its complications through the support of research

National Association of People with AIDS
1413 K Street NW, 7th Floor
Washington, DC 20005
1-202-898-0414
Fax 1-202-898-0435
www.napwa.org
patient support and information

National Cancer Institute (CancerNet)
NCI Public Inquiries Office
Bldg. 31 Room 10A03
31 Center Drive MSC 2580
Bethesda, MD 20892
1-800-422-6237
http://cancernet.nci.nih.gov
credible, current and comprehensive cancer information from National Cancer Institute

National Stroke Association
9797 E. Easter Lane
Englewood, CO 80112
1-800-787-6537
www.stroke.org
patient information on prevention, treatment, rehabilitation, survivor/caregiver resources

Sickle Cell Disease Association of America
200 Corporate Pointe, Suite 495
Culver City, CA 90230
1-310-216-6363
www.sicklecelldisease.org
patient information and support; education and advocacy through network of affiliated members

Quality and Oversight Organizations

Agency for Healthcare Research and Quality
Executive Office Center, Suite 501
2101 E. Jefferson Street
Rockville, MD 20852
1-301-594-1364
www.ahcpr.gov
provides evidence-based information on health care outcomes; quality and cost; use and access enabling people to make informed health care decisions

Consumer's Union
101 Truman Avenue
Yonkers, NY 10703-1057
1-914-378-2000
www.consumersunion.org
information and educational materials developed by Consumer's Union, publisher of ***Consumer Reports*** *magazine*

HealthGrades.com
www.healthgrades.com
Internet service which grades performance of U.S. health care providers, including hospitals, physicians, health plans

National Committee for Quality Assurance
2000 L Street NW, Suite 500
Washington, DC 20036
1-202-955-3500
www.ncqa.org
non-profit group dedicated to assessing and reporting the quality of the nation's managed health care plans

Other

Alliance for Health Reform
1900 L Street NW, Suite 512
Washington, DC 20036
1-202-466-5626
Fax 1-202-466-6525
www.allhealth.org/home.htm
aims to be an unbiased source of information for members of public and opinion leaders so they can understand the roots of the nation's health care problems

National Governors' Association Center for Best Practices
444 North Capitol Street NW, Suite 267
Washington, DC 20001
1-202-624-5300
Fax 1-202-624-5313
www.nga.org/center
assists governors and key staff in developing the best policies and programs for their states; health care is a key issue being explored by this group

The Commonwealth Fund
One E. 75th Street
New York, NY 10021-2692
1-212-606-3800
Fax 1-212-606-3500
www.commonwealthfund.org
a philanthropic foundation which, through national programs, seeks to improve health care services, better the health of minority Americans, advance the well-being of elderly people and develop the capacities of children and young people

LCHC (The Latino Coalition for a Healthy California)
1535 Mission Street
San Francisco, CA 94103
1-415-431-7430
Fax 1-415-431-1048
www.lchc.org
a coalition which seeks to develop, propose and support policies in the public and private sectors of California that support and advance wellness, health promotion and healthy behaviors within the Latino community

Outreach Partners

South Carolina ETV thanks the following organizations for their invaluable assistance in alerting their audiences and the general public to **CRITICAL CONDITION with Hedrick Smith.** Use these organizations as a resource in your exploration of the complicated world of health care.

American Diabetes Association
National Office
1701 N. Beauregard Street
Alexandria, VA 22311
1-800-342-2383
www.diabetes.org

American Medical Rehabilitation Providers Association
1606 20th Street NW
Suite 300
Washington, DC 20009
1-888-346-4624
www.amrpa.org

The Center for Patient Advocacy
1350 Beverly Road
Suite 108
McLean, VA 22101
1-800-846-7444
www.patientadvocacy.org

Families USA
1334 G Street NW
Washington, DC 20005
1-202-628-3030
www.familiesusa.org

H. Lee Moffitt Cancer Center & Research Institute
12902 Magnolia Drive
Tampa, FL 33612
1-813-972-4673
www.moffitt.usf.edu

Medicare Rights Center
1460 Broadway, 11th floor
New York, NY 10036
1-212-869-3850
www.medicarerights.org

National Association of Children's Hospitals and Related Institutions
401 Wythe Street
Alexandria, VA 22314
1-703-684-1355
www.childrenshospitals.net/nachri/

Society for Healthcare Consumer Advocacy
1 N. Franklin, 31st Floor
Chicago, IL 60606
1-312-422-3774
www.shca-aha.org

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Questions or Comments

Please refer any questions or comments about these educational materials to:

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South Carolina ETV Outreach
PO Box 11000
Columbia, SC 29211

CRITICAL CONDITION with Hedrick Smith Production Credits

Executive Producer & Correspondent—Hedrick Smith

Producers—Ariadne Allan, David Murdock and Marc Shaffer

Editors—Bill Creed, Cliff Hackel, Carol Slatkin and Wendy Wank

Coordinating Producer & Production Manager—Sandra L. Udy

Segment Producers—Ginny Durrin and Mort Silverstein

Field Producers—Tom Jennings, Catherine Sager and Anne Rosenbaum

Principal Camera—Keith Walker, David Brown and Bill McMillin

Principal Sound—Alan Chow and Bill Ruth

Writers—Hedrick Smith, Ariadne Allan, David Murdock and Marc Shaffer

Associate Producers—Leora Broydo, Teresa Gionis, Maria Raquel-Bozzi and Jeanette Woods

Senior Researcher for Guide and Web—Tamara Neely

Production Associate—Joy Ardizzone

Production Assistants—Erin Essenmacher, Susan Kerin and Saidah Said

Assistant to Executive Producer—Janina Roncevic

Photo Coordinator—Susan Zox

Original Music—Eric Kaye

Graphic Opening—Jannis Productions

South Carolina ETV

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Outreach Director—Pat Dressler

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