FEDERAL TRADE COMMISSION

ROUNDTABLE ON THE COMPETITIVE SIGNIFICANCE OF
HEALTHCARE PROVIDER QUALITY INFORMATION

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MR. WROBLEWSKI: Thank you all for joining us this morning. My name is Michael Wroblewski and I’m an attorney in the Bureau of Competition, the Office of Policy and Coordination. My co-moderator today, and the person who has been my partner in crime, is Pat Schultheiss, also in the Bureau of Competition, Office of Policy and Coordination.

Before we start, I need to go over a couple of housekeeping security matters. Please if you’ll turn off your cell phones or put them in silent mode, any BlackBerries, electronic devices.

The restrooms are right outside the double doors to the left-hand side.

In the unlikely event that the building alarms go off, we’ll proceed calmly down the stairs, which are down to the right-hand side, out across the street to the sculpture garden. But please follow directions and remain calm.

If you spot any suspicious activity, please alert Pat or me or the security staff downstairs.

CHAIRMAN KOVACIC: That doesn’t include unorthodox thinking.

(Laughter.)
MR. WROBLEWSKI: As we’re assembling this morning, these microphones actually are on the entire time. So, if you’re not speaking, if you can turn the microphone away, that will reduce some of the chatter going on in the background.

I’d like to introduce everyone here before we get started as well. I’m going to start on my right-hand side. I’m just going to give names and titles. More biographical information is included on the FTC Web site and also in the packets that are outside.

First, we have Dr. Michael Barr, Vice President, Practice Advocacy and Improvement, at the American College of Physicians.

Next to him we have Elysa Ferrara, Director, National Provider, Quality Performance Programs for Aetna.

Next to her we have Nancy Foster. She’s Vice President for Quality and Patient Safety at the American Hospital Association.

Jack Fowler is to her left. He’s the President of the Foundation for Informed Medical Decision Making.

Dr. Ardis Dee Hoven, she’s a member of the Board of Trustees of the American Medical Association.

Kristin Madison, Professor of Law at the University of Pennsylvania Law School.
Andy Webber, President and CEO of the National Business Coalition on Health.

I’m going to skip over the Chairman for just a second.

(Laughter.)

MR. WROBLEWSKI: Markus Meier, who will be joining us shortly, is the Assistant Director for the Bureau of Competition for the Health Care Management Services and Products Division.

Dr. Beth Nash, Manager, Partner and Product Development for Consumers Union.

Then Dr. Clyde Chumbley, he’s the President and CEO of ProHealthcare Medical Associates and he is representing the Wisconsin Collaborative for Healthcare Quality this morning.

Dr. Vincent Kerr, President, Care Solutions and Chief Medical Officer, National Accounts for United Healthcare.

Peter Lee, Executive Director for National Health Policy at the Pacific Business Group on Health.

And, finally, we have Barbara Rabson, Executive Director, Massachusetts Health Quality Partners.

Thank you all for joining us today.

To kick off the roundtable it’s my pleasure to introduce FTC Chairman Bill Kovacic. Bill was
instrumental in me coming back and I really appreciate
the opportunity to put into play what we actually started
-- what we talked about in April, May time frame. It’s
actually nice to see that it’s coming to fruition this
morning. So, thank you.

Bill?
INTRODUCTORY REMARKS BY CHAIRMAN WILLIAM KOVACIC

CHAIRMAN KOVACIC: Thank you, Michael, and my thanks also to Pat for your extraordinary and characteristically skillful efforts to assemble this program.

I think, as many of you who are students of the Commission know, this format for policy development has become an increasingly important part of what the Commission has done over the past certainly 15 years. And I thought to begin today I’d put today’s proceedings in a little bit of context to give you a fuller sense of why Michael and Pat asked you to come today and what purpose this type of discussion serves for us.

For many years, many observers realized that the FTC had capabilities that went beyond simply being a law enforcement agency. We do enforce competition and consumer protection law in this area, but a major, I think, renaissance for the agency took place just about 15 years ago, when Bob Pitofsky began the process of coming back to the agency as Chair.

And Bob’s particular insight for the agency was that it had a distinctive role and mission to be a forum for discussion and to use a variety of different tools to assemble a base of knowledge to make judgments about key areas of policy concern.
We deal with a number of subjects that could be called complex and difficult. I’m actually not accustomed to seeing any industry or sector that we deal with call itself simpleminded and routine. All are able to identify complexities associated with what they do and what they provide.

But I don’t think anyone would contest the notion that the preparation and delivery of health care services is certainly as complex, as difficult, as complicated as any, not simply because of difficult issues of science associated with the formulation of treatment programs, the unique and difficult regulatory context in which health care services are provided in this country, a mix of competitive processes, a mix of particularly elaborate and complex public regulation at the national and local level, but also a host of extremely difficult substantive issues associated with choosing a business model and organizational approach that delivers the best possible results for American citizens.

For all of those reasons, this body of endeavor is especially difficult. And I think the agency, beginning with Bob’s tenure, recognized the importance of investing in knowledge, that if we were to do good policy work by way of making recommendations to our legislature,
making a wise choice of enforcement programs, designing
public education programs, that we had to make a
conscious effort on a regular basis to invest in
accumulating knowledge, and that the holding of
workshops, conferences and related programs ought to be
an indispensable part of that.

That the Commission could play a distinctive
role by being a convener where individuals in a setting
such as this, all committed to a search for the best
solutions, could discuss in a constructive and
informative way what the way ahead ought to be for the
FTC.

The role of competition in generating
information about quality to consumers has been something
in this decade that has been highlighted again and again
as an important possibility. As you know in watching
what we do, it’s not the first time that this topic has
come up.

Indeed, because of the past work of people like
Pat and Michael, the agency has had an eye for this topic
over time and this can be considered to be the latest of
what will be a continuing set of explorations about this
issue.

As you are more keenly aware than I am,
particularly where one is dealing with complex goods and
services, the question always arises what role is there
for information about quality to guide the choices of
consumers or intermediaries who act on their behalf? Are
consumers able to absorb the relevant information? Can
they make sensible judgments based upon information
that’s provided?

Whether one is a scholar and teacher in the
field of contract law, a physician working with a health
care provider, whether one is working for an NGO that
acts on consumers’ behalf, I think all of us are quite
aware that basic questions about how consumers absorb
information, how they form judgments on the basis of that
information, whether selected types of information can
properly be assessed by individual consumers or those who
act on their behalf is a continuing and important
question in this field, as well as others.

My hope for today is that through the very
skillful and thoughtful assembly of the panel, that by
the close of the discussion today and in the proceedings
to come, that we will have a better understanding of
these topics.

For those of you who have not engaged in this
process with us before, I can assure you that your
comments today become the stimulus for significant and
ongoing consideration of what we ought to do. In many
ways today, we are your students and we look forward to
learning from what you have to say.

Two further thoughts. One, I want to give you
my profound thanks for being here to do this. As Michael
and Pat have seen -- and you will see their real artistry
in assembling panels and formulating issues because
they’ve done this so well in the past -- the essential
ingredient of successful programs is to have the most
thoughtful observers come and spend their time with us.
And we are deeply grateful for your taking a day to come
back and forth, even more of your time, to make this
possible and to give us your thoughtful reflections on
the many topics that are here in short.

If you’re not willing to do this on our behalf,
the undertaking is not successful. So thank you, thank
you greatly, in advance for doing this.

And the second is I think to see this as part
of a process of policy development that’s going to
endure. There are always questions associated with a
change in regime, a political electoral cycle in which
management changes, in which new leadership comes to the
agency, about what the future of the agency will be. If
we were to see ourselves as a firm, this is a product
that’s going to be in our inventory for a long time.
This issue will be a perennial.
If we were to see ourselves as being the Kellogg’s Company, I can imagine that a new chair at some point will come in and say maybe we ought to have granola, maybe we ought to put frosted sugar on this product, but we’re certainly going to keep making cornflakes. That is, we have a number of well-respected brand items in our product line. And this format for discourse, this set of policy issues I think will be enduring ones.

So I want to add the further assurance that by contributing your thoughts and your energy to this program today, you’re making a contribution to the capital account of the agency that we will be drawing on, I think, as long as this agency exists, not simply to its centennial in a few years, but I hope for the many happy centuries beyond that.

So, thank you again. My deep thanks again to Michael. I can’t tell you how much our stock went up when the market saw that Michael was coming back to us. But I’m enormously grateful to Michael and to Pat for doing this on our behalf. And, once again, to you for making this what I’m sure will be a most informative and successful event. Thank you, Michael.

MR. WROBLEWSKI: Thank you, Mr. Chairman.

CHAIRMAN KOVACIC: I’m going to go next-door to
mission control.

(Laughter.)

MR. WROBLEWSKI: Thank you.

CHAIRMAN KOVACIC: Thank you all.
CONSUMER, PHYSICIAN, EMPLOYER AND INSURER QUALITY INFORMATION NEEDS

MR. WROBLEWSKI: The objective of today’s discussion is really to look at what’s the competitive significance of health quality information. This morning, we thought we’d do it a little bit differently and try to go through each four groups -- we’ll call them the demand-side groups -- consumers, physicians, employers and insurers -- users of health quality information, and find out what really makes consumers move from one provider to another provider. What is it about that information?

So, the first session that we’re going to have this morning is really going to focus on the needs of consumers and of physicians, primary care physicians in particular. And to help lay the groundwork for this discussion focusing on consumer and physician needs, Dr. Chumbley of the Wisconsin Collaborative and Barbara Rabson from MHQP will present what they’ve been doing in their states to advance these issues.

Dr. Chumbley, you can stay there if you’d like.

DR. CHUMBLEY: I think if that’s okay, I’ll just stay here. That’s good. It’s always good to go first so you can get it out of the way here.

MR. WROBLEWSKI: You may want to move the
microphone a little closer. There you go.

DR. CHUMBLEY: This is just a copy of who we are and what we do. That’s in your packets. I’m not going to read through that for you. But we are a voluntary consortium of organizations that are listed on this. I think the important point here is that we represent 40 percent of all Wisconsin physicians and 50 percent of the primary care physicians.

Wisconsin is lucky when it comes to this sort of thing by being organized into medium-size and very large multi-specialty groups. I think that’s because we were so close to the Mayos and the Mayo Clinic and a lot of our clinics were actually developed by Mayo graduates anywhere from 50 to 75 years ago.

We have a number of business partners. When we established the collaborative, we looked for business and purchaser partners and this is a list of some of the partners that we have from the business community. It doesn’t show up too well.

But in your packet it basically gives you a chronology of the history of the Wisconsin Collaborative Healthcare Quality and it was really the brainchild of a number of these large group CEOs back in 2002, about seven years ago. They published their first report in 2003. That was about five years ago. Since that time,
we’ve increased the number of measures that we’ve reported on and we’ve increased our membership.

When they first started this, I think there was only about 12 organizations and I do recall writing them and asking to be one of the founding organizations, but they were already well on their way at that point. So, we came in the next year, at least my organization did.

The key characteristic of the Collaborative is it’s a voluntary data collection by provider organization. So when my organization joined, it was voluntary. We went in and said that we will report on these measures. We have administrative data to identify the denominator, the patients, combined with the clinical information, again, whether they had clinical -- had an A1C or some type of laboratory test.

We report performance at the group level, which includes all patients, regardless of payer. So, this data actually comes from the medical groups directly into the Collaborative and it was -- an important part was it was outside verified initially by Medistar, and since that time we’ve developed an outside auditing function where the data is audited as well.

So, what is the value of this? It gives us an option to view the performance of our individual groups compared to other groups in Wisconsin, drill down to the
provider level if we choose to. We do include all the
patients within a system, within the clinic. All payers
are represented. It delivers a road map for the
improvement. And it has stimulated a number of
collaborative efforts by large multi-specialty groups in
the state to improve cardiac performance or orthopedic
performance by looking at what others are doing.

I know in my own organization, we were not
doing well on cancer screening measures that we were
reporting, and so I initiated an effort to improve the
number of screenings we did in the area of colonoscopy,
mammograms, et cetera.

This is just what one of our Web pages looks
like. You can access it. It’s a fairly, I think,
user-friendly Web site. You can look at the Institute of
Medicine categories, you can look at a particular
clinical topic. It is listed by the clinical topics or
you could look at all ProHealthcare Medical Associates’
parameters. It is divided up by region as well. So, if
you ever have time to go on, you can play with it a
little bit and see what we report on.

This is just a list of the current measures,
A1C screenings all the way down to cholesterol
management. We also have preventive care screenings,
which is the one I was mentioning for my organization.
And we have some new measures coming up, adult screening for tobacco and screening for osteoporosis.

We have tried to engage the consumers over time, but frankly we’ve not been too successful. When you look at the hits to our Web site, the vast majority are the organizations that are looking at their competitors to see how they’re doing and to see where we need to improve.

I believe it has increased the quality of medical care provided in Wisconsin on that basis alone, but we have not seen a great deal of consumer or patient use of the Web site. We’ve encouraged businesses to use it in their open enrollment, but I’ve not seen a great deal of that as well.

Our philosophy has been to report the information unaltered and allow the reader to drive the conclusions. So, we don’t have three-star, two-star, one-star ratings for the individual organizations.

Again, the primary users are the providers. We have an RWJ research project to try to increase the awareness of patients in Wisconsin, consumers in Wisconsin, and we’re also in the middle of a complementary strategy called “Ask Me 3,” which is what do I have, what do I do about what I have, medical condition I have, and why is it important. And, so,
we’re trying to get that drilled down to the patient
level as a way to improve the use of the site.

And I think -- maybe not last, but the near-
term evolution is that we are thinking about increasing
or expanding to ambulatory quadrants, the cost versus
quality measures. We have some of those for some of the
hospital measures. We are considering some specialty
measures in cardiology, orthopedics and nephrology.

We would like to start reporting at the
practice site granularity like Minnesota does, so that
you could go on the site and you could go to one of my 28
clinics and click on that and tell what our diabetic
screening rate is or what this rate is or that rate is.
We don’t currently do that. We just report totally by
the organization, all sites.

There’s a lot of talk about physician-level
reporting. It is still our policy that we do not report
at the physician level. We believe that there are
significant problems remaining in this data. I think I
recently heard Beth McGlynn report on some of the
Massachusetts data which highlighted some of the -- at
least on the cost side. It’s cleaner on the quality
side, but not as clean on the cost side. But we are
working more in teams than individuals and we wonder
about the fairness. So, we still report just at the
practice level.

So, last few thoughts, we were lucky enough to have a lot of people involved, a lot of multi-specialty groups, a really shared vision. The groups themselves did the work, which made it credible to the physicians, and I think if you ask any of the physicians in Wisconsin -- and I hope the business partners we have -- that we have credible, reliable data at this point, although it’s certainly not doing everything we had hoped it would do for consumer engagement.

MR. WROBLEWSKI: Thank you very much. If you’ll hand the clicker to Barbara at the end of the row there, we’ll start with a look at Massachusetts. Thank you.

MS. RABSON: So, I appreciate the opportunity to speak with you all today and look forward to the discussion. I’m going to talk about the experience we’ve had in Massachusetts on performance reporting, both on the physician and consumer side. We’ve been reporting for over a decade publicly about performance measures in Massachusetts.

Our first public release was in 1998 and this was the first-in-the-nation statewide hospital-wide survey of patient experiences with acute care hospitals. It was a voluntary survey, but we had the majority of the
hospitals in the state participate and it was really very
-- it stimulated tremendous improvements on the side of
the hospital.

This was actually before the IOM had recognized
patient experiences as one of the important measures,
that care should be patient-centered. So, we were a
little bit ahead of our time.

We switched over to the physician measurement,
and since 2005, we’ve been having annual reports of
physician performance on clinical HEDIS measures. We
report for 150 medical groups across the state. We’ve
also been reporting on patient experience with patients’
visits with their primary care doc at the practice site
level. We’ve had two public releases in 2006 and 2008.
Just this year we added specialties, although we did not
publicly report on the specialists that we added. It was
a first-time round and it wasn’t quite ready for prime
time.

MHQP, similar to Wisconsin, is a broad-based
quality collaborative. We have different players at the
table for Massachusetts. I’d say that what’s really
important about these collaboratives that are springing
up all over the country, which is terrific, is that the
concept of fairness really shifts when you have all these
people in the room.
So, if you have a group of physicians, what’s fair is that nobody gets hurt. If you have a group of consumers in the room, and employers and health plans, they’ll begin to say, but wait a minute, I’ve been making decisions with no information for years and people have gotten hurt.

So, it’s a really important concept and I think that’s why there’s so much new highlight or spotlight on these coalitions, because they add a lot of value.

Our goal is to provide health care information that you can trust, and we have -- provide this information both to physicians so they can improve the care they provide, and to patients so they can take a more active role in their health care decision-making.

And it really, at times, creates great tensions that we are trying to do both, that we really have these two goals of meeting the consumers’ needs and meeting the providers’ needs.

But what we found is that we feel it’s very important for people to get the same information and be working off the same data set. We also know from numerous focus groups that patients turn to their physicians as a first point of getting health care information and they really trust their physicians.

So, if you provide information to consumers,
they bring it into their doc and the physician discredits it, well, you haven’t gained anything because then you’ve just, you know, sort of lost what you have. So, I will say this is a harder route to go, but I feel it has great value in the long term.

Certainly, engaging physicians in performance measurements has been a very -- it’s been a very -- it’s a journey that started hard and has been getting easier. I’ll say it that way. But the way we do it is that when we started focusing on physician measurement, we felt it was really important to have physicians at the table whose job it was to implement improvements within their organization. And having a medical society at the table was great, but we needed these on-the-ground docs.

So, we set up what we call our physician council, and these physicians are leaders from 16 of the largest groups across the state. They are advisors. They’ve become ambassadors from MHQP. I think of them sometimes as the jewel in our crown.

Here’s a quote from one of our physician council members, who’s no longer there, but continues to be an ambassador. She says, “A voice at the table is huge. Physicians know all their concerns are not going to be met, but to be able to raise what is really important and have it taken seriously and used to modify
the process is worth everything."

So, I think the importance of this is that some people say if we get the physicians to the table, everything will grind to a halt. Well, that’s not the case. It does create some challenges, though.

Here is a list of some contrasts in what consumers and physicians -- physician preferences for comparative information. And I think sort of the top level here is that consumers want easy to understand and physicians want fairness. And, so, if you look at symbols, consumers want symbols they can easily recognize and interpret. Physicians don’t want anything judgmental. They want it purely statistical.

Consumers want simple messages. No caveats. I heard from a study, the more caveats you put, people just sort of doze away and say, wait a minute, what you’re telling me is that there’s nothing I can believe here, and so, they walk away. On the other hand, physicians want full disclosure of all the limitations, caveats and methodology.

Consumers want a synthesis of all the information. So, clearly, you can just tell me who’s good and who’s bad. Physicians are saying, well, wait a minute, if you have a specific measure, that measures that specific thing. It doesn’t mean that that physician
is good at everything just because they’re good at one thing. Like all people, physicians are good at some things and not so good at others. And, so, they feel that it shouldn’t be rolled up into a yes/no.

And, so, we’ve tried to navigate between these two. I think it’s been a very challenging but rewarding experience. It’s something you have to continually address because these things also shift in terms of preferences.

So, as far as the impact of MHQP’s public reporting, I’m going to talk about the clinical HEDIS reporting we’ve done. We are currently involved in a study with the Commonwealth Fund to look at the impact of our patient experience reporting. But that hasn’t been completed yet.

So, in terms of the impact, there’s a much greater impact on physician behavior than consumer behavior. We know that. Physicians have improved -- of all the measures that actually can be trended over the period of time we’ve been doing it, physicians have improved on eight over nine.

Clearly, there is lots going on in the Massachusetts marketplace, so we can’t claim that this improvement is due solely to MHQP’s reporting to physicians and the public. However, it has some impact.
The fact that we can track it is a key issue because most communities can’t track this because they don’t have this kind of reporting.

I think the greatest impact on our public release is to influence physicians on sort of understanding that they need to improve how they practice and changes they’ve made. And I’ve got two great stories. One is from Tom Lee at the Partners System.

The first time we had a public release it was actually in 2004 on the physician side. It was at the network level, so the very large physician organizations. All of Partners, all of Harvard Vanguard, all of Lahey Clinic, Fallon Clinic, UMASS, Caritas, so on, and Harvard Vanguard was at the top and Partners was not.

So, Tom Lee called over to Vanguard and said, well, can we come over and see what you’re doing, how we provide care, because we consider ourselves number one and we want to get there. And what they focused on was the idea that there was a centralized electronic health system, electronic health record capture was centralized.

And Partners was beginning to embark on a requirement that all the physicians in their network implement electronic health records, but they had no rules around sort of what they’d pay for. There was sort of a list of eight different approved vendors.
After seeing the results of MHQP’s data publicly, after talking to Vanguard, they realized they needed a much more centralized system. So, they changed what they were going to pay for in terms of implementing electronic health records. So, they could either get onto the Partners homegrown system or one other vendor, which was huge really.

The other example is a very small group that wasn’t in the first public release, but they saw the writing on the wall and they had been planning to implement electronic health records, but not for quite a while. They saw what their quality scores currently were.

They saw what the benchmark scores were, those that we’d already publicly released. They said the only way they were going to get from where they were to where they wanted to be to be competitive was to implement electronic health records earlier. So, they fast-tracked two years earlier than planned and implemented their electronic health records.

The other use of this reporting is that physician organizations use the information internally to -- for pay-for-performance to reward individual physicians with the group. We currently only have the primary care data. They’ve asked for specialty
information, both for distributing within their specialists, but also the primary care docs have said they’d like to have that information when they make referrals.

But it’s hard to get -- so, this is on the physician side. It’s hard to get consumers engaged. This is what we know about consumers from some focus groups when we showed them our publicly-reported data. It was really very eye-opening. We’re very proud of our Web site.

So, we showed them a slide of our data showing how different groups performed on screening for breast cancer. And, so, one woman looked at it and she said, okay, so what you’re telling me is that 92 percent of the women that go to Fallon Clinic get their mammograms on time. We said, yeah. She said, well, why should I care? I go. I get mine on time. So, why are you telling me this? This is not helpful to me. What I want to know is if I go, I’m going to be cured, or I go, I’m going to be treated with respect.

So, consumers want outcome data, physicians want outcome data. We clearly need to move to outcome data if we’re going to get all parties more engaged. So. that’s on the clinical side.

On the patient experience side, consumers are
engaged with this data. They love having information about how their physicians communicate and listen to their patients, whether they know their patients well, whether they coordinate their patients’ care.

And, so, on the patient experience side, consumers really felt this was the kind of information that would let them pick the type of doctor that they wanted. And, so, strategically, if we had started I think as a rule to engage consumers, starting on the patient experience side is really the way to go. We’ve all started on the clinical side because that’s been more developed and that’s more helpful to clinicians, at least that’s how it evolved. But I think that there’s an issue there.

Finally, just having any information, consumers have said in our focus groups, having options, the ability to make a choice in finding a doctor is really empowering. They felt like they could take charge of their health more because they had information that helped them do that.

Interestingly enough, they said I really hope the doctors use this information for quality improvement, which was surprising to us a little bit, but it really reinforced the idea that you should have the physicians using the same data and embracing the data that you have
because, you know, it basically goes full circle. The purpose is to improve quality. And if physicians use this information for improvements, that makes the patients happy because they’ll get better care.

I think that this is just a summary slide. We have not done efficiency yet. I just make a note of that. As Dr. Chumbley mentioned, Beth McGlynn has been working in Massachusetts on efficiency metrics. We’re still on the research side of that, sort of kicking the tires on the efficiency metrics that are out there and looking at the validity.

We did ask consumers about efficiency and they said they didn’t really get it at all. It’s a challenge to understand. They associate it with businesses, not doctors. To them it means somebody is going toShortcut their care.

I just wanted to take a quick tour of our Web site and make a few points. Consumers really need context to engage and embrace and understand quality information and lots of different levels. And what we found on the way we report, we report at the medical group level, the practice side and not yet at the physician level, but we hope to do patient experience down at the physician level. Consumers didn’t get those different sort of concepts. So, we drew pictures, which
people felt really helped them ground sort of what the relationships were.

Our site is interactive in that you can put in your Web site -- excuse me, your zip code and you can enter a name either of the medical group if you know it, practice site if you know it or the doctor and then it will map to the appropriate group.

I just went to a conference of IT folks in Boston and they basically said if you have a Web site that pushes information at people and doesn’t let them interact with it, just forget it. People will stop using it. So, I think that’s a challenge for us all as we move ahead.

Understanding sort of all these concepts again, we worked with a health literacy specialist and we ran focus groups to understand what categories or labels to use in the public reporting that we do. So, we came up with these different categories of how we could group the patient experience survey.

We put summary results up, as you can see, and do use stars. But we also put the item detail here for those patients who want to drill down and also physicians felt it was important to have these specifics. So, it’s a phenomenal amount of data actually to put on the Web site. So, for every practice we go down to every
question asked and how every patient answered it.

And I want to put this up because we also put up data on our Web site that we know is not consumer-friendly, but for a policy perspective. We really feel that the policymakers in the state were looking to say, okay, where should we focus our improvements in Massachusetts.

And, clearly, what jumps out at you is while we’re really good at giving the tests, controlling HbA1C and controlling cholesterol is another story altogether. So, we really need to move into that area. And that requires -- while we have the test data at the statewide level, we don’t have it down to the individual physician level because we don’t have the data sources coming in.

On our Web site, we also put explanations of the ratings that we use and, finally, we really want to put some information for consumers about what they can do and other useful resources. So, we really try to identify ways -- what they could expect of their doctor and we’ve had -- just as an example, what your doctor should do. And that was totally pushed back. So, ways your doctor can help. It was -- you know, these things are -- you know, you have to understand all parties when you put the wording down. So, it’s very carefully worded.
And, also, when we go public with information, there’s two public releases, the press releases in your Web site. We always put a checklist on -- one is working with your doc to improve your care. On the other, we talk about things they can do to improve their diabetes or their cholesterol. So, that’s...

MR. WROBLEWSKI: No, that’s perfect. You’re going right to my next slide. Thank you very much. Thank you, both of you.

What I’d like to do in this part of the discussion is really focus on consumer information needs. And I think what we heard this morning really that can be broken down into three -- we heard about two main areas and then a third area that I’d like to add at the end of our discussion when we focus on consumers.

The first one really is what are the types of performance measures and scope of differences that allow consumers to differentiate or select among providers? That would be the first topic I’d like to go through this morning.

The second one is the presentation and format issues that both of you talked about this morning. And then the third is what comparative effectiveness information would assist consumers to evaluate and select treatment options?
So, I’d like to start with Beth Nash. Barbara indicated in her presentation that patients were looking for outcomes that show differences. So, I’d like to get your reaction to that. And then as we work the panel, if you’d like to add a comment, if you can just turn your name card on its side, that would be great so we won’t have to raise hands. Thanks.

Beth?

DR. NASH: Thank you. So, yeah, I’m going to hit upon some of the things that have already been mentioned. I will get to the outcomes question. But I’m going to try to focus on, you know, do patients really care about this stuff? If so, what do they care about? What do they perceive their needs to be? How do they want the information presented?

Just by way of background, you may think it’s a little strange that somebody is here from Consumer Reports talking about this stuff and a doctor to boot. And I just wanted to say that, you know, at Consumer Reports, we have over seven million subscribers to our various publications, and we really have been providing health information from the very first issue of the magazine in 1936.

And over the years, what we’ve found is that consumers are increasingly interested in health care.
They’re really demanding information about comparing
different things in health care, just like we compare
different refrigerators or automobiles. And, so, we do
think it’s an area that’s very necessary to the American
public and also in which Consumer Reports is
well-positioned to provide that kind of information.

So, we clearly know that consumers are
interested in health care information. They want to be
part of the dialogue. And they’re particularly
interested, as Barbara alluded to, in issues around
communication, how well their doctor communicates. And
in terms of clinical measures, they really are
interested, they want to -- they know they should be
interested, but they really don’t quite get it.

So, as an example, we just recently did focus
groups as well where we showed consumers different
information about different hospitals and, you know,
said, well, this one’s infection rate is this, this one’s
hospital mortality is that and that kind of thing, and
they just sort of looked at us like why would I be
interested in that because even if that’s what the
hospital does, my doctor’s really good, so it won’t
happen to me.

So, there’s this really big education piece.
And I think the really good news is that consumers can be
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educated. So, for instance, on our own site, we recently
presented some very complex information about comparing
hospitals which came from the Dartmouth Atlas.

This is information that’s all about the
intensity of services. The point of this work is that
more intensive services, so getting more care, if you
have a chronic condition may be worse for you. And I
think it’s a non-intuitive concept. And the bottom line
is that we were able to present this in a way that
consumers really understood.

And, so, I think the issue is that you just
really need to go slow, be very transparent, be very
clear about why a consumer should be interested in this
information and they really will get it.

In my former life, which was working in
evidence-based medicine at the British Medical Journal,
we had a similar experience where we were able to
communicate really complex issues to consumers and they
really got it, sometimes better than the doctors get it,
because in some ways the consumer is much more invested
in getting that information.

Now, there are also some challenges. So, for
instance, in the issue of hospitals and selecting a
hospital, again in our focus groups, patients said to us,
I don’t pick my hospital, I go where my doctor is. And,
so, you know, I think that there’s some education there as well.

Now, they are interested in knowing if that hospital is good or not, but not entirely clear on the fact that they really have some choice in the matter and how they might go about exerting that choice.

MR. WROBLEWSKI: Beth, can I interrupt for just a quick second? How did Consumer Reports present its hospital information in terms of the format? Was it a score? Was it a symbol? Was it a -- in terms of trying to get that information across to find out kind of what was usable for the consumer.

DR. NASH: Well, first of all, and this is another piece that I think Barbara touched on as well, it needs to be interactive. And, so, the way that, again, this Dartmouth Atlas information that we presented, you needed to be able to search, to be able to find hospitals nearby, that kind of thing, you know.

And I think the other piece of that, which I’ll come back to if I have time, is it really is all about me, you know. So, consumers really need to not only get the information that they need, but understand how it’s relevant to them.

Now, in the Dartmouth Atlas example, again, what we did was to present things sort of on a scale. So
where an organization is on a particular scale. Now, as you all know, Consumer Reports is all what we call blobs, so little red circles about what’s the most effective and what’s the least effective. And we don’t have time to go into that here, but where we can, we are using that very same blob system and applying it to health care because it’s something simple that consumers understand.

So, whatever the scale is, however you present it, it needs to be visual and it needs to be clearly understandable to the consumer and, again, Barbara mentioned this a moment ago as well, it can’t really have too many caveats and disclaimers and asterisks and special cases. It’s really got to be very simple and very clear.

Another challenge I just want to mention is that, again, when it comes to clinical information, outcomes information, it’s got to show some differences. So, if everyone’s kind of the same, you know, why do I care? Or if most things are the same, why do I care? So, there’s got to be something that distinguishes one place from another.

And a further challenge is that -- and, you know, this was a little discouraging to us when we recently did some focus groups on hospital ratings, is that patients really care a lot about parking and
cleanliness and, you know, those sorts of factors, which
I’m not saying they’re not important, but those are the
things that they know. And, again, I think there’s a big
education piece, and I think an organization like
Consumer Reports can play a big role in educating the
consumer.

One last thing that I’ll say that, again, some
of the others have mentioned, is this whole notion of
experience. What has been the experience of others?
Really, really important. Patients really, really care
about that. They’re particularly interested in the
experiences of their own family and their friends, but I
think any kind of rating system or any kind of comparison
really has to bring in that piece.

And if I have one more second, I just want to
close --

MR. WROBLEWSKI: Just one.

(Laughter.)

DR. NASH: Thank you. With just a brief
mention of comparative effectiveness, because, once
again, I’ve had some experience in this area and patients
really, really do understand the notion of comparative
effectiveness. Some drugs work better than others. Some
treatments work better than others.

And I think in this whole health care arena,
what we’re trying to do is to level the playing ground. So to get the same kind of information in the hands of the doctor and the patient so that they can engage in a meaningful dialogue to figure out what’s best for that individual patient.

MR. WROBLEWSKI: Thanks, Beth.

Peter, did you have comments in terms of what consumers were looking for to make a difference?

MR. LEE: Just to maybe build and reinforce a couple of things that Beth said, and I thought that the last two presentations were great in sort of queuing things up. Though many ways they were framed, to my mind, largely from a QI, quality improvement, provider perspective, not from a consumer perspective. And I think Beth sort of reflected some of that.

I thought Barbara notes what consumers look for versus physicians was, in many ways, a telling piece to start some of this discussion because I just -- consumers want outcomes. They want the results. Am I more likely to get cured or not? They’re less interested in process measures which are more useful for quality improvements. There’s tensions we have here. So, that’s one.

The other that I’d reinforce is patients like me. Consumer experience resonates very strongly, is a very compelling thing for consumers.
Third is the more specific the better. I know we’re going to get to treatments in a minute. But we heard from the focus groups and others, the groups are kind of interesting. But I want to know about the doctor. Or I want to know that -- I just got diagnosed with breast cancer. I want to know about treatment. And, so, the more specific, the more relevant and it needs to be interactive.

And the last two other points I’d note, and I know this is a scary one, but this is where -- validity is not -- consumers don’t start looking at statistical significance. They will get on the Web and they’ll look at an N of one because someone logged on and said I had this experience with this doctor.

If that’s better than nothing, they’ll take that. That may be totally wrong on a statistical basis, but validity is not where they start. They start with does it speak to me and is it relevant to me?

Finally, in terms of types of information, I know you’ve got it in your slides, I’m jumping ahead, I shouldn’t do this, but the thing that we really haven’t heard about yet is cost. Efficiency doesn’t play at all as a concept.

But, increasingly, consumers are very concerned about what is this going to cost me? And what is my
financial exposure going to be, given I’m in this PPO and
I’ve got a $5,000 out-of-pocket maximum and a deductible.
From our experience at looking at this, they are very
interested in cost. So, this idea about efficiency is
like a huh?

But it’s not to say what are these two
different treatments going to cost you. What’s this
choice going to mean? That’s a piece that really didn’t
come up in the last two presentations. It’s really not
what they’re looking at so much. They’re looking at
system issues. But from a consumer perspective, I’ll
tell you that is an increasingly important piece of what
I think they’re looking at. I don’t know if Beth would
agree with that.

DR. NASH: Yes, I do.

MR. WROBLEWSKI: Thank you.

Nancy, you wanted to add something to that?

MS. FOSTER: Sure. Thank you very much. And I
appreciated both presentations, very helpful to me in
thinking further about the discussion today.

I just wanted to highlight a couple of things.

One, Peter, I think you actually touched on this a little
bit, but we talk about consumers as if they are monolith,
which we know they are not, and we talk about consumers
wanting information for choice, as if that is their only
relationship to hospitals, doctors or others. And we know that’s not true as well.

Consumers may want to know things that may not affect whether they vote with their feet and go elsewhere, but may affect their interaction with the health care system in a very productive way.

So, to the extent, Michael, that you want us to tease out some of that as well in this discussion, maybe we need to expand our thinking around what consumers use information for, because it may be as simple as having a more informed discussion with their clinician or in how they approach their upcoming hospitalization, whether they take someone with them, whether they ask particular questions when they’re there in the hospital.

And the only analogy I can think of to just sort of make it a little more concrete is to say I’m an active member of the PTA at my son’s school. There’s very little about the national or even regional test scores that are going to make me pull him out of that school and take him to another school. But I’m keenly interested in that data, and it does affect my interaction with the school and with his teachers. So just a different frame on that.

MR. WROBLEWSKI: Sure.

DR. HOVEN: Thank you. I’ve been very
interested in the presentations thus far. I’m going to speak to some physician issues obviously a bit later, but I want to go back to Beth’s comment on hospital selection and I go where my doctor sends me. And in one of the slide sets for today, there is -- you know, you don’t have a laptop in the ambulance when you’re going to the hospital and you’ve had an accident.

And I think that sort of has -- all these issues are going to have to come into play as we talk about these things. I may have to send a patient to a particular hospital because the cardiologist I want to see that patient is there and not at some other particular facility and I think that cardiologist is the best one for my patient.

And, so, I think hospital selection has got to be done very cautiously. Yes, we need to know what their infection rates are and, yes, we need to understand what happens in those facilities and are they adhering to the Joint Commission and all the improvement guidelines and that sort of thing.

But, you know, I really do think that this is going to be something that, again, has to be personalized. Back to what you talked about is, in fact, I need to be able to talk to that patient and make them understand why they’re being sent to a particular
facility. But they still have choice, if there’s a choice. I practice in a community with one hospital. There ain’t no choice.

So, having said that, I think we’ll be coming back to this again in different ways going forward.

MR. WROBLEWSKI: If there were a way to prioritize what consumers wanted, whether it was outcome measures or performance measures at the hospital level, at the group practice level, at the physician level, at the medical condition level, where should we be putting -- where would it make the biggest difference in terms of consumers selecting one over the other?

If there are barriers to hospital selection, should we be putting our resources into selecting primary care physicians because they don’t have -- or the specialists because they don’t have a choice of hospitals? Anyone can -- Vince, you had your card up, you can answer that question.

DR. KERR: I thought I misunderstood. I got this up. Maybe it was this one.

(Laughter.)

DR. KERR: I’ll take that just because it’s on the table. I think it depends. This is back to the comment that consumers are not monolithic. We developed a construct inside our company that looks at
decision-making. It’s really three-dimensional.

So, when you think of consumers, they are different and it’s not just by education levels, et cetera. You can measure something called activation, which is their sense of empowerment, their sense that they can interact or control whatever the outcome is. That’s very different. And you can divide them into four distinct groups. That will influence how they process information and what they do with that information.

It is also influenced by perception of the risk or benefit. So, we map sort of various sort of decisions that consumers have to make. A one-time instance is a lot easier than persistence, like taking a medication five times a day for the rest of your life, even though that sounds like a simple task. So, there are various factors that influence risk versus benefit and the effort that’s required to achieve that.

It may be very difficult to maintain a woman who’s pregnant, expecting, may be able to stop smoking for that nine months because highly motivated, but find it very hard to quit lifetime, those sorts of things.

So, when you ask a question like that, you have to remember it isn’t -- the answer is it depends. For someone with an acute condition that is perceived as high-risk, they will be very interested in the treatment
information, in the things that might make a difference to them and their outcome or the side effects that they’re going to feel or something else that affects a part of life. They may not care where they get a flu vaccination or, for that matter, an MRI or something else. That’s not perceived as high-risk or with much differentiation.

So, if I were to, given those comments, try to answer your question, it would proceed from treatment to physician to facility.

MR. WROBLEWSKI: Thank you. I’m going to turn to Elysa. I think yours was up next.

MS. FERRARA: Actually, I think his was up next.

MR. WROBLEWSKI: Okay. Dr. Chumbley, I’m sorry.

(Laughter.)

DR. CHUMBLEY: Oh, I’ll pass. We were just testing you.

(Laughter.)

MS. FERRARA: Well, I had wanted to speak to a couple of things. One was the comment on personalization and one was a comment on variations and populations and the fact that we are not monolithic. There is not a question that there’s a body of literature that shows
that half of adults in the U.S. cannot locate, match and integrate information.

So, health literacy, you had mentioned it, and it’s something we really need to be mindful of. That’s why we go to symbols that are self-explanatory to some degree. That’s why the Consumer Union and Consumer Reports is so successful, because it’s understandable to consumers.

We cannot forget as we’re talking about a non-monolithic population racial and ethnic disparities, an obligation that we all work toward around this table to eliminate those disparities in health care and health outcomes and services. So, there are special things we need to focus on in order to address that.

Then in terms of personalization, I think this is where competition on the health plan level emerges because health plans -- you’ve done it, we’ve done it, we’ve built personal health records, we’ve built the ability for consumers to have a personalized space within their own health E-records.

So, it’s not just their personal health records, but I can go into my Web site with my insurer who, of course, is Aetna, and I can say I have a 16-year-old son who I’m worried about accidents and I’m worried about drugs. And, gee, I’m in that menopausal
age. Gee, my mother had breast cancer. And I will get alerts, I will get information that are very much tailored to me.

Over time, we’ve certainly seen, combined with employers creating incentives for use of that information, that consumers will come and they will use the information. But definitely personalized, definitely not making me wade through things. We find that our members over time will stop going to the Web site and type in breast cancer cure, you know, in a Google world, and will start going to more informed choices. I think that’s the other thing we have to remember.

Consumers aren’t out there not getting information. They’re Googling. And I can tell you you can Google any physician’s name in this country, any physician’s name, and you’re going to get one member experience somewhere off one of those public Web sites. So, to the point that people will act on one experience.

When you said that it reminded me of an experience I just had. We went on vacation to the wine country of Upstate New York. I bet you didn’t know that even existed, but it does.

(Laughter.)

MR. WROBLEWSKI: They have to import the grapes.
(Laughter.)

MS. FERRARA: No, they grow them. But they have no hotels. So, I did my Google search for a hotel and I read this review, one review. It said the rooms were dirty and a two-year-old was murdered in the hotel five years ago. I didn’t go to that hotel. It was only one review.

(Laughter.)

MS. FERRARA: But sometimes one review can be extremely -- well, it actually turned out to be true, once I got there and found out. I figured that’s good enough for me. The rooms are dirty and it’s probably not too safe.

So, I think consumers act on the N of one and a lot of what we need to do is really get credible information out there and credible information means all of the partnerships we just talked about at this table. You know, it’s physicians and health plans and consumer groups working together to make this information credible. So, the symbols really mean something.

MR. WROBLEWSKI: Thank you.

Kristin, can I also ask you to address -- we had talked earlier about efficiency and what -- first of all, if you can at some point explain what efficiency is so that we’re all kind of talking about the same thing
and then your comments as well.

MS. MADISON: Yes. That’s a really interesting question about what efficiency is. When I think about efficiency, I think about productive efficiency. So, minimizing the input that you need to produce any particular output. So, quality, for example, would be a measure of output.

So, when I think about what an efficiency measure within health care should be, I would think about it as the cost of producing a certain level of quality. I think the way that a lot of people end up defining it is the cost of producing a particular type of care, right, a typical episode of care, for example. And I think it’s a really confusing measure for consumers. I don’t think it has a lot of meaning. You need really to couple it with quality for it to have any meaning.

If you think about, say, the most efficient restaurant, it’s probably McDonald’s, right? It’s very, very good at what they do, producing things at very low cost. But if your choice is between a McDonald’s hamburger and another hamburger at a fine French restaurant, if they have hamburgers, you would probably choose the fine French restaurant because what you care about is quality and not the efficiency of production.

And, so, at the very least you need to couple
efficiency with quality, so choose the most efficient producer at the quality level that you want. Or you could just make it more straightforward and talk about cost and quality, so the cost next to the quality measure.

What I wanted to actually talk a little bit about was consumer satisfaction or patient experience or patients that are going to switch. A couple people have brought it up already. And I have to admit I’m a little conflicted on this kind of information.

In one sense, I think it makes total sense to produce these measures and to disseminate them widely because patients, as people have been saying, really do care about them and in a competitive marketplace you try to meet the needs of your consumers.

On the other hand, I have a couple of problems with them. One is just a question of comparative advantage. As someone mentioned, you can get quality information from your friends. You can get quality information, patient experience quality information from yourself, right?

You see a doctor once. You can decide whether they like that doctor, whether they like that office, whether they want to go back there. So, there’s a lot of places where you can get that kind of information or the
cleanliness of rooms.

You can’t get information about past mortality rates from your friends or from your past experience. And, so, in terms of where we want to put our resources in measuring quality, I think that’s something that you have to take into consideration.

The other thing goes back to this comment about how people don’t understand clinical quality information, and that’s something that troubles me as well, because the question is if you go to a Web site and you’ve got six measures of patient experience and you’ve got two clinical quality measures, which you don’t get, what are you going to decide based on?

You’re going to decide based on that patient experience measure, which may be perfectly fine. Maybe that’s what you care about. Maybe it’s correlated with clinical quality. That may be a good thing. But I worry that people will overweight those patient customer satisfaction or patient experience measures.

There was a sort of an experiment that was run, a study was published where doctors had -- the question was basically do people choose higher technical quality or do they choose better patient experience doctors when you’re forced to make a choice?

The answer was that when it was sort of a clear
choice between those two, people were more likely, in fact, to choose the technical quality. But there was a substantial majority of people who preferred the higher patient experience doctors over the clinical quality doctors.

There are other studies, Kaiser ran a survey saying, you know, would you rather go to a doctor that your friends have gone to, not even that your friend said was good, but your friends have gone to, or would you rather choose a doctor that has good quality as shown by independent reviewers? Again, a significant number of people chose the doctor that other people had gone to.

And, so, maybe this is just a question of presentation. How can you educate consumers, as Beth was saying earlier, to understand what that clinical quality is? How can you present that information so that they take both into account? But I’m feeling a little bit paternalistic and a little bit worried about the use of patient experience in these settings.

MR. WROBLEWSKI: Thank you.

MR. WEBBER: Thank you, Michael. It’s great to be here and hear this conversation. And, of course, this conversation sort of reminds me, having been in health care for 30 years, that there is an active debate about whether competition in health care is even possible.
And I think already we’ve had comments from people suggesting that really the end goal of information, whether it’s for providers, information for consumers to better interact with the system really challenges the notion of competition.

I, for one, because we’re at the FTC, would like us to at least have the premise that we are talking about, the vision and possibility of value-based competition. And it’s not a discussion of no because of all these things that we know. We don’t have good measures. Consumers don’t know how to use the information. Physicians don’t like to compete.

I think our discussion today, again, because we’re here, Michael, at the FTC, is we should be saying, yes, if we do certain things. So, I hope we could get away from the debate, even if we feel it passionately, that competition as a vision in health care has too many obstacles that we can’t get there and try to focus our attention as experts on building the infrastructure and those basic market dynamics that would get us to a value-driven health care delivery system.

And, yes, it includes things like having good measures of value, which we’re not there yet. Yes, it means full transparency and ways that consumers can really understand the information. Yes, it means health
care plans, how to organize provider networks and
differentiate reimbursement to providers based on
performance and value.

And, yes, it means consumers and employers need
to be making better choices at all levels for consumers
not only choosing doctors and hospitals, but, as we’ve
talked about, choosing high-value medical services. For
purchasers, it’s about perhaps choosing the right health
care plan that’s providing the health care services to
our employees.

So, anyway, I’m just feeling a sense that we’re
back to the debate of, you know, the last 30 years about
whether competition in health care is even possible.

MR. WROBLEWSKI: You know, I appreciate those
comments, because the reason why we’ve started this, why
we started the way we did was to look to see, well, what
has worked so far and what are consumers looking for,
and we’ll go through each of the other groups as well,
in terms of what would make a difference, kinds of needs
-- an ideal world. What would you need in order to
select based on value? And, so, I think these
perspectives are important.

I want to go to Dr. Hoven and then Barbara and
then Nancy and then I want to turn to Jack -- and Dr.
Chumbley, and then I’m going to turn to Jack to start on
the last bullet point.

Dr. Hoven.

DR. HOVEN: Thank you. I will be brief. I want to go back to Barbara and the slide comparison of what consumers want reported and what physicians want reported because this gets to the guts of what we’re really trying to talk about today.

I’m intrigued by some of the comments which have been made around the table because if you think about it for a minute, this is all language and it’s the interpretation of language. And what I need and what I’m telling you I need is based on the way I think. I want validated, sound data that’s relative and timely and that sort of thing.

What my patients want, though, is an entirely different mix of information. They’re rating me in a process, maybe because they couldn’t find a parking place in the parking garage. They get to the front desk and they’re mad as hell when they get there. So, the whole experience wasn’t very good for them that day. They were late for their appointment and they had to wait.

So, I think you’ve got issues here which -- and back to your point, Kristin. I think you’ve got to weigh out some of this personal stuff that gets mixed in in interpreting information. But I think we really have to
be very challenged on this.

This is a language issue that what I need and what my patients need are going to be two different things. How we make those come to the middle and be interpreted are going to be very, very difficult.

MR. WROBLEWSKI: Thank you. We’ll go to Barbara and then Nancy.

MS. RABSON: Okay, thanks. I’m going to come back to the point of definitions around patient experience because, you know, some of your comments worried me, both of yours, and so I want to be clear that patient experience -- you know, there’s patient satisfaction I see as different than patient experience.

And, in fact, we are vigilant about people who talk about our survey to say this is patient experience; it’s not patient satisfaction. Because it’s not about the food, it’s not about the parking, it’s not about cleanliness. This is not part of our survey.

What we’re really doing and MHQP is using a survey that was developed by Dana Gelb Safran, so it’s very methodologically sound. There are plenty of surveys out there that don’t follow this, and that falls into the patient satisfaction bucket.

But in the patient experience bucket what it really gets at is issues that are key to improving the
relationship and improving the care of patients and
improving patients’ willingness to actually do what the
physician tells them to do or the care provider. And,
so, it talks about communication. It talks about
respect. It talks about understanding. It talks about
coordinating care. And these are really key to a good,
solid experience in health care.

And, so, it is part of quality. It gets to the
IOM, as I said, the patient centeredness of this.

So, we have to be careful not to throw out the
baby with the bath water because this is something that,
as a rule, physicians are not very good at all the time
because we’re learning that as we’ve issued our results,
physicians are coming back to us and saying, help me with
this, and there’s not a whole lot of programs out there
or not as much understanding as we have on the clinical
side, what do we do next in improving some of these
things.

So, I think it’s a really, really important
area. So, we do have to differentiate.

MR. WROBLEWSKI: Thank you. Nancy?
MS. Foster: I, too, will be brief. I just
wanted to address Andy’s point. I’ve been in many of
those conversations myself. I don’t really want to
rehash them. But I think maybe to the point of today’s
conversation, it’s really about getting smarter about how
we use competition and to use it as part of a panoply of
activities that are both encouraging quality and
encouraging consumer engagement in a whole array of
aspects of health care.

But as I think about it, there are at least
some deep concerns about whether competition, in itself,
will lead to some things that we wouldn’t want in the
health care system, like is it really acceptable if some
places give aspirin and beta blockers to heart attack
patients and others don’t and we’ll just let the
consumers choose on that, or is that a basic element of
care that really has to be there? Where do we want
competition and where don’t we want competition is a
question I think we need to ask ourselves repeatedly.

And my delight has been to watch some of the
consumer engagement and use of the, unfortunately, too
small number of decision support tools that exist right
now around choosing treatments. They really resonate
with those, at least at the data I’m looking at.

And despite the efforts that a number of us
around the table have been involved in in getting quality
data out there for the last five, six, seven years, they
normally don’t resonate with it. At least the latest
data suggests fewer of them are looking at it than were a
year ago.

So, they’re telling us we’re not doing it right, at least.

MR. WROBLEWSKI: Dr. Chumbley?

DR. CHUMBLEY: I think there is another level of competition and that is between the medical groups to improve the quality of the care that they deliver, which is external to the patient or the consumer. I mean, we haven’t seen shifts in Wisconsin of patients between one organization and another based on this, but we have seen improvement because the organizations and the physician leadership in those organizations want to improve. We’re not proud of our international record of providing health care. And, so, we have seen a great deal of improvement just based on that level of competition.

So, I think the reporting of this information, even if the consumers are not involved, is raising the bar and raising the quality of the medical care in Wisconsin.

MR. WROBLEWSKI: Thank you. Michael, did you want to add something on that point and then we’ll turn to comparative effectiveness of treatment?

DR. BARR: Just I was holding my time a little bit earlier because I was going to say something. But I think what Nancy and Clyde just said is sort of -- for
some things, we may want to remove choice or remove the need for choice, for example. That raising the bar.

Why should people have to be able to choose between a hospital that does not give aspirin and beta blockers? That level of competition should go away. We shouldn’t have to compete. Everybody should be doing that.

I think that’s sort of what Clyde is saying and I think that’s important, we recognize that. Not everything needs to be judged in the form of competition. We need to simplify things so that patients or consumers choose on the things that are relevant, that are important.

But the goal should be there should be no need for competition on these kinds of things. They should all be delivering that kind of care.

MR. WROBLEWSKI: Go ahead, Jack.

MR. FOWLER: Okay.

DR. CHUMBLEY: That is the goal.

MR. FOWLER: I think one of the things I wanted to address, getting down to point three there, is whether we have the right measures for how well-served consumers actually are by the health care they’re getting. And I think this also resonates for some of the things Nancy and Michael were talking about.
Al Mulley makes a distinction between doing things right and doing the right thing. Most of the measures that we’re talking about for quality have to do with doing things right, and that’s everything from giving proven treatments to people where we really know it’s right to not infecting folks and having clean restrooms or whatever that is, and whether you get out of the hospital alive when you have bypass surgery.

None of that addresses the question of whether you should have bypass surgery in the first place. It’s hard to get into that, you know, clinically when your measures are records and claims, as your sort of measures of quality. That’s one of the reasons we don’t have that.

But I think the notion of whether the process of care involved communicating to patients the information that’s available about the options and about the comparative effectiveness information that we have, prior to getting people on an operating table, not as part of the informed consent process, but as part of the informed choice process before you get there, is really an important part of getting -- is measuring the value of the care that people are getting.

One of the things that bothers me about all the measures that are prevalent in our society about quality
performance is it’s all about doing more stuff to people
and there are hardly any measures of doing less stuff and
of overtreating and of giving people meds that aren’t
doing them any good and of giving people tests at a time
when it probably won’t do them any good and if they
understood them, they wouldn’t want them in the first
place.

There are some challenges in getting good
measures of how the decision process went. We have
pretty good data from a Michigan study that shows that
the decision process, at the moment, is pretty terrible.
It’s hard to get from just a patient experience survey if
you’re kind of generalizing across all, but when you look
at individual decisions, it’s pretty cursory and doctors
pretty much sort of tell people what they think they
ought to do and they pretty much do it. That’s not
astounding, but kind of a model built in.

But we can do better than that. I think that
when you’re talking about measuring quality of what the
medical care is that’s being delivered to people, and if
you’re going to move that, I think you’ve got to work a
little bit on the process of getting the other aspect of
how involved patients really were in the choices that
were made about them.

And the value of that is both, one, that you
can get them more to buy in and be committed to the stuff that will actually do them some good, rather than just walking out with a prescription and not understanding why.

And, on the other hand, that they can protect themselves from -- some of my friends would call it overtreatment, from things that if they were really informed and understood and knew the pros and cons, they really wouldn’t want to do them.

So, I’d like to expand the discussion about the measures of what’s good and what’s bad and how you tell good care when you see it to include that sort of patient-centered approach.

MR. WROBLEWSKI: Beth, did you want to add anything when we had talked earlier in terms of comparative effectiveness?

DR. NASH: Yes. Actually, I want to add something that’s not about comparative effectiveness, but which is something related and was spurred by what you were saying, which is it seems to me there’s this balance that we have to try to find between coming up with a composite measure, an overall measure really, taking into account all the important things.

So, everyone here is commenting on, for instance, when we’re looking at hospital quality or
doctor quality, you know, that not everything is equal. We don’t want to over weigh the patient testimonial piece, for instance.

So, I think there is value in coming up with composite measures that take into account and weigh different things that will really be helpful to the consumer. On the other hand, we don’t want to lose this other piece, which is really important, which is that what’s important to me may not be what’s important to somebody else. So, there’s this whole value-based decision-making that needs to happen as well. And, so, I actually think we need both.

But, you know, how do you provide a composite but then sort of say to the patient, but you really need to make the best decision for you, weighing this, that and the other thing. So, I just think it’s an interesting challenge.

MR. WROBLEWSKI: Peter, I’m sorry. Go ahead.

MR. LEE: I want to sort of do a hooyah to Jack’s point. But, also, you asked a question earlier about in this sort of dashboard, where should we put in our chips. I think the answer is clearly across the board.

(Laughter.)

MR. LEE: With that said, I want to note that
in the framing, both agreeing with Andy and disagreeing a little bit. It’s not a matter of which boxes are competitively significant. Which boxes are significant to consumers for which purposes? Sometimes it’s going to be for choice, which would call for competition. And others it’s going to be to better partner with their provider they’ve already selected. And others it’s going to be for a whole range.

I think Nancy’s point is really well-stated there. But when we look at that, I would note that the area that is most salient to consumers and future patients is on the treatment side of the choices. And it’s least on the insurance, except for once a year, the plan choice. And that is a very discrete choice where for a large employer, at least, they’ve got a real choice and they engage in that and they do that. Those that have a choice. Many don’t.

But really we aren’t seeing so much this treatment issue. I just want to highlight two pieces in that. One, what aspects are in the shared decision-making about where we know something about where preference plays a role?

But the other is -- Dr. Hoven or another of the physicians could flesh this out better than I can -- but a huge amount of treatment isn’t well-developed on the
evidence. So, we talked about what really is the right
treatment. In a lot of areas there’s huge uncertainty.

I think it really comes to noting that we have
major gaps both on the physician side and then on the
patient side to say, boy, which of these drugs are
better? We aren’t really that sure. Should we be doing
anything? We aren’t really that sure.

I actually think -- if I had my 100 chips that
I’d be putting here, one of the areas that I’m not really
seeing on here is not just treatment choice where we know
here’s the implications of risks and benefits, which is
incredibly important.

But it’s on the level of absence of information
of should it be that X device versus X medical therapy
versus nothing and what are the benefits and what we
don’t know. And that’s an area that there’s a lot of
discussion across the park, so to speak, compared to
effectiveness research for good reason, because right now
we’re driving blind in that area.

Again, I think it’s what patients care about.
They start with, boy, I just got a diagnosis. That’s
what I want information and help about and I’m going to
do that with my doctor. And the doctors are driving
blind, too.

DR. HOVEN: If I could just make a quick
comment. I couldn’t agree more. This is the one thing that I think every physician in this country will support and embrace because we don’t have that information.

I would like to be able to say to my patient who comes in just having watched a direct-consumer ad on the television that requires a very expensive drug, this isn’t going to make any difference and it’s going to cost a lot more money and it’s not going to do any better than this generic medication which you can buy over the counter very inexpensively at your local drugstore. It’s that kind of information that needs to be out there that we can all use and feel comfortable with and know that we have done the right thing.

Now, having said that, this is going to be expensive to do. It’s going to be hard work. It’s going to take a lot of time. But I don’t think -- I think at this day and age, we have got to go there now and get this done. And it’s something we’ve all been waiting for.

We know all the new information on new cures and new medicines. And I’m an HIV specialist, so, by golly, I’m cranking this stuff out every day. But, on the other hand, it’s imperative that we get this information. And absent that, we’re not going to get where we need to be.
MR. WROBLEWSKI: Dr. Chumbley?

DR. CHUMBLEY: I just wanted to comment a little bit about -- I think all this data that’s in the marketplace right now is very hard to sort through. One of the hospitals I’m affiliated with was designated to be one of the top 100 heart hospitals by some organization. We have an internal joke that says we are now one of the top 100 500 hospitals.

(Laughter.)

DR. CHUMBLEY: Nationwide. Unfortunately, it doesn’t stop the system from using that in its marketing or the other system from picking out what it wants from this survey or that survey or that and then delivering that. So, there’s just so much noise in the system. I don’t see how consumers can sort through that on a direct marketing basis.

MR. WROBLEWSKI: Thank you. Andy?

MR. WEBBER: I also wanted to say an amen to Jack Fowler’s comments on informed decision-making and state the obvious, that those consumer choices, whether you do surgery or medications or lifestyle, that is a competitive choice. There are suppliers on the other side of that choice who are going to be winners and losers, big time, when consumers are making those decisions.
And I do agree, too, that in terms of looking at value-based competition, this might be the arena where we can generate, at the consumer level, competition, perhaps a lot faster because we have information that can be arrayed in ways that consumers understand than we can do it on the provider choice side of competition. So, Jack, thank you for those comments.

MR. WROBLEWSKI: You know, one of the things that we’ve talked about this morning is kind of the difficulty in using a communications direct to consumer kind of information strategy to try to get either provider differences or comparative effective differences to the decision-maker, to the consumer.

And, so, in the panel that we have later this morning, I’d really like to come back to this idea on what are the strategies that employers and insurers can take to kind of incentivize that people will have -- that they’ll be incentivized to go to the higher quality provider or to the more effective treatment.

Because if we’ve talked about the difficulty in a communication strategy, whether it’s stars or relevance or interactivity or all the things that we’ve talked about, what are other ways to get that information so it’s actually acted upon?

We have about a half-hour left and I wanted to
turn to -- turn the focus slightly to physician information needs. And these are really -- this is the idea of, as primary care physicians, what do primary care physicians need in terms of specialists and hospitals in terms of making decisions on behalf of their patients? And are they aligned with what consumers are looking for?

And I’ll turn to our two primary care physicians, Dr. Hoven and Dr. Barr, to start us off on that.

DR. BARR: Thanks very much. Just the last reaction to the former, I think the information in terms of informed medical decision-making has to take place at someplace. One of the places folks often turn to, of course, is their primary care physician. I think whereas the information and the tools and resources are there, Jack does a great job.

The timing and the opportunity to actually interact with the patient in that way doesn’t exist currently in the current system. So, I think we need to think about that for the afternoon discussion. I think I’ll bring that back up.

But in answer to the direct questions about primary care, I think the conversation really -- I jotted down in my notes, I had to go back -- is so much aligned
with what the consumers need. In terms of being a primary care physician, what we want to do on behalf of our patients in terms of advocate, we need some of the same information that Barbara is collecting and others are looking for in a useable way because that’s our role, at least it should be our role when we have the time and the space to do it, is to advocate for our patients appropriately.

It’s important that the information needs to include hard and soft indicators because there are things we can measure and things that we can’t quite measure just yet. I’ll give you some examples later. We shouldn’t discount the credibility of that latter part.

So, we also need to not forget, and I sort of alluded to it, that there are significant challenges faced by physicians in practice even if we develop a credible, reliable, transparent and accessible source of information, the workload challenges and the demands on the office to actually use that would be significantly challenging in the current environment.

Finally, this is what Barbara is doing so well in Massachusetts, the measures need to be credible, reliable. The differences need to be apparent and they need to be meaningful. I think there are a lot of principles that a lot of organizations, such as the AQA
and others, have developed that guide some of that.

But when I think about the actuality, I think there are sort of three categories of information as a physician that we would be interested in. There’s sort of this basic information we need. Then there’s condition or need specific data for that specific patient.

What does this patient need and how am I going to get it for that patient or help them get it and navigate the system? And then there’s this past experience, what happened before. So, let me break that down in terms of real specifics, though.

As I look across, generically, the practices that I might relate to as a primary care physician in the community, I want to know -- and I can’t know a lot of this right now -- is what’s the access like to these specialists? What is my patient going to experience when they get -- can they get in, number one? What are the scheduling options? What’s the scope of that practice?

I had a personal example. I was referred to one physician who said, oh, I can’t take care of that. So, I was referred to another physician. I’m sure that happens over and over again. So, knowing fully well what that practice can take care of so I make the appropriate referral the first time and don’t get this endless cycle
for folks who go through the system and more
opportunities for errors and safety concerns.

    How does this practice I might refer to, or
hospital, for that matter, communicate? Do they do
email? Do they do some of the advanced modalities? Do
they have other kinds of access for the patients? What’s
their turn-around time on the requests for information?

    What kind of technology are they using? If
they have an electronic health record, is it going to
work with mine? Am I going to be able to share
information, participate in health information exchange?

To the extent they are available or in there, has this
practice adopted sort of the community standards for
transitions in care?

    Some of the things we were talking about in
terms of let’s agree that our communication about
patients when we make a referral is going to be in this
way. The turn-around time is this. We’re going to use
these modalities. This is the acceptable standard in the
community.

    Now, some of these things don’t exist. I’m
sort of projecting the ideal. That’s all sort of
challenging the current.

    So, that’s still the generic. If I want to
look at the population that I’m going to potentially --
I’m sorry, the groups of physicians I may want to refer to, that’s sort of generic stuff. Then you’ve got to drill it down into I have a patient with a specific need. Who’s doing it best in the community?

That’s where you start looking at special qualifications, procedures that they do. What is exactly -- if it’s a procedure-oriented consultation, what is it that that particular physician does? If you go, for example, in orthopedics, one orthopedic surgeon is different than another orthopedic surgeon in terms of what part of the body they’re going to operate on.

I remember I was at one practice, a large group practice, an academic medical center, the department of orthopedics sent around a picture of the human body with their names attached to the different parts of it so we would know who to refer that.

(Laughter.)

DR. BARR: I mean, that’s sort of a comical example, but it really gets down to, you know, within the specialty, there are subspecialties and sub-
subsspecialties and I want to make sure I can get my patient to the right person as quickly as possible. That information is difficult to come by often, even where I work now.

Quality metrics and cost metrics. We’ve talked
about that quite a bit. I think it’s important, though, that we separate them. Even if it’s blended into a star or a rating system, we need to know the difference. We need to be able to look and I think -- I want to be able to find the best cardiac surgeon for my patient. Yes, cost is a consideration. But if it’s complicated, I want to see who’s the best in that and who’s done the most around the country. I want to be able to do that for my patient. So, those are sort of the harder ones.

Then you get into the softer ones. This gets to the experience. When the patient has gone somewhere and then they come back to me, I get a lot of information about what happened when they went and that’s really important. It’s not codified anywhere. You can’t look up the stars on an -- you can’t look at a measure. But I want to know what that patient experienced.

There’s also my perception about how reliable, how relevant, what the communication was between that specialist and referring back to me or the hospital. How that patient was able to navigate the system if it was a complicated care.

What happened when the patient was out of my vision and now is back and what was their perception of that? And, yes, some folks are going to look at was the office clean and stuff. But it’s more important, did
they relate to the patient? Was there a connection?

Did that physician understand what the patient was trying to tell them? Did they take into account their needs and their preferences and work with them? Those are really important, and I don’t know how we measure them, but that would be useful if I was going to make the appropriate referral and consultation with the patients.

We get into other things with hospitals. What I’ve just said is very important. But then the other key is what’s the relationship with the hospital in terms of am I able to get -- many doctors don’t often go to the hospital anymore. The hospital has inpatient services. So, their relationships have changed over time.

I think there are opportunities now in terms of transition support for the patient. How did that work? Are there services in the hospital that will support my patient coming back and forth, that white space between inpatient and outpatient? Let’s make sure the patient doesn’t drop through.

The technology support and technical assistance. Can we build those bridges so the information about the patient flows with the patient for the patient wherever the patient goes? That’s real critical.
Communities -- that’s challenging if you start referring outside your community for the other subspecialties that may be a couple of states over. That becomes more challenging.

So, that’s sort of it. And I think the one quote that always comes to mind when we talk about these is from Einstein, which is “Everything that can be counted does not necessarily count and everything that counts cannot necessarily be counted.” I messed that one up. So, that’s pretty important. Thanks.

MR. WROBLEWSKI: Sure. Thank you.

DR. HOVEN: Thank you. And before I get to the questions, I wanted to make a couple of background comments, but, first, just thank you all for having the AMA here at the table. This is a great opportunity and we’re very much engaged in this process. So, I do want to thank you.

I think it’s important for us to talk real-time, real-world information right now, and then, as I said, I will get back into the questions. A physician’s performance is dependent upon three big items. The first is the patients they treat. Secondly, the practice and community resources that are available to them and our health insurance coverage and payment systems as they stand right now.
Physicians practice in teams of care and across a continuum of care that often will dictate the outcomes for the patients. I think we cannot lose sight of that. This is a critical point for patients in particular with chronic medical conditions and it dictates how we’re going to handle referrals and how we’re going to handle their actual care coordination.

Systems have got to be in place to allow physicians to develop and utilize quality information. Right now, there’s an inadequate investment and development of that infrastructure, and this is something that clearly is going to have to be addressed.

Having said that, let me go on to what doctors need or could use in delivering their care. And in the ideal world, we need to look at three categories: Physician performance itself, the clinical information to inform treatment decisions and information that can guide physician referrals to other providers.

This information that I need for me to deliver quality care must be timely and it has got to be accurate. It’s got to be based on quality measures developed by physicians, measure both process and outcomes, be adequately risk-adjusted and it’s got to take into account severity of illness, the multiple co-morbidities that’s we deal with and the important
economic and cultural characteristics that have already
been referred to today.

And this information has got to be well-linked
to actionable strategies of quality improvement. It must
not be just measurement or recordings simply for
compliance or payment purposes. And it’s got to be
available at the point of care. It cannot be in some
cyberspace out there which is useless for me to deliver
care. It’s got to be relative to my peers. It’s got to
be timely, frequent and detailed enough to allow me to
make corrections when the data is there that warrants the
adjustments and the change.

The next one is the clinical issues, the
comparative effectiveness information, and I’ve already
made a comment about this. But, again, it’s got to be
real-time. It’s got to be available at my fingertips in
the office with the patient, with a computer and updated
and user-friendly.

It’s got to be very interoperable because,
absent that, I don’t have time to run out to my office
down the hall, look up some information and come back.
It’s going to have to be very, very available to me in a
timely manner.

And then, thirdly, information to guide
referrals to other providers. And in thinking about
this, we’ve got to look at a very large picture. I want
to make the best decision for my patient regarding that
particular problem, and to achieve this, I’m going to
have to take into account a composite of factors, not
just one or two. I want to know the quality and outcome
information that’s out there, that’s valid, that’s
substantiated. I also must consider patient
satisfaction, their preferences and convenience issues
for them.

And to the previous speaker, the timelessness
of communication. If I’ve had dealings with a particular
specialist who communicates with me readily, I have no
trouble getting the information and I share information
with he or she, it makes the care for that patient so
much better, and that is so important.

The access and the availability of that
physician or hospital or outpatient facility. It’s got
to be there. If it’s not there, it’s going to be very
difficult.

What are the physicians’ hospital privileges
and contractual issues? You cannot imagine how many
hours we spend navigating this to see whether such --
this patient can be seen by that psychiatrist or they
have to go someplace else. It is a huge issue. And the
health plan is what dictates that.
So, there’s got to be feedback on how the patient is doing so that I can work in partnership with that physician to whom I’m making the referral or to that facility, and those communication systems have got to be absolutely in place.

The other audience, though, that is of significance, of great significance, and the reason I’m where I am today as a physician is my patient. I want my patients to be engaged. I want them to be informed. They must be uniquely motivated to receive quality care. And how we do that is going to be very, very important. But we also need as we partner -- and we’ll be talking more about this this afternoon, as we partner with the insurers themselves, all this information out there has got to be transparent to us.

Payment, physician contracting, data collection, reporting, tiering, all those issues have got to be very transparent. Our patients don’t understand this and they don’t care about it until it starts really messing with their care. Until it makes their ability to get the care that they and I think is the best for them becomes an issue. So, these have got to be very transparent in order for us to move ahead.

MR. WROBLEWSKI: Thank you. Kristin, you wanted to add something?
MS. MADISON: I actually had a question. So when I think about the kinds of measures we’ve been talking about and where consumers need more measures, I would say the biggest thing they need more measures on is outcomes and they need broader measures of outcome. So, when I look at the list of measures available, almost all of them are mortality probably because a lot of them are cardiac measures and that’s sort of an obvious and easy kind of quality measure.

But I would think that as a consumer, I’d want to see more kinds of outcomes. Do you feel better? Do you function better? Things like that. I was just curious about your perceptions, you as physicians, what kind of outcomes do you want to hear more about?

DR. HOVEN: I want to know when my patient comes back to me from a specialist, let’s say I’ve sent them to an orthopedist and they had knee pain to start with. I want to know, you know, from the outcome what was actually done for the patient, what diagnostic testing was used and did they, in fact, get the result they need in order that they can go back and be functional? Now, that outcome may not be a knee replacement. That outcome, in fact, may be they’re able to function and work and exercise and that sort of thing.

So, from the patient’s perspective, I’m looking
not only at the quality of care they receive from the
provider, the experience they had with that provider, but
when they come back to my office I can say, how are you,
and they say, I’m doing great, this was wonderful, my
knee is fine. So, that outcome can be somewhat
intangible. That’s the problem in measuring these
things.

DR. BARR: I have not much more to add. I
think that’s what I was trying to emphasize, too. There
are some intangibles or things you can’t measure. That’s
sort of what the patient experienced. Then there’s the
hard ones, like you said, the mortality, morbidity,
length of stay, those kinds of things. But I think when
it comes down to what’s going to benefit the patient the
most is me being able to direct the patient to the best
person I know that can handle that condition without
having to go to two or three other folks because I sent
them to the wrong person.

Then the consideration of the patient’s
interests and unique needs, family, support, all those
things, if it’s a procedure, in other words. Do you want
to really replace the knee in somebody who’s not mobile
to start with and never is going to be mobile for other
conditions?

Did you put a pacemaker in somebody who really
probably only has a limited life span? I mean, those are the kinds of questions that currently there’s no measure currently of overuse that we’re getting in the way that we’ve just been describing or appropriate use that we can see. I think that would be important.

That’s what you get to know in terms of the relationships. You know that this cardiologist will do a stent, but will not do a stent when it’s not necessary, in other words. And that’s really important and I don’t know how we get at that right now. That would be important for me as a referring physician.

DR. HOVEN: One of the things I frequently do is when I’m talking to a patient about something that needs to be done in a referral, let’s say they need to go to a surgeon for something, I will frequently tell them, based on my experience with this particular surgeon, you know, this guy’s a big teddy bear, but he’s technically the best guy I know, and you’re going to be very pleased with how he manages your particular situation. But that is accumulated knowledge that comes over time in how to manage my patients.

And I will say to them, I can send you to another one. This is my preference. It’s based on this. And you’re going to be very pleased with the way you do. So, it’s very difficult to put numbers and measurements
on a lot of these things.

DR. BARR: The opposite is this guy’s got a
terrible bedside manner, but he’s the best technical
person, has the best technical outcomes. Just tolerate
it and have your family member with you.

(Laughter.)

DR. BARR: You know, that actually can happen.

MR. WROBLEWSKI: Dr. Chumbley?

DR. CHUMBLEY: I just wanted to add to what

Ardis was saying. There are dynamics in referring from a
primary care to a specialist. She mentioned one of them.
That’s the insurance network. Some of the insurance
plans are now ranking and, so, the co-pay may be
different if you go to a different specialist. So,
that’s a dynamic.

Which hospital staff -- if you want to follow
that patient in the hospital, you have to use specialists
that are on that hospital staff. There’s large groups
that typically refer internally and there’s employment of
primary care physicians by systems and with or without
the expectation that they utilize specialists and are
aligned with the system. So, it isn’t a clean decision.

There are dynamics there.

MR. WROBLEWSKI: Peter, you wanted to add

something?
MR. LEE: Like many of us, I have relied upon accumulated knowledge of going to family members and friends to get referred from my family member physicians to other physicians. I guess I’m a little troubled. Instead of saying shouldn’t we be going beyond accumulated knowledge that’s personalized to -- and I thought there was a leading question, if I may, which is rather than to say here’s the body chart and three doctors point at the knee, which of those three doctors have, in a standardized way, better functional status six months after a procedure is done or whatever that mix is.

I would hope -- and to my mind when I look at that dashboard -- again, I’m going to pull it up there -- primary care is measured up the whazoo. And the ability to actually have data that is based on 60 primary care doctors’ referrals, accumulated knowledge and the experience of specialty care on functional status so you can make better referrals, I mean, quite honestly, I heard a lot of information about what I would call service issues, insurance relationships. Those are a big pain in the butt. You’ve got to know those.

But I’m struck by not hearing quite as much as I would have, on some levels, don’t you really want to know where there is differences, what the differences are. So, I’d actually just sort of challenge my
physician colleagues to -- you know, outcomes are
important to patients, but they should be important on
the referral side, at least as much from the referring
primary care doctor and for the patients making choices.

DR. BARR: Peter, maybe you misheard, but
clearly the ACP has been out there supporting performance
measures. We were one of the first professional sites to
say, it’s okay to link payments to health care quality.

I think what we haven’t heard enough of is what
we try to describe here, that there are hard indicators,
as I started off with, and the soft ones. We shouldn’t
discount some of the soft ones because they’re very
relevant.

So, I chose to emphasize that a little bit,
with the idea that I think it’s pretty open that -- I
mean, at least the ACP is supportive of the professional
measurement, performance measure, as long as it takes
into account the very things that Ardis was talking about
in her comments, in terms of it’s got to be credible, the
AQA principles have all worked and been hammered out.

So, I took that perhaps a little bit for
granted and I wanted to make sure it was balanced in
terms of how we’re considering this, because I think a
lot of the other stuff gets lost. I think there is value
to a primary care physician knowing the needs, wants,
desires of his or her patient and their family and then making sure that we can direct appropriately. Some of those things aren’t measured. So, I don’t think that there’s the chasm that you sort of just described.

DR. HOVEN: I was going to say the same thing. We believe in this process of the performance measures. I wouldn’t use that doctor if I didn’t know for a fact or had data to tell me that the outcomes were where they needed to be and they were doing what I wanted them to do. The other piece of this --

MR. LEE: But what if we don’t know that today?

DR. HOVEN: But we’ve got to get that information. I mean, there’s nothing wrong with that. The other piece of this, though, is the big elephant in the room is the risk adjustment and not every patient looks alike. And you’ve got to have the ability to say Dr. A will be fabulous with a diabetic, morbidly obese, cardiac patient who just fell and broke their leg, and being able to risk adjust this. So, you’ve got to be careful how you put that data out there because it all isn’t going to be clean like we would -- it isn’t black and white all the time.

DR. BARR: The other key is just, as I said earlier, making the time and the space for that physician
to make those sort of evaluations and look at the data
that are out there. It doesn’t exist right now. We
can’t layer on this responsibility in terms of, at least,
primary care on top of it without giving them the
opportunity.

We mentioned about consumer incentives. I
mean, the incentives for physicians to actually look at
the data was part of the original NCQA tool that came out
because we didn’t think it was achievable in the short
term. We maybe ought to relook at it, hopefully.

MR. WROBLEWSKI: Beth, did you want to add into
this?

DR. NASH: Yes. I want to say something
actually in support of accumulated knowledge. You
know --

(Laughter.)

DR. NASH: -- there is something --

DR. CHUMBLEY: But we lose the opportunity to
keep relearning the things we already --

DR. NASH: I would argue that those of us on
the panel who are doctors, and there are a lot of us, who
probably evaluate some of the doctors, if we saw them in
practice, we would have a similar evaluation of them. But
we don’t really have very -- they’re kind of squishy
measures. If we can find a way to measure that a little
better, I think it would be great.

Now, I was a managed care director many years ago and tried and I think it’s incredibly, incredibly difficult. I also think that a doctor who I think is fantastic and I love everything about them, I could send a patient to and that patient might not like that person. And, so, that’s something else we need to think about, which gets back to Jack’s point. I mean, there is this whole piece about choice that’s really important.

And I also wanted to say one other thing about research, getting back to something that Ardis was saying, which is we do need more research to make the right decisions, but the research we have is flawed as well. So, you know, the selection criteria to get into a clinical trial, you know, may not apply to your particular patient.

You mentioned comorbidities. We need to figure out what to do with a patient who’s got more than one medical condition. And the research today doesn’t necessarily deal with the outcomes that are important to patients. They may be the outcomes that are easiest to measure.

So, I would argue that we actually need a different kind of research, and this is going to sound a little out there, but I think that when authors submit
their articles for publication, they should submit their
data sets and those data sets should be searchable so
that you can ask clinical questions around data and find
out something specific about your individual patient. I
think that’s something that is certainly worth exploring.

MR. WROBLEWSKI: Jack, did you want to follow
up on that?

MR. FOWLER: I think one of the realities
that’s here is that everyone’s saying it would really be
good to know what the outcomes were for particular
doctors. We don’t have that information, which means
that we’re making rankings basically without the
information that’s relevant. Hardly any medical care is
life and death, so that mortality is not the right
measure. You would really not want it for your knee
surgeon, to have mortality be the measure.

(Laughter.)

MR. FOWLER: If you can measure that, you’ve
got a real problem.

But that’s true for almost all the specialist
interventions that you’re thinking about. Mortality is
just the teeniest tip of the iceberg.

So, the fact of the matter is that we don’t
have good information about outcomes for almost any
doctors. I think that’s the important stuff that they do
and, so, the bases on which they’re selected. They could be the interpersonal things and those you can measure, I mean, some parts of it. You can find out if they talk and listen and if they’re accessible. And those are good things to know. I don’t want to down that.

And you could find out whether or not they are patient-centered when they make decisions in some ways. And that would be really good things to know, too.

But the outcomes part are really tough. I think we just need to acknowledge that the bases on which they’re being evaluated are probably irrational or, at least, not science-based.

MR. WROBLEWSKI: Andy, did you want to --

MR. WEBBER: Yes. So, Michael, I want to get to the role of the primary care physician in informed decision-making, where there are sort of different treatment options. And of course the worry is, you know, you diagnose someone with an illness, it’s off to the specialist.

That specialist is biased towards certain intervention strategies that they are comfortable with, and the individual never gets a trusted source and an unbiased view of all the different options. And isn’t the primary care physician best equipped to provide that information? And how do we make that happen?
DR. BARR: Thanks, Andy. I mean, that’s what the goal of the patient-centered medical home is. In other words, to create a system in which the needs of the patient are known, the relationship is reinvigorated and that when a decision is made, that the tools and resources are there and the medical home takes the responsibility for actually having that discussion and not just generate the automatic referral, which right now in a volume-based, episodic fee-for-service system; volume in is what the doctors have to do.

So, what we’re looking at, and that’s what we’ve been advocating so strongly for, is a different way of thinking about primary care to actually get exactly what you -- doctors would like to do that. I firmly believe that physicians would like to have that conversation. Some of them still do. It happens erratically.

I think there are tools and resources out there that if we make the time and space and we give the responsibility and accountability, as well as the support financially for them to do that, some of this will happen. I think it will pay dividends so you won’t have those unnecessary procedures.

One other point. I know we’re looking at outcomes, but sometimes a proxy for whether things happen
is looking at process and structure measures. I don’t think we should throw those out necessarily. That’s part of the medical home right now. It’s a model to be tested. We heavily emphasize the process and structure within the practice as a proxy. Then you can have the measures to see how things happen down the road. We don’t have to be upfront.

So, this is a pilot to test and I think we should emphasize that and build it in the system. I think that’s very important and I think it would be well-accepted among the physician community.

MR. WROBLEWSKI: Thank you. Vince?

DR. KERR: I wanted to react to something Jack said. It’s clear that the outcome metrics we have are rudimentary. I don’t think anyone would dispute that. But they’re not useless. Those two things are not the same.

And while mortality may be the crudest judge -- and I would argue there are people who might want to know at some level, five times the mortality rate versus another, that that is an important indicator for selection, their complication rates, their redo rates.

There are structure or process measures that have to do with functionality, time to recovery, length of stay in the hospital, that could all be useful,
particularly when added to a set of other determinants that help you select the physician. I wouldn’t discount those. I think we have those on the table and don’t use them to the extent we could.

MR. WROBLEWSKI: Thank you. I’ll give -- Nancy and then Dr. Hoven and then we’ll take our break.

MS. Foster: I’m reluctant to do this, but I want to just throw this idea out on the table which is that we’ve been talking about this as if it’s a measure of a clinician and his or her practice. But as I look at most knee patients, there’s sort of a set of providers across the continuum and that’s a fairly short episode of care relative to diabetes treatment. And, so, I just wanted to raise this notion that maybe measurement at the clinician level isn’t really going to get us where we want to go.

MR. WROBLEWSKI: So, in our chart up here, you would put all your chips in the column, the second from the right-hand side, in terms of outcomes?

MS. Foster: I would love to put all of my chips there, but I don’t think we’re ready to do that yet.

MR. WROBLEWSKI: Okay.

MS. Foster: But in terms of an end goal, that would be my desire.
MR. WROBLEWSKI: Okay.

DR. HOVEN: I’ll be brief. To Nancy’s comment, I couldn’t agree more. I mean, I really believe that this continuum of care, as I said in my comments, is an absolute. I don’t practice in a silo. I am surrounded by people who help me deliver the care.

The point I wanted to make with Andy -- pardon?

MR. WEBBER: Oh, no, no. I was just saying something to myself.

DR. HOVEN: Oh.

(Laughter.)

DR. HOVEN: I don’t think so, but anyhow.

MR. WEBBER: For transparency, I’ll tell you what I said. The comment was, yeah, we all want to get to continuum of care in integrated systems and we have to have payment systems that reinforce that.

DR. HOVEN: To follow us. Exactly.

MR. WEBBER: That was what I was saying to myself.

(Laughter.)

DR. HOVEN: Here, here, I agree with you.

I wanted to come back, though, to your question, Andy, about the primary care physician being in the seat to coordinate the discussion with the patient about the treatment options and choices. And I will tell
you in the perfect world, that would be ideal.

There are going to be a lot of clinical conditions that I think -- and, Michael, correct me -- that I may not have all the tools to provide them that information, so that we’re going to have to have systems in place to make sure I can do the collaboration to get the information that my patient is going to need or get them to somebody else who can provide that information.

So, the medical home concept does meet the bulk of those needs, but I think we’re going to see some on both ends of the spectrum where that isn’t going to be appropriate.

MR. WROBLEWSKI: Okay. Thank you. Why don’t we take a break now. We’ll resume at 11:15 starting with the employer and the insurer discussion.

(Brief break taken.)

MR. WROBLEWSKI: Why don’t we get started with our second session this morning, really looking at the quality information needs from the employer and insurer perspectives. Peter Lee has volunteered to provide some opening remarks from the employer side. Then we’re going to turn to Vince Kerr for the insurer side before we start our discussion.

MR. LEE: Thanks very much. It’s interesting, from an employer perspective, obviously the primary
choice an employer is making is of their health plan. I’m going to talk about this in two ways.

First, the choice of plan and what goes into that, but then follow that with some of the discussion of what our expectations are of the plans once they’ve been selected. So, it’s sort of a two-part framing and it will tie back to a lot of our discussion earlier this morning.

The first thing that I would note, though, is this is -- you know, I’m on record, but employers don’t look at quality. They look at performance that includes quality. I think that’s an issue when we talk about competition, there’s different performance domains. It actually resonates strongly with what we heard earlier this morning.

In many ways, the physician perspective could say, well, the first thing employers will look at, which is absolutely the case, is cost. So, when they’re looking at a plan, they’re looking at what for their population is the total cost going to be for a certain set of coverage compared to other plan options. That’s number one.

Number two, this really does track to some of the notes that we heard from Michael and Ardis earlier, it’s not first about -- second about quality. It’s
second about what I’d call service elements, which is
similar to issues about accreditation, is someone
trained, et cetera.

Employers will look at which plans handle them
well, will process claims, will deal just on the
day-to-day brass tacks issues with their employees, deal
with them well, efficient in their management.

And third is quality. Quality domains fit into
a range of factors that include HEDIS scores, some roll-
ups and include some of the dimensions I’ll talk about,
what our expectations are of health plans.

Andy is here and he can speak to this later,
but one of the better tools used for employers to get a
handle on what plans do is an RFI called EValue8 which
collects in eight or nine domains what does a plan do in
terms of delivering effective care for the chronically
ill, wellness promotion, engaging patients, et cetera.
Those are elements that I call the quality performance
elements that employers look at. So, that’s sort of the
framing when you think about what employers do.

I want to note a couple things about what’s
happened in the last ten years, though, to frame this and
thinking about what employers go through in their
choices. This is very recent data on the migration over
the last 20 years from fee-for-service to HMOs and now,
largely, to PPOs.

What is misleading here, though, to my mind, is what we’re seeing in what employers are choosing in their plans isn’t a movement to no management. It is a movement towards, in many ways, a blurring of what you see in an HMO or PPO.

You see now what was a PPO in the mid ’90s was very, very similar to fee-for-service. It was an unmanaged network with better discounts. As opposed to today what you’re seeing -- and we’ll come to this in a moment -- is the selection process of looking at we don’t care what the label is, we have expectations of you as a health plan and we’re going to buy based on these expectations, based on what you deliver on two primary tracks.

And one of those tracks is a provider-directed track of how you select your providers, what you -- strategy to engage them, in terms of chronic illness, et cetera. The other track is how you engage the enrollees, the consumers.

So, the other data point that I’m going to note on plan selection, and this is again very recent data, it’s on the footnotes, et cetera, what do employers think is effective? And it really does come into what I call two tracks for employers, selection of the plan, which is
anchored, one, in a provider-centric view. We’re looking at those that manage our networks well, have the right folks in the game and do good disease management on the provider side.

And the others would say it’s really about engaging the consumers. It’s about having, you know, consume-driven plans with high deductibles, it’s more cost sharing. And I’m framing those not as mutually exclusive. Obviously, they are overlapping parts of a Venn diagram. But they are both sort of two distinct approaches.

When an employer says which plan am I going to buy and hence how plans are competing, they’re both competing again, number one, on cost and then competing on how they do these things better. These things say, we’re selecting and steering to better doctors and hospitals, or we’re doing a better job giving consumers tools to make their own choices and then cutting across the disease management.

Now, the main thing I would note on this is we often talk about silver bullets. If you look at the data here, no one thinks anything is very effective, okay? I mean, one of the big lessons is -- this goes back to the uncertainty -- employers are not jumping to particular solutions saying, and, boy, we really have the answer.
What you see is, with one exception, which is the only thing that gets over 25 percent of employers finding it to be very effective is disease management and that’s for large firms. These are large firms that have spent a lot of time and investment. And many of them are carving that out, but they get it, that chronically ill patients cost a lot, need big intervention.

Besides that, there’s less than 20 percent that think any of these things are very effective. So, they are definitely using shotguns. If you think it’s somewhat effective, you get 50 percent either somewhat or very effective. But you see, you know, a huge percent of employers are saying we don’t know which of these really work. That’s the bad news on this.

What does that mean when they come to what they look at for choice of plan, back to what performance domain? The number one performance domain they come back to is what’s the cost. Now, I wish it weren’t the case, but that’s what it ends up coming to.

Within that mix, the other performance elements they look at are, again, HEDIS scores, EValue8 results, and, not dissimilar to consumers, it’s a minority of large employers, even small employers in particular, that use those scores, but those that do, I think, drive the market.
So, let me then talk from what -- that’s how employers choose plans. So, now, what do employers do with that information? This is, I think, an important framing. We were noting the fill-in-the-grid. One of our members, Wells Fargo, uses a chooser tool. Large employers still offer choice of plan. Small employers rarely do. There’s been a decrease even of large employers offering choice of plans.

So, here you have a tool that actually PBGH designed that helps an employee choose which plan is right for them. Now, it starts with about you, including how much health care do you use, do you have a chronic condition, et cetera. So, it doesn’t start -- I think the note about interactivity that we heard earlier, 15 years ago report cards were put out there saying here’s your health plan’s HEDIS score and here’s four, you know, big, huge, think reports. Choose the right plan, as if people could use that. People weren’t using it. People said, well, why is that?

I say the same thing when I now look at, you know, some of the great reports out there, for instance, from Pennsylvania on hospitals. Really great reports on hospitals, but totally unusable and unengaging.

So, this starts a patient -- excuse me, an enrollee, in that once a year time when they’ve got the
reason to make a choice. Start with about you, how much
do you use the health care system, your circumstances.
Then it says here’s costs. For your plan option, not
just what the cost of premium is, but your total cost
over the year is likely to be, given how much you say
you’re going to use the health care system. So, it loads
in out-of-pocket costs, et cetera.

Then it says -- and this is based on testing,
what consumers care about -- is your doctor in the
network? That’s because they care more about that than
they do about abstract quality. Then it takes in the
quality ratings. These quality ratings use NCQA, HEDIS
scores, use patient experience in standardized ways.

In this case, you’ll note that Wells Fargo says
team members because they evaluate Wells Fargo’s members
cap scores on plans, not the global scores that NCQA has
because they speak to them in that language. And then it
takes you through features of service.

The interesting thing here, back to our earlier
discussion on how do you engage consumers, is it doesn’t
throw out there at the starting point here’s a HEDIS
score. It starts with where people are, walks them
through a process, and through this, there is huge
migration or there has been at different points.

Then once people get settled on a plan, they
don’t change. But they move a lot. And 50 percent of the consumers that go through the tool use every element and appreciate every element. Some go through cost and doctors and then they can jump to the end. You can stop at any point. You don’t have to use every point. But it engages them actively in some of these performance elements.

Next, I do want to note about what we, as employers, look to our plans to do. This is some of my chasm crossing attempts earlier, noting that there is a distribution of where physicians or groups or hospitals fall in terms of how they use resources and how effective their quality is.

And this is actually -- and I know I always alienate physicians because each of these little dits is a doctor. So, that’s probably one way to alienate doctors right out of the gate. So, they’re distributed across the board in terms of use of resources by episodes and then scores on outcome and process measures.

Employers look to our plans using -- to do two things. To either help consumers make better choices towards the up and right, so identify folks in a better way that are higher quality, more cost effective, and to do payment designs that encourage providers to move up and right.
And we look to providers to use quality improvement and tools to move up and right. It’s not ever about let’s get rid of the bottom quarter because, oh, there aren’t enough doctors there, there aren’t enough hospitals there. It’s all about moving up and right.

But the tools we look to our plans to use is consumer tools for selection, payment tools for wards, all to sort of move up and right. So, that’s one of our expectations of plans.

The next expectation of plan -- and we actually score and evaluate again the RFI. Ask specific questions about what are you doing as a plan to steer patients to make better choices, what are you doing as a plan to pay differently, et cetera. So, we assess how plans are doing this.

We spend a lot of effort at our selection of plans on what are they doing relative to the chronically ill, the 5 percent of the population that, from an employment perspective, costs over 50 percent of the dollars.

That’s where you saw large employers that spend a lot of analysis, almost a third of them believe in DM. I think there’s huge questions about should DM live in the medical group or live in the plan? How is that
shared? Great discussion we could have, probably not for today.

But employers look to the plans and say, what are you doing to make sure that those that are sick people, that are expensive, are being served well? And what are you doing to keep those 50 percent of the people that cost nothing down there?

So, there’s a lot of focus on what plans are doing to promote wellness and keep well people well. So, we will assess the plans in terms of their wellness strategy, their consumer engagement. That’s another expectation.

The third big expectation, and it relates very much to the whole framing of the day, is very much seeing health plans as infomediaries, as information sources for enrollees. And this is a question of consumers of saying what is your health plan doing now, not doing now but want, not doing now but don’t want? If you look at the biggest expectation that is desired but not being done, it’s providing information on best doctors and hospitals.

This is what -- and people often say, oh, people don’t trust your health plan. You know, if consumers think they’re evil, they won’t go to them. When consumers are asked what do you want your health plan to do that they aren’t doing, over 52 percent said
they want that. The other 35 said they’re doing it now. So, you have almost 90 percent of their consumers want their health plans to be doing this, see this as something they want them to do, whether they’re doing it or not. So, that’s part of the expectation side.

A couple other data points, and then I’ll wrap up. I think Nancy actually alluded to some of this data. This is data from ’06, which was updated three weeks ago. I do have a new slide. I forgot to load it in here, but I’ll do the foreshadowing, which is the really interesting thing here is two things.

Because I know we’re supposed to be talking not just about physicians, we’re talking choice across the board. The health insurance plan, the left-hand side of this is who saw the information; the right-hand is who saw information and said they used it.

I want to do one huge caveat here. This survey did not then drill down and say to a consumer, what did you mean by quality information? It said quality information. And, so, for some this means that doctor quality, N of one, I had a bad experience. For others, it may be a full-on report that shows scores on X, Y and Z, and rolled up patient experience, et cetera. But consumers believed it was quality.

And the two big things that I’d note here is,
if you look at health plans, there’s been some increase
and some increase in hospitals in ‘08, the health plan
and the hospital numbers actually went down a little bit.
So, that’s what Nancy was alluding to. The rate of those
that actually used it went down a tiny bit on the
hospital and insurance plan.

Now, I’ll tell you, the hospital point
surprised me a little bit. The insurance plan didn’t
surprise me at all. One of the things we’ve seen over
the last five, ten years is more and more employers not
offering choice of plan.

So, the fact that large employers continue to,
but even large employers instead of offering 12 plans are
offering three plans. So, you’re seeing quality
information about plans and open enrollment, but fewer
employers are offering choice. So, that’s not that
surprising.

The other thing is if an employee has been in a
plan for a long time, they might skip right over it and
they stay in the same plan. What you are seeing here,
though, is continued growth of the number of Americans
seeing quality information on doctors, whatever that
means. And the thing that I find most striking -- and
the last slide is taking the information and translating
it into numbers -- is what’s this mean. And this number
is about exactly the same for 2008, even though it’s
2006.

Twelve percent of Americans said they saw
physician quality information. Fifty percent of them, so
about 7 percent of Americans, said they used that
information in making a decision. Now, I think that is
not a 93 percent glass empty. I think that’s a huge
number.

I think one of the questions, that’s enough of
a number, back to Dr. Chumbley’s point, to make sure that
you don’t need a lot of folks to make sure doctors
themselves or medical groups are going to use that
information, too, because they will.

There will be a lot of use for quality
improvement, whether it’s public or not. But there are a
huge number of Americans that are using quality
information today either to confirm a choice, to engage
with their provider or to change their choice.

And these are choices that unlike the health
plan, which is you know when to reach out to them,
employers spend a huge amount during open enrollment to
say, hey, you guys, you got your plan choices, we’re
giving you financial incentives, et cetera, et cetera.

On the physician side, increasingly, plans are
where folks go. But this is -- you’ve got to diagnose
us. You have a new treatment. That’s when you’re sort of searching around in the ethernet or with your plan and other sources.

And we’re seeing, you know, again, more than one out of 20 Americans finding stuff that they’re using. And, often, they’re using very inconsistent information and I think that’s some of our charge, to try to get better standardized, et cetera. So, that’s my quick review.

MR. WROBLEWSKI: Thank you. Vince?

DR. KERR: As usual, Peter is always thoughtful and I think very thorough. He’s teed up a number of things that perhaps I can expand on a bit. I’m really going to make only four points, not because only four points are important, but, at this age, four points is probably all I can remember.

Health plans occupy a unique space if you think about it and Peter alluded to this. We have, as customers, employers who come to us seeking administration of services or depending on what they buy, product they buy, indemnification against the risk of health expenditures for their employees. So, we interact with them, we hear very loudly what they’re seeking and we see how they make purchase decisions based on those parameters.
We also have business relationships with physicians, contractual relationships, and a very different arrangement with physicians, and with the end consumer, people who are sometimes patients. We call them members. They don’t always see doctors, believe it or not. And, so, we’re at the nexus really of this and getting inputs from all three sides. And that sort of shapes a little bit about what we do.

Clearly, imperative for doing this, Peter alluded to, it really is about cost. A lot will say value. They don’t want lower cost at any cost. They’re really looking for improvement in the care or in the services that their employee populations receive.

And, often, plans are held to pretty strict standards around those things. Parameters are created, penalties are created when you’re unable to meet those in order to ensure that.

But it is impossible to avoid this. The largest opportunity in health care, if you think about reducing the drain on resources, the CDC would say is prevention. Something like 60 to 70 percent of current expenditures are tied to modifiable risk factors. If you could magically remove all of those, somehow you would remove at least those costs, maybe not reduce the entire pie.
The second largest opportunity is really around this: 30 percent of the incremental value of health care is locked in consumer decisions, decisions about which treatment to pursue for a given condition, the setting for that treatment or facility and which physician is going to provide that.

And I say 30 percent because that’s, on average, the variation we see inter-hospital, between treatments or between doctors in rendering a service of treating an episode or a condition, achieving a similar outcome with very different total cost.

So, let me just set up what I think might be the way you could think about quality measures. And it’s important to remember -- I think this was my number one point, that the spectrum is broader than simply quality the way we think about it or talk about it typically. If you look at it as a consumer and the way we have to look at it, it really spans a much broader spectrum.

So, regulation you could put in quotes. That could be things that are driven by contract as easily as by regulation or law. You see the things that are probably not as strongly driven, that are evidence or consensus-based or a community standard of practice. And then, finally, over into preference, which is very individualized.
The things on the left are typically system driven. Things on the right are driven by individuals. And the outcomes for doing these things are at the bottom.

Part of the problem we have, and one of the things that I want to avoid if you talk about the ask, is picking something that is so narrow that you cannot really meet the needs of this entire spectrum. So, if I looked at it from a consumer point of view, they might care about the 50 percent moving from the right to the left. They may assume that things are safe. After all, hospitals and doctors are licensed. That isn’t even an open question. We probably care about the 50 percent or 60 percent moving from the left.

The problem with focusing on a narrow band, unless you’re trying to drive -- and I listened carefully to your comments -- a public health goal, it would be great to get all hemoglobin A1Cs down and you would have a massive impact on the system.

What you miss there are the 90 percent of consumers whose concerns have nothing to do with that particular parameter. So, we’re forced to have a broader view even though driving system change or public health change may mean using a very narrow band of quality measures.
The other thought here is that health plans do this in sort of a tiered fashion. All health plans do some sort of initial screening or quality measures for physicians. And I have to be careful. I would make light of this, but I’ll get grief from the network people if I make jokes about it. But, you know, you have to be breathing, walking.

(Laughter.)

DR. KERR: You have to meet certain criteria that are really important, license, privileges, lack of sanctions, et cetera. Those are kind of barriers to entry, if you will. And the vast majority of physicians meet those. Those will not help anyone, you, me or any consumer, or a health plan differentiate between the levels of quality delivered. And, so, it becomes necessary to do something more than that.

And, in fact, it isn’t hard to do something more than that. What you’re looking at here are two charts which I think are my second and third points. And one is the -- the top chart is a bubble chart similar to the scattergram Peter showed. The size of the bubbles are volumes. Those are actual providers in a market. It happens to be interventional cardiologists in Atlanta. They’re splayed on a scale that looks at efficiency compared to a market average, which is one, so less or
more, and on a vertical scale, which looks at a composite quality score.

But I could take out a single measure like complications, I could take out a measure like redo rates, you would see a very similar graph to this. So, the marketplace presents an opportunity to do differentiation without changing anything. In fact, it almost feels, and it’s to your consumer survey, that we’re obligated to begin to do this at some point. I mean, consumers will want to know what we know and they will want to pull that into their decision-making.

The second graph does something totally different and it’s a separate point that is important to make. So, efficiency was defined earlier this morning. It can be confusing. We think of it as the product between resource consumption and pricing.

The second chart is that it is important to look at cost or efficiency in that way and not as unit price. What you see here is a scattergram of all ETGs. This happens to be one market’s claims. We used diamonds, too. That way you can get around calling them dots. Diamonds for the physicians.

And you’re looking at the correlation between the price of an office visit, so that’s a unit price, and a set of ETGs, which you would think of as driving office
visits, so a rash, a routine visit for follow-up for
diabetes. What you see is that, in fact, unit price --
and when you look at the total cost folded in around that
single visit or episode -- varies markedly. In fact, the
correlation is below .01. There is no correlation.

So, unit price can be very misleading if we’re
putting that there to drive consumers in a way,
particularly if we’re sensitive to cost. We think there
are some attributes to measures, which I won’t go through
here. We have some standards for putting these in.
They’re very similar to AQA, in fact, probably overlap,
and many other agencies that have interacted to begin to
regulate or express what a good measure should be. We’ve
talked about all of this this morning.

Meaningful, meaning meaningful to consumers.
The difference means something. And I would argue that
those differences in quality for the cardiologists
clearly mean something that would be explainable to a
consumer.

The cost clearly means something that would be
explainable to a plan sponsor when it’s literally several
thousand dollars per episode difference that you’re
talking about, sometimes for a worse outcome.
Comprehensive in a way that -- by that I mean not a
single measure that you need to have, measures that are
relevant to the specialty accurate.

We think national standards for quality make sense. So, instead of a relative standard, well, you’re the best in Peoria. But I don’t know what that means. Maybe you want to drive up to Chicago for this procedure.

(Laughter.)

DR. KERR: That a national standard and measuring everyone regardless of region against that standard if it can be agreed on is more useful to consumers, having the process externally validated. It always has to be paired with efficiency. Or you could say it the other way. Efficiency always has to be paired with quality to satisfy, once again, our customers. It needs to be fair in this process to physicians.

I took out the chart because of our discussion on what happens with this information because that should have fit under consumer. But we have three and a half years of data, of putting this information out in front of consumers, and some very interesting statistics. That if you compare behavior in a marketplace pre and post-introduction of this information, you get somewhere between 11 percent and 23 percent of consumers shifting behavior.

So, the fact that they say they want this, they
actually do incorporate it. That could be with or
without benefit design incentives. Some would say
penalty. Most employers choose to do relief, meaning
there’s a copay, but you don’t have to pay it if you pay
attention to this information, or some other sort of
reduction.

The fact is, though, that when we look at what
the difference is between using incentives and using
information, information contributes an equal amount of
consumer behavior shift if done in the right way to a
financial incentive. Financial incentives, in our view,
probably serve only as a cue that there’s something in
this information you want me to pay attention to. In
some instances, it’s trivial, the forgiveness of a $10,
$15 copay are relatively trivial for most people.

So, consumers are shifting. There’s some other
information about how consumers use this behavior, and
setting and context is critical. Setting and context is
critical.

You need to present this information in a
variety of ways because consumers access and process the
information in a variety of ways and that includes
putting in the hands of physicians the same information
you’re putting in the hands of the consumers who might
use it. Having that conversation with them so they know
what their patients are talking about when they come in, and you can either validate or dispute that, depending.

We find that when that happens, referral rates change. That when objective information is given, particularly about procedural or surgical specialties, many physicians are not aware of complication rates, mortality rates, length of healing, redo rates. They don’t know those things.

They have a sense of how someone performs, but the vast majority of physicians have not done the homework, if you will, to understand what’s beneath that sense that they have. They’re folding in multiple factors.

So, the third point I make about consumers is that when this information is presented to them at the point of making a decision, there’s certain things that don’t work. You won’t get change of a primary care physician or what we would call relationship physicians. Those exist over time and across family members and you need to be respectful of those. But you have huge opportunities to influence subspecialty and specialty usage.

The other thing that often happens is when this is presented at the point of decision-making around a treatment decision, when you give quality information so
they can then couple that with where should I have this
1 done? I’ve just decided, you know, to have that lobotomy
2 because it seems like a cool thing, what’s the best place
3 for doing that?
4
(Laughter.)
5
DR. KERR: Well, it’s important to you now.
6
Trust me, after the lobotomy, it won’t matter.

(Laughter.)

DR. KERR: They will make a decision. The
9 survey that’s done immediately after that structured
10 conversation where you’re trying to present all of the
11 treatment options, that often, by the way, does not yet
12 happen in practice. I know from calls and discussions.
13 I didn’t even know that could be done that way. It
14 depends on who you see, as was made earlier -- a point
15 made earlier.

That when you do this in the context of that
17 sort of decision-making, the immediate survey rate, about
18 well, you were planning on having this done here, do you
19 think you will change, is about 7 percent. If you look
20 at claims data, it’s about 33 percent that shift.
21
So, something happens. They leave that
22 conversation. They have time to think about it. They
23 cross-check it with their physician. They validate it on
24 the Web. Something goes on. But their ultimate decision
seems to be influenced by providing objective information in a fashion that helps answer the questions and lead a consumer to decision around choice.

And, so, I’m going to end there because I’ve used up my ten minutes. But the point at the bottom is the one that’s important. I think you need to pair performance information with treatment decision exercises so that the two can be made together.

If I could ask for anything -- and we do get an ask here, right -- I think at the top of my list would be the ability to get CMS data under a set of controlled circumstances, that CMS data for hospital and physician and drug, that could be folded into a database, provided the user of that meets certain sets of conditions that ensure safety of the data, security of the data, fairness to the parties that might be impacted by the data. You could craft a list of things. But that would greatly enhance the ability to make this information relevant.

The wish, not the ask, would be to have more clinical data folded into comparative performance evaluation. We get some today. We can get lab results. We can get drugs. But it’s not universal. It’s not as complete as some of the other pieces of administrative data. Those would probably be the two asks that I would have.
And, finally, comparative effectiveness. There isn’t enough of it.

(Laughter.)

DR. KERR: I don’t know how to solve that. I think that’s a problem we all share.

MR. WROBLEWSKI: Okay, thank you very much. I’m going to turn to Andy to kind of kick off our employer information needs. Peter broke it off nicely in terms of two ways to look at quality information. One in terms of the selection of the plan, and then once the plan is selected, within the providers and treatment options within it. And I’ll ask Andy to start off.

MR. WEBBER: Sure. Peter had a, I think, follow-up comment for Vincent’s remarks.

MR. WROBLEWSKI: Oh, I’m sorry, go ahead.

MR. LEE: Very briefly. I just want to connect two dots. One is to the earlier discussion around expectation of plans relative to performance information is unlike consumers, which will take an N of one and delegate validity, employers do.

I mean, Andy may speak to this. But, for instance, in evaluating, we actually ask the plan to what extent are you using NQF approved, nationally standardized measures, to what extent are you complying with national patient charter for physician performance...
reporting, et cetera.

So, that’s one thing I want to sort of connect a dot to. So, this is the place where purchasers see things very similarly, in many ways, to physicians and providers.

MR. WEBBER: But then beyond that, how do you use that information to generate value-based benefit designs or high performance networks or to differentiate reimbursement based on performance? All of those issues start with the foundation of provider level measurement and making sure that we have confidence that plans are doing that the right way. But, again, that’s just the foundation for lots of other things that we want plans to do.

DR. KERR: Could I add another ask?

(Laughter.)

DR. KERR: With that comment. And that is that we work to create a system that is less prescriptive around performance measurement. We could be prescriptive about a core, but we should be able to evaluate a process to measure generation which will allow much more rapid expansion than we can get through sort of the current means for approving and stamping measures. It’s too far short of what consumers ask for.

I get about four calls a month and that’s only
because most people don’t have my number. But those calls will be things like, I’m a senior executive at this large Fortune 500 firm that you do business with, and my 13-year-old son, who’s a star athlete in three sports and a straight A student, is just going to be stellar and a CEO himself one day, has sustained an injury to his shoulder and needs repair. I’ve done the research and found that there are three places that can do this pediatric shoulder surgery, and here are the surgeons. Who should I go to?

That’s the level of -- it’s those kinds of requests. If we’re held to 40 measures, there’s just no way of answering that for an individual in my capacity or, I would even think, in practice.

So, if we had a process that could validate how measures are vetted, generated and the validity of them, sign off on that and let the folks who are using them adhere to that, that would be an advancement over the prescriptive.

If you look at OSHA, as an example, safety in the workplace -- that used to be a past role of mine, as part of my job -- I would say that over almost 30 years of existence, maybe a little bit less, OSHA promulgated something like 22 rules for chemical safety in the workplace. At the companies I worked at, we were
introducing somewhere close to 1,000 new compounds into
the work site.

If we were simply calling it safe because we
adhered to the 20 -- it takes them three years to
promulgate a rule. They’ve got to investigate it, public
comment. We wouldn’t create safe workplaces. We
wouldn’t be able to.

But they had a general duty clause, which
there’s stuff that we can’t possibly anticipate, but if
it is harmful and you haven’t taken actions as a
corporation to understand what that is and protect your
employees from exposure or screen them, then you are
liable. It allowed a process outside of the sort of
fixed process. In a similar way, I think we need
something for quality measures.

MR. LEE: The other thing, if I could note --
and I’m saving my ask list for this afternoon, because I
do have one.

(Laughter.)

MR. LEE: This is a hand back to Andy. It’s
related to this morning and an expectation on health
plans, is a lot of the framing so far has been quality
information as if it’s on the Web or in paper as opposed
to human intermediated. I think the issue of coaching,
who is that coach, sometimes it can be your primary care
doctor. Other times it’s going to be an “advocate” or
navigator or nurse or whatever.

Large employers look to plans to say we want coaching because you’re going to call. And some get through to Vince. But there’s two million that get through to trained nurses that have this information.

So, these bubble charts aren’t what you necessarily send out, but there’s millions of conversations that United enrollees or Aetna enrollees are having with nurses saying, I have an X, what do I do? And that is an expectation that people won’t -- the literacy issue, we don’t expect people to be able to digest charts or even a full dot or a half dot necessarily. But then you’ll have conversations.

So, that issue about quality information translation is, I think, often going to be the human role in the middle of it.

MR. WEBBER: And just sort of one comment on that is sort of what is the trend in the health plan role? We’ve counted on plans, historically, perhaps because of the fragmentation of the health care delivery system and the fact that there have been gaps in care, particularly around chronic care management and coaching and counseling. Employers have relied heavily on plans. But I don’t think that’s static.
I think there is this evolution as we build out more integrated delivery systems, as we build out, Michael, the medical home model, where perhaps the more -- and I would argue for this, the more trusted source for coaching and counseling at the individual level is more the primary care physician than the big, bad, you know -- I respectfully say this, Vincent, but we all see the public opinion polls -- the trusted source or not very trusted source of the insurance company.

DR. KERR: You know, you have to be careful with that, Andy, because, A, if you look at polls that have been done sequentially, that has actually changed. If you look at the data Peter showed, that would be directly in opposition, an expectation that you get this information. Our focus groups that we’ve done tell us that. That’s perhaps a limited view when you speak with consumers and their view of plans.

If you talk about it from the perspective of, will I get paid for what I want to do and can I see who I want to, that’s absolutely true. When you talk about in other domains, you see very different ratings.

MR. WEBBER: Well, that’s good. The issue is still on the table in terms of sort of the division of responsibility and maybe, Vince, you’re arguing for it takes a village and we should reinforce at every level,
whether it’s coming from a health plan, whether it’s
coming from an individual physician, the support that
individual consumers need to make better decisions.

DR. KERR: Yes. I think that’s the ideal
world, where you’ve tied all three points.

MR. WEBBER: Right. But that is -- I just want
to sort of identify that as a very active debate that’s
going on in terms of how do we divide or share those
responsibilities moving forward?

Barb, you had a comment?

MS. RABSON: I just wanted to comment on the
role of the health plan because I think the regional
coalitions, like MHQP, like Wisconsin and California
have, also get into the area of the role of the health
plan. Because we come together, shared stakeholders, and
put this information out, our plans don’t have to do that
anymore because we’re doing it.

We don’t want them to do it themselves because
then physicians get lots of conflicting reports and they
spend a lot of money doing something they don’t need to
do because they’re paying the coalitions to do,

MR. WEBBER: And, more importantly, you’ve been
able, at a community level, to aggregate plan information
so you have more robust information than Vince at United
1 could provide in any one market where he’s working, even
where he’s got, you know, very large customers and lots
of business.

MS. RABSON: Right.

MR. WEBBER: Right? So, that’s the other

6 virtue of moving in that direction.

MS. RABSON: Right. And I just want to say one
thing, if I can, to Vincent’s point about CMS data.
Because there were BQI or better quality information
pilots that Minnesota, Massachusetts, California, also
Indiana, Minnesota, yeah, and Arizona got. So, there’s a
precedent for that. I mean, it’s a little discouraging
what’s happened with those pilots after. But I think
that we have something to build on in terms of to say,
you know, let’s keep pushing on that.

MR. WEBBER: Well, Michael, I don’t have much
to add after Peter and Vincent’s comments, but let me
just say a few things.

First, to state sort of the obvious, how
important this employer plan relationship is. I mean, as
both of them said, employers are the paying customer and
employers count on health care plans to be their agent in
the marketplace, to do a lot for them.

Peter teed it up well in terms of measuring
performance, the transparency issue, rewarding providers,
and then this big role in influencing decision-making at
the individual consumer level.

Let me just say sort of, historically,
employers I don’t think have done a very good job, as the
paying customer, in evaluating the performance of health
care plans over time. And I think a lot of employers
have been making decisions about selection of health care
plans not based on the robust information that we think
they need in terms of all the different roles that plans
have. And we hear this from health care plans in
response to our evaluating tool.

You know, MBCH and your 20 coalitions and some
employers who are asking good questions and you have a
very robust tool. But when I go out and talk to a lot of
employers about decisions, you know, that sort of
information base is not being used when a decision is
being made by an employer to choose an individual plan.
So, I just want to note for the record that, you know,
we have to be, as employers, more discerning customers
and consumers when we make selections about health care
plans.

And that is the tee up to the other comment.
NBCH developed the eValue8 tool with some large
companies, particularly General Motors, 10 years ago to
really create a voice from the employer community and a
set of expectations about what we think health plans should be doing in the marketplace and as a way to differentiate performance among different health care plans.

And, so, that tool, together with other tools, NCQA, obviously, accreditation and HEDIS performance measures and other factors that employers put into the equation, particularly on the cost side, provider network side, can be used as a tool to make better decisions about plan selection. This is a critical choice that individual employers have, that basic decision. Even as Peter said, the trend has been moving toward fewer plans or selecting a single plan. This is particularly true with small employers, a single plan that then perhaps offers different choices to a plan. But it will be United Healthcare that has the entire book of business for a large employer, but you’ve created different sort of plan choices or coverage choices for individuals. And I do think that is a trend.

So, there are still employers that are able to select multiple plans and then provide for their employees a choice of plan. There, the individual employer has a big role in making information known on those different plans. Again, Peter identified the health plan chooser tool that Pacific Business Group on
Health has used and I think there are other models like that around the country. And, importantly, too, there are a few large employers that actually provide economic incentives for individuals to choose the higher-performing health plan. And we would like to see more employers do this, based on, again, more robust, objective information. Those employers say to individuals, if you choose the high-performance plan, your premium share will be reduced. We’re going to create an explicit incentive for you to shift your selection and to move the market. So, certainly, we would like to see more of that happen.

The last comment that I make is information that employers can generate on health care plans, much like information that can be generated at the provider level, can be used as a quality improvement tool. A lot of what coalitions do in using EValue8 with individual employers is simply to feed back the information on EValue8, to identify opportunities for improvement, to set performance expectations for a health care plan, to have that ongoing dialogue between the customer and the provider of the service, and that can generate, again, a very positive endpoint in terms of overall plan performance and setting priorities, again, from your customer, Vince, about what is the most critically
important things that you want us to focus on in the coming year.

So, there is this sort of quality improvement aspect of the generation of plan-specific information that, again, employers and coalitions can use in driving better performance at the health plan level.

MR. WROBLEWSKI: Let me ask a couple questions about the first bullet up there and then we’ll go to the second one.

Peter, you indicated that cost was very important, number one concern. Andy, obviously, you can answer, too. Do employers have sufficient information to compare to actuarial benefit of plans -- of competing insurers’ plans?

MR. LEE: That’s a great question. And it’s -- I think Ardis rightly raised when you look at outcome at the physician level, risk adjustment, sine qua non, you’ve got to have it done well. When you really look at employers’ selection of which plan costs the right amount, it’s very hard to actually do -- which on the employer side is the actuarial adjustment to understand what am I really paying and what’s being gained versus not gained, I think the answer in the end is large employers, absolutely. But that’s because they spend a bucketload of money with large consultants to look at
what am I spending, what is the risk mix of my population and we’ll then be able to have actuarial equivalency. When you get to where the majority of Americans are actually covered, I think it’s relatively opaque. It is not as clear because they aren’t benefitting from actuaries that they’re bringing in and they’re looking at the rack rate, so to speak, of what they’re being charged. It becomes very hard because the actuarial equivalents, adjusting for benefit design, often you’ll have two benefit designs being compared that aren’t just the same. And we’ll have different implications. So, what the costs are, you aren’t really dealing apples to apples.

So, my sad note is that it’s a mixed bag. There are larger employers which, I think, often large plans have to be responsive to, so drive the market in many ways, get it. Smaller employers, I think, are all across the board.

MR. WROBLEWSKI: Okay, thank you. Did you want to add a --

MS. FERRARA: A comment to that.

MR. WROBLEWSKI: Yes, please do then.

MS. FERRARA: The comment that I wanted to add was this is an area where health plans compete for employers, right? So, we want to be able to demonstrate
that we have the strongest risk assessment methodology
and we can stratify their population in a meaningful way
and we can tie that to cost and we can tie that to
benchmark index. Then we can tie that to what we’re
offering for solutions for those different populations,
whether it’s the wellness or the chronic disease. And we
want to talk about ROI. Because that’s really what you
want to know.

You know, if I’m investing in your disease
management program or your wellness coaching program, how
do I know you’re capturing the right people? How many of
my people is this helpful for? Is cardiac disease a big
issue for me in the relative scheme of issues? How do I
compare to other employers for cardiac disease? And what
can you do about it and what’s your ROI? Are people
healthier? Do they return to work faster? That’s how we
compete.

We used to compete potentially more on price,
you know, what’s their fee versus our fee? But these are
the things that matter. So, if you talk about
competition, you have to talk about how we’re competing
as well.

MR. WROBLEWSKI: Nancy, you wanted to add?

MS. Foster: I just wondered if I could ask

Peter a question.
MR. WROBLEWSKI: Sure.

MS. Foster: Or anybody.

MR. LEE: No, not Nancy.

(Laughter.)

MS. Foster: That’s one, Peter.

MR. WROBLEWSKI: And, Nancy, I have a question for you afterwards.

MR. LEE: I didn’t mean to say that.

(Laughter.)

MS. Foster: The question I wanted to ask was does the picture change a little bit for the self-insured large employer because they’re using some plan to manage --

MR. LEE: I’m saying virtually all the large employers, if you’re big, they all have significant self-insured and some insured because of where they are, et cetera, and will do just as -- will look at the data with real discretion and will expect the plans will come in and say, here’s what we can tell you about your population and where they are. So, for that large population, self-insured, absolutely, they look at it really closely. It’s just when you get into mid and small employers, it becomes very much about price.

And then major tactical choices that employers make. Am I going to do a consumer pay through a
1 consumer-directed plan and some features of a plan and
2 price that are more sort of philosophical.

MR. WROBLEWSKI: The question I ask for you,
3 Nancy, based on your comment, and actually it was
4 Michael’s comment from earlier this morning, and I
5 thought one of Vincent’s slides maybe teed up maybe how
6 we could discuss this for just a real brief point because
7 you both have brought this point up. So, I wanted to
8 address it.

9 You said, where is competition appropriate?
10 So, I was looking at if you were to move that red line
11 from left to right, are you saying that in terms of when
12 we were talking about consumers this morning, that
13 competition on moving -- if the red line were, say, more
14 in the middle of the screen rather than where it is right
15 now, that competition would probably be better when it’s
16 to the right? Is that what you’re saying? And that
17 there’s a certain baseline that you expect that would be
18 on the other side of the red line and that’s where it
19 would not? I saw this graphic and was just thinking
20 about it.

21 MS. Foster: I think competition on safety is
22 not appropriate. I mean, just personal opinion.
23
24 MR. WROBLEWSKI: Right.
25
26 MS. Foster: Competition on compliance -- the
terms here are befuddling me a little bit because you
used them in a slightly different way than I would have
used them. I mean, in some degree you’d expect everyone
to be able to deliver patient-centered care. Would you
have competition on I can be more patient-centered than
you? Yeah, that might be appropriate.

MR. WROBLEWSKI: Or dimensions of cases.

MS. Foster: Dimensions of cases. Compliant
care -- again, I would hope that people were compliant
with well-founded, evidence-based guidelines. But as
we’ve talked about here, there’s a lot of territory out
there for which evidence is insufficient. And, so, some
of that might be appropriate.

DR. KERR: If it’s clarifying at all, I would
say that given the bubble charts that we’ve seen, you’re
stuck here. I mean, you are going to compete on being
able to be in that upper right-hand quadrant as a first
order of competition.

It would be great if everyone were there
already. It would change the domains.

MALE SPEAKER: I won’t speak for Nancy, but I
don’t think we’re saying anything different except we’re
saying there should be, across the board, an assumption
that there’s a certain level of performance that we
shouldn’t have to bother our consumers about worrying
about who’s doing what. And I agree with you, we’re not there yet.

But, at some point, that level of competition should be moot and we should be competing on other elements that really are truly differentiating providers and systems, et cetera. So, I don’t know how to interpret the diagram any better than just describing what I was relating.

DR. KERR: I think, if I can, safety is foundational. And the reason that’s sort of a sliding chart is that when you get to the other end of that, it’s an assumption. You don’t even ask.

Right now, when you leave town, for those of you who are flying, you’re not going to look on a Web site to see whether Delta or Northwest has a better crash record. You’re not going to do that. You’re going to look at other parameters. If, in fact, there were vast differences --

MALE SPEAKER: Cost.

DR. KERR: Yeah, cost.

MALE SPEAKER: How much does a pillow cost?

DR. KERR: And time. Can it get me there?

All sorts of things.

MALE SPEAKER: Sure.

DR. KERR: If, in fact, there were vast
differences in the crash rates, you would be paying
attention to that.

MALE SPEAKER: Well, yeah, I mean, back to
Beth’s point earlier and some others. I mean, the way we
judge airlines right now, after you’ve been a few -- you
know, you look at whether the cabin is kept up, whether
the tray table is clean. Is that a proxy for how well
the pilot’s doing? I don’t know. But it’s what you can
see. And I think that’s where some of the measurement is
right now. I think that’s what we’re all trying to move
away from, so it’s meaningful. Although I would like a
clean cabin.

MR. WROBLEWSKI: Barbara.

MS. RABSON: It’s interesting because this
whole competing on safety issue is playing out a bit in
the Boston market. Peter Levy from Beth Israel Deaconess
Hospital has begun posting infection rates, never events,
all kinds of complications on the Web and they’ve run
into turbulence as they found a wrong site surgery in the
last few months. Unfortunately, a young woman died
delivering a child. So, there’s these issues that are --
they’re very transparent about it.

And, so, there’s one worry that because these
have been in the Globe, people say, well, I don’t want to
go to the BI. But there was a great quote from one of
the surgeons that the BI is safer than it’s ever been.

This is not an anomaly that these things are happening at Beth Israel. These are happening everywhere. Beth Israel happens to be very transparent about it.

And Peter was joking that some of the other CEOs are pressuring him and saying he’s doing this for competitive purposes. And he’s laughing and saying, wait a minute, you know, like what are you saying? So, the idea is, you know, he’s one of these innovators that’s out there saying this needs to be done and we’re doing it. But this whole issue of drawing the issue about what we take for granted is not -- it’s hitting the press.

MR. WROBLEWSKI: Andy, you wanted to --

MR. WEBBER: Well, sort of to bring this to a sort of practical level in terms of some examples out there, you know, what if Vince created a high-performance network that was based on good information that demonstrated that the hospitals and physicians in his network are providing higher quality, more efficiently, driving costs down. He’s able to create that product and go to employers and go to employees of those employers and say, if you’re willing to join a plan with just as high-performance network, this is sort of back to the future. We all remember these days. But your choice of provider will be restricted.
But particularly in this economic environment, remember, all the cost shifting that’s moving on to employers. Look at the economic meltdown. You’re able to say to an individual consumer in choosing this more restricted network -- and, by the way, I’m going to demonstrate to you, because I’ve got the data, that you’re going to get higher quality at lower cost. Your quality is going to go up. It’s not going to be compromised. And you’re going to have a lot fewer dollars in your premium share. It’s going to cost less for you, individual consumer.

I think that is competitive. I think that is a winning product in the future. And I think even individual consumers, at least some of them, not all of them, are willing, if, again, they had trust in the information, to go in that direction.

MR. WROBLEWSKI: How does that square with -- you raise such a good point. I was fascinated by Peter’s slides. When you look at the ability, at least from what employers think, in terms of the ability to use a tighter managed care network to actually reduce costs would be that when I added the numbers, it looked -- even though none of them were a silver bullet, it was really, you know, pewter. I mean, it was really very low in terms of that number. So, how does that square in terms of what
employers are saying?

MR. WEBBER: Can I --

MR. WROBLEWSKI: Sure.

MR. WEBBER: Well, again, we all went through the wars, the managed care wars, and we all heard from the public that choice is everything and employers and plans got beat up. That was not a sort of pleasant time. And yet there were elements of that period -- and, Michael, back to -- remember how we used to call it the primary care gatekeeper?

MR. LEE: Yeah.

MR. WEBBER: Does that sound an awful lot like the medical home concept?

DR. BARR: No, no.

(Laughter.)

DR. BARR: Can that be struck from the record, please?

MR. WEBBER: No, but in terms of the vision. But in reality --

DR. BARR: Not to be flip, you take away the gatekeeper, but you think about as a facilitating system, where there’s an organized principle around how you deliver care, but not the barriers that were put in force before.

MR. WEBBER: Right. The vision of managed care
was never created. But if you take the elements of where we wanted to go with some of those concepts, having a medical home, having a provider network that’s high-performance that’s been identified, again, having individuals be part of a more integrated, closed panel, high-performance network, that was -- that was what, at least, the theorists were talking about when they talked about managed competition.

The marketplace didn’t realize it. There was tremendous political pushback. But I think those issues and that vision is still very relevant in terms of competitive marketplace.

MR. LEE: What I was going to say, if I could, the tighter managed care networks -- and I’m not surprised why it’s pewter -- is that it does bring up for employers 15 years ago a managed care backlash. What’s changed, though, and this is what I think we see in the major plans, is that -- and that migration from an HMO model to more PPO, is it’s variable. There’s money on the table and you can make a choice. It’s a choice-based model where it’s not anchored in tighter management; it’s anchored in more information that links quality and cost and incentives to make a different choice, as opposed to, sorry, you picked X and that means one-third of the doctors are in.
I think that’s a conceptual change in terms of a -- which, to my mind, is both pro value, encourages quality improvement better and is more competitive. But it’s not a tighter managed care network. It’s a very different model. So, the pewter side of this doesn’t surprise me.

MR. WROBLEWSKI: Okay. Dr. Hoven, you wanted to raise another issue.

DR. HOVEN: Correct.

DR. WROBLEWSKI: Go ahead.

DR. HOVEN: Thank you. And this is directed to Vince, a comment and a question. And I would be extremely remiss if I did not put on the table the discussion of physician tiering and bring that out in the open and what those discussions are centered around and what the financial incentives are for the patients and what the implications are for that. Because as most everybody in this room knows is that the data that has gone into this tiering has not been good data in most situations. And I think that that has created, if you will, a real barrier -- and we’ll discuss it more this afternoon, but a real issue in terms of where plans are going to go with this.

And, again, I understand the mentality behind it, but I think as you’re going forward with this, you’re
going to have to look very critically at what you’re
doing with that information and that data and, more
importantly, how valid and good is that data. So, any
comments you would make, I would be appreciative.

MR. WROBLEWSKI: Go ahead. She jumped ahead to
my next questions, but, please, go ahead.

DR. KERR: There are many ways of structuring
tiered networks. The most extreme would be sort of what
Andy’s talking about, which is a completely closed
network. You don’t have access to physicians other than
those who are named.

I don’t think many are going that route and I
think there are a variety of reasons for that. It’s hard
to go back. And large employers particularly --
actually, this is where the small employer market leads.
So, there are products out there that make
differentiation around benefit design based on those
metrics. And individual members, people who are buying
their own insurance, and small employers are rapidly
electing that product.

What they’re saying is I can handle the
difference. I have choice, but that choice is going to
cost me something. And the rationale behind that is
while there are a host of issues around trying to depict
quality performance, there are not as many issues around
depicting efficiency. There’s some, but not as many. And you can do those depictions at a level that would satisfy the scientific community, meaning at a .95 percent confidence interval. If you hold yourself to that standard, why wouldn’t you use that as a way of differentiating?

In saying to a consumer, you’re perfectly free to make the choice, but just know that this costs me more, so it’s going to cost you more. You’re going to share in that additional cost. When the availability of service at equal or better quality is available, that would be less costly. I don’t think that’s an unfair conversation to have.

Your point is absolutely well-taken. The structure around that in terms of not doing it strictly as an internal, you know, this isn’t Vince’s mad, you know, scientist lab cooking up, but exposing that to external scrutiny and validation, receiving input from the stakeholders who might be impacted by that are all requirements for, I think, developing that sort of system. It’s not a no-go in my mind.

MR. WROBLEWSKI: Elysa, you wanted to add something to that?

MS. FERRARA: Yes. I would say, in addition to those comments, that we can’t forget that there’s a
consumer purchaser disclosure project in the patient charter. We can’t forget that there was a New York AG’s settlement agreement and, in fact, the plans fared well. Ours was one, but we weren’t the only one.

So, there is a rigor to the work that is being done. There’s a commitment to exchange and development with physicians and with other providers for any of these tiered networks. Quite frankly, the employers are demanding it. And many of these innovations for measurement are coming directly from what we’re hearing at the table from the employers.

They started Leapfrog, they started Bridges to Excellence, they started HEDIS, and they were the innovators for the consumer purchaser disclosure project. So, the demand is real, and we talk about tiering, which would say, as you said, we pay more, you need to pay more. There’s evidence of quality here.

We have employers who are demanding domestic tourism programs and international health tourism programs. So, for them, differentiation is important and they’ll invest. They’ll pay $10,000 for travel to invest, to get high-quality, value-based purchasing. And, so, that’s the world that we all live in.

I spend a lot of time internally with that with our medical directors and with our network people,
sharing with them this information from EVealue8, information from the Leapfrog users group surveys and information from RFIs. We also do that when we’re out with the physicians. There’s an IPA we have a contract with that’s 2,200 docs. That’s a lot of docs.

When we sit with them and we show them the questions -- I had one yesterday that I responded to. How specifically do you profile your physicians for quality and efficiency? How do you give that information to your physicians? How often do you give it and what do you use it for? That is nearly a quote. And it’s not uncommon, I’m sure you know. This is what we get asked every day.

So, these are the payers who are asking for this kind of information from us. But they’re also asking us to be credible, respectful and collaboratively engaged when we do it. And I think that’s the challenge for us. How do we do this together? Because it will happen. It’s already out there on the internet. It’s our obligation to work together to do it in a way that is prudent and disciplined.

MR. WROBLEWSKI: Dr. Chumbley, did you want to add something? Then I’ll turn to Nancy and to Michael.

DR. CHUMBLEY: Sure. I think you said it very correctly. In Wisconsin, when the collaborative looked
at episode of care and efficiency a numbers of years ago, we realized there just wasn’t enough data out there to come up with it. So, we spearheaded creating the Wisconsin Health Information Organization, which we haven’t spoken of yet this morning. But that organization brings together the medical society, the collaborative, as well as Anthem, BlueCross-BlueShield, Humana, United Healthcare, Wisconsin EA Trust, Wisconsin Physicians Service, which is another insurance company, and probably two private plans, and we’ll have about 1.2 million members and associated data that we will come out with our first pilot period early this next year.

The most important part, we’re trying to do exactly what you did. We brought the medical society, the physicians, the major payers. We have a clinical advisory group that looked at how the measures were going to be developed. I sit on that. So, we’re trying very hard to do it collaboratively.

The biggest question that came up early was the tiering question. The physicians on both sides, the medical society and the collaborative almost backed away from this project because we really couldn’t get the plans to say we won’t tier.

Well, we’ve got an advisory group, we’ve got this. And, so, I think it’s in that test period now and
we’ll see whether we actually can collaborate and cooperate and come up with something that serves the needs of the people in Wisconsin. I’m pretty hopeful and supportive. But it’s going to be tough.

MR. WROBLEWSKI: Nancy, you wanted to add something?

MS. Foster: Yes, and thank you. Sort of picking up on that notion, because you spoke to the collaborative, I just wanted to, a while ago, just sort of put on the table one of my underlying fears about over-reliance on competition or over-exuberant competition I guess would be the right way to put it.

The ways in which providers have most successfully, in my opinion, made improvements in the quality of care that they are delivering around this country has been to work together, to share strategies about how to get done that which we know needs to be done, that which there’s evidence to show us needs to be done.

Those collaboratives are very open. The information, the tools, the strategies they share would not normally be shared among competitors who are seeking to differentiate themselves. And I don’t want to lose that, because that’s what’s driving safety. That’s what’s driving down the infection rate.
Folks point to Michigan. There are a lot of states now engaged in similar projects. It’s really that sharing. If we stifle that by being over-exuberant with our competition, I think we will do real damage to our patients.

MR. WROBLEWSKI: Michael?

DR. BARR: Just a quick follow-up to Nancy and then a question for Vince, which hopefully will be pretty simple. We’re starting to see, interestingly, the plans compete on the medical home demonstration plans. So, you have these several plans in a community and one wants to go real fast, real forward and not play with the others in the sandbox, so to speak. That becomes a problem at the level of the practice. You duplicate sort of the fracture and different things.

Vince, in your comments earlier you said something about efficiency and quality. If I heard you correctly, you said it was easier to measure efficiency than it was to measure quality. I wasn’t quite sure I understood because I’ve always thought of efficiency as a measure of cost versus quality and if you’re having difficulty measuring quality. Can you help me understand what you meant by that? Because it doesn’t jive with at least my understanding.

DR. KERR: I was speaking from partly a
technical aspect of both and definitional. Quality is a broad canvas when you try to define it. And when you hold to a handful of measures, you cannot be complete enough. Primary care you can cover, oh, maybe 15 conditions with an average of about five measures for each condition, something like that, or four measures for each condition, and paint a pretty robust picture. For surgical procedures, you have some information that’s probably important, meaningful, indicative and relates to outcome.

Efficiency is easier in some ways because the definitions around what you’re looking at are more discreet. That’s what I meant. So, you note cost as a number and it’s not -- it doesn’t need a qualitative explanation.

Quality, that’s a redundant term, but you will translate into numerical, but describing what it is and deciding what’s in that box or out of that box requires some decision-making or judgment. That’s what I meant.

DR. LEE: I think, Vince, if I may, that you used the term “efficiency” as we often use global cost of care.

DR. KERR: Yes, right.

DR. LEE: As opposed to one of the other technical definitions of efficiency is always the
combination of cost and quality. So, this is back to the
-- we often speak past each other because efficiency is
used in different ways.

DR. BARR: And there may have been others at
the meeting with the AQA where we talked about efficiency
for a whole day. I don’t want to duplicate that. But I
think it points out that when we talk about these things,
we have to understand talking the same lexicons. So, I
appreciate the clarification, Peter.

DR. KERR: And they are related in some way.

DR. BARR: Oh, absolutely. I mean, I just
brought the AQA principles just for reference because I
knew it might come up. And I won’t read all of it, but
efficiency is a measure of cost of care associated with a
specified level of quality of care. It talks about value
as a measure of specified stakeholders; preference-
weighted assessment of a particular combination of
quality and cost secure performance. That was hammered
out over a long time, for those of you who are familiar
with it.

DR. KERR: I actually would disagree with one
point. Why isn’t efficiency an absolute? Why can’t you
look at it -- why is it attached to? Why aren’t those
two independent variables?

DR. BARR: I think you get to the different --
I think Peter’s point earlier is that you’re talking about a total cost.

DR. KERR: Yeah, okay.

DR. BARR: And we’re saying that if you’re looking at the efficiency of, I’m a doctor --

DR. KERR: I got you, I got you.

DR. BARR: -- how do you measure my efficiency because it includes quality?

MR. LEE: And that’s what I think Vince was very articulate about, not about defining efficiency, but was that you must look at total cost of care with quality to get to efficiency. Those two have to be together. That’s in the spirit of what’s the AQA definition without getting into the -- yeah.

DR. BARR: Exactly, right. That’s why I hesitated to read it, but I had to.

DR. KERR: We probably should use the word “cost.”

DR. BARR: Total cost. Global cost, right. I mean, it points out your other -- I don’t mean to take -- but your nice graph about the initial cost of a visit versus the total cost. We start getting into transparency and the movement to doctors to post their prices. It has no reflection in reality when you think about the rest of it, and you just proved the point right
there.

MR. WROBLEWSKI: Go ahead. Go ahead.

MR. LEE: Just one anecdote on consumer transparency. I see Andy’s flag is up. So, I’ll be really, really brief.

MR. WEBBER: And yours wasn’t.

(Laughter.)

MR. LEE: This goes back to consumers and cost versus price. One of the plans, which isn’t at the table here, in California, wanted to educate consumers about how much it would cost, and they put dollar signs next to hospitals thinking that would indicate be careful, this is an expensive hospital. Consumers said, hot damn, I’m going to the more expensive one because I don’t pay much, and, clearly, more expensive is better.

This comes back to the issues around how do you communicate some of these issues. Multiple dollar signs, if that means -- well, generally, we Americans think if it costs more, it’s a better it. We know in health care that’s not the case. So, we have a lot of communication challenge. But I want to note that the confusion we have on efficiency versus global cost of care translates, in a big way, out to consumers as well.

MS. Foster: Couldn’t you solve that by paying all hospitals all the same, high rates?
(Laughter.)

DR. LEE: I thought we did.

MR. WROBLEWSKI: But, Nancy, you raise a good question. Actually, it was a great segue to my question. To the extent that if higher quality is paid more and you’re trying to incentivize consumers to go there by giving them a lower share, copay, how does that work?

DR. KERR: Well, you lower the -- when you say how does it work, you mean how is that --

MR. WEBBER: The total cost has come down, so there’s some sharing to --

DR. KERR: Do you mean from a total cost perspective?

MR. WEBBER: Yeah.

DR. KERR: Yeah. It’s very easy to do the models to -- yes. Exactly. You’re sharing the savings. You’re paying for that --

MR. WROBLEWSKI: So, that’s always assuming that higher quality is of lower cost?

DR. KERR: No. No, in fact, you can’t do that. If you go to that bubble chart, you will see very high-quality cardiologists who cost a hell of a lot, and there are very few people who would want to put an incentive to drive folks to those docs. It’s because you’re using that right quadrant I think on everyone’s chart. They
shift around. It gets very confusing.

But it’s the most cost-efficient --

DR. BARR: I see a standard in the future.

(Laughter.)

DR. KERR: It’s the most cost-efficient who are also in the top tier from a quality performance to the extent you’re using quality measures.

MR. WROBLEWSKI: And do you pay differentially now for higher quality, for hospitals and/or providers in that upper right quadrant?

DR. KERR: For physicians.

MR. WROBLEWSKI: For physicians.

DR. KERR: For physicians, we do. And all of those things have to align. You’re really sending mixed signals if you don’t do that. So, information that physicians get around this quality measurement will be more detailed and robust than what the consumer will see or that you could even let the consumer see. You will have patient-level detail around measures with patients identified. So, you can validate or correct the derivation of that quality metric.

That’s important, that there’s symmetry in the information that’s shared. And it’s also important if you’re going to align any kind of reward or incentive, that you give credence to that in your compensation.
MR. WROBLEWSKI: Elysa, did you want to add anything to that?

MS. FERRARA: Just a couple of quick comments. If you use an example, we all want our quality providers to be identified in that top quality tier, and then we do look at the differences in total global cost, looking at readmissions, looking at total costs, and sort of taking an interest that’s not at the table. The surgeon may learn that the reason they’re at the highest cost is because of the choice of implantables they’re using from across multiple types of implants, which are equally efficacious. It may well be that the hospital has been looking to partner with the physicians and potentially do some gain sharing around this.

So, you know, one of the opportunities is to be able to open the doors to those kind of initiatives. You know, you certainly want your members to have access to that very high-quality cardiologist. We’d like to see them reevaluate, work with the hospital, make some other choices and have that greater option, because they are more of a value for the consumer. And I think that’s what folks are driving at.

Get meaningful information out there. Get it to the consumers. But, please, get it in the hands of the providers and the health systems together so that
they can act on that information. And that’s an area
where you’ve maintained quality. You haven’t imperiled
quality in any way. And, yet, you’ve resulted in lower
cost, which puts more money in the health care system.
It’s not money that disappears.

DR. KERR: And to that extent, your point about
higher quality being related to better efficiency, there
is a component of that that is true, and that is if we
simply look at, in our system, the docs who have met
quality criteria, and compare them to the universe, all
the other docs, docs who we don’t have enough information
on to gauge a quality ranking, docs who we do have enough
information on to gauge a quality ranking and they don’t
meet the set of standards that are agreed upon, you will
see a 200 percent increase in the complication rate for
that other group. You will see a 70 percent increase in
the redo rate for surgical procedures. All of that gets
folded into the cost.

So, there’s something about the process or the
ability, risk-adjusted, to obtain results that partly
influences the cost. There are other things that do that
that are elective or can be choice-based, particularly in
orthopedics.

MR. WROBLEWSKI: Thanks. Jack?

MR. FOWLER: I was just going to talk about the
measure of quality again. Complication rates and all those things are really great, but I remember that Rudy Giuliani said he was so happy that he was operated on in the United States where 80 percent of the prostate cancer patients live five years as compared to Great Britain where only 40 percent did. And, of course, the problem is we operate on twice as many people.

(Laughter.)

DR. KERR: Some of them didn’t have prostates.

(Laughter.)

MR. FOWLER: But, in particular, complication rate is only one measure of quality. And the cost thing, it’s really hard to get population-based rates for a provider, because figuring out what the population is is really tricky. Doing a lot of stuff in a vacuum.

MR. WROBLEWSKI: The one last point that I have -- and I wanted to ask both Kristin and Beth and Jack and anyone who really wants to participate -- is does the information that was listed that Peter put up in terms of what consumers were looking for and what Vince talked about square with what your -- what are your reactions to that?

DR. NASH: I’m not sure if this is the question that you are asking, but one of the things that certainly came to mind for me is that, in our experience with
consumers and also in focus groups, consumers don’t
really care at all about the cost of care. And they kind
of look at you quizzically like, I have insurance. Why
would I care about that?

And, you know, so I think it’s a really
fascinating dynamic. I think it’s going to change and I
think it’s an educatable moment. I think there are some
very illustrative examples of -- and there are some
people doing a lot of really good work that we’re working
with in this area, that a person with breast cancer, you
can go through an example and show to a consumer that
their out-of-pocket costs could be extremely different
with one plan versus another. But I think, generally,
they don’t get the cost issue.

MR. WROBLEWSKI: Okay, thanks. Kristin?

MS. MADISON: I guess I would agree with that.

As a consumer, I’m most interested in the cost to me.

DR. NASH: Right.

MS. MADISON: Whatever form those costs take.

And I should say we’ve mostly been talking about insured
patients. For uninsured patients, they really do care
about the bottom line cost of all these things.

I’d also -- I mean, thinking about this
question of insurance design, I wasn’t sure from your
comments, Vince, whether -- if you do tiering based on
efficiency, whether you tell your enrollees that that’s what you’re doing. I mean, from my perspective, if quality is really the same, I’m not sure that I care or I need to know that information when what I really care about is quality.

I think, Peter Lee, you can correct me if I’m wrong, but I think you’ve used an example of a Las Vegas union group or something, where they looked at efficiency, they cut out a very few doctors from the network on the basis of that kind of measure, and then they communicated to their enrollees some information about their quality which they could then use. That seems to make a lot of sense to me, as a consumer, of how you might manage something like that.

MR. LEE: Well, it is a real and true example. But this comes back to that scattergram. This particular union excludes very few of those shining diamonds, not dits. But it was very few, a small handful who were incredible outliers on inefficient use of global resources. They still did identify, of those that were still in, higher-performing and all the others and they had some incentives to choose and they actually had a huge impact on trend.

But I think the issue of -- that exclusion issue, which I think for many physicians is one of the
more troubling areas, is what I’d call the tighter
managed care element. It was used very sparingly. And,
also, they engaged the physicians in conversations about
how they were measuring episodes, et cetera, et cetera.

But I would just strongly agree, I think I said earlier, episode cost is like -- is a nonstarter for a
consumer. Cost to them and how that relates to episode
is very much an engaged element. And I think that we’ve
seen a lot of demands to help plans, of enrollees saying,
give me information what it’s going to cost me. If I get
an MRI, what’s it going to cost me, which I think is the
healthy thing. Because 15 years ago, people didn’t ask
at all because it’s insured, it costs me nothing, as if
it costs all of us nothing.

So, there is, I think, a movement towards
looking at exposure to the consumer to the price.

MR. WROBLEWSKI: Let’s have Elysa and then,
Michael, final comments.

MS. FERRARA: I was actually going to answer
your question. Under the PHQ standards of NCQA, in order
for us to be compliant and hence to be compliant with the
patient charter as health plans, if we have tiering, if
we make comments about efficiency and put it into the
public domain or quality, we have to provide member
placing materials, plan sponsored placing materials and
physician detailed monographs on what was the basis, how was it measured, what were the statistical rules that were applied. So, there is tremendous transparency and methodology that has to be out there.

MS. MADISON: So, is that if you call it an efficiency-based network or is that for any -- so, you’ve got all sorts of --

MS. FERRARA: If you act upon -- if a health plan acts upon -- you’re the expert over there. This is like a test.

If a health plan acts upon information, so if you’re publishing it, if you’re putting report cards out, if you’re tiering, if you’re using it, if you’re acting upon that information in some manner, then you’ve got to be transparent about it. Now, you could choose not to pursue PHQ NCQA recognition. You could choose to ignore the purchaser disclosure projects. But the large employers -- the employers are not really going to allow you to do that.

MR. LEE: If I could just, it’s not just the employers, but the patient charter was endorsed by -- supported, I won’t say endorsed, by the AMA, ACP, the physician community as a set of physician expectations.

I think one of the important things, back to this discussion, is that one of the elements of that
charter was that plans wouldn’t use cost alone. That’s because there’s such concern that the only element looked at would be cost and, rightly or wrongly, the concern that it would be driving people to "cheap doctors."

But if a plan is using only quality information, even that needs to meet all these standards of transparency. If you’re using quality with global cost of care, you need to show how they’re weighted, their respective weights.

I mean, there was a very long, good legal piece on the different elements of regulation. And that piece -- that was yours. Excuse me, sorry. I haven’t read the law reviews in a long time, but it’s sort of how regulation works. This is an element of self-regulation. The plans don’t have to do this by any legal standard, but that their clients, purchasers and their other clients, the doctors that work with them are saying, you need to do this, has, in some ways, become a regulatory process in terms of how physician performance measurement is happening.

MS. FERRARA: And I think part of the beauty of it was that it brought together the physicians. So, there is a major process built into there for reconsideration. So, a doc can come back and say, my member got her mammography at the public health bus that
came to her or her employer has a mammography clinic. It’s something unique in our community.

So, there is a process that is a disciplined process to correct errors, to make the data valid, to give a notice period for the providers where they have that information first.

And then the other process on it is it’s as stringent -- and I used to be in government, and I was a director of internal audit for a state health department, and it is the most stringent audit process, you know, that I have seen in terms of if a physician asks for a reconsideration, show us the file that shows that you responded, examined and charged.

MR. WROBLEWSKI: Okay. I’m going to give Vince the last word.

DR. KERR: Wow. Because I never get that at home.

(Laughter.)

DR. KERR: I’m going to savor this. I hear laughter. So, apparently, you share my pain.

I made the statement that you always had to pair -- if you’re going to show efficiency, you have to pair it with quality. So, I don’t know anyone that’s doing a pure -- or there may be, but we just would not believe in doing a pure efficiency network. In fact,
when that information -- there’s a second principle that we strongly believe in.

If you’re rating along those domains, you show them separately. That way the consumer can make his or her judgment. And we don’t show docs who meet efficiency but can’t meet quality. So, you wouldn’t, as a consumer, have that information to be able to even make that choice.

MR. WROBLEWSKI: Okay, thank you. We’re going to break for lunch. A couple announcements. If you go out for lunch, please keep your badge and then you won’t have to sign in again. You’ll have to go through the metal detectors, but not the screening process. For the panelists, we do have lunch being brought in. That should be here by now.

And we’re going to start back at 1:45. Thank you all very much.

(Morning session concluded.)
BARRIERS TO QUALITY-BASED COMPETITION AMONG PROVIDERS
AND TREATMENTS

MR. WROBLEWSKI: Good afternoon. For those of you who are just joining us, my name is Michael Wroblewski and I am with the FTC’s Bureau of Competition. My co-moderators this afternoon are going to be James Cooper, who’s Deputy Director of FTC’s Office of Policy Planning, and Pat Schultheiss, who’s my colleague in the Bureau of Competition.

I know we have some new people that we’ve joined in to our discussion and we are grateful for your participation.

Security has asked me to go over a couple of details that everyone heard in the morning, but I do have to go over them again. In the unlikely event the alarms go off, please proceed outside the doors to the right. There’s a staircase to go downstairs, and the meeting place is across the corner street over at the sculpture garden. If you spot any suspicious activity, please alert me or James or Pat or the security personnel and we will act accordingly.

Restrooms are out the door to the left-hand side. And if you can please turn off your BlackBerries or cell phone or at least put them on silent mode, we’d really appreciate that.
We have five people who have joined us this afternoon. Let me go around and introduce them first.

To my far right is Richard Sorian, Vice President, Public Policy and External Relations for the National Committee on Quality Assurance.

To his left is Karen Milgate, Director of the Office of Policy Centers, for Medicare and Medicaid Services.

At the far end of the table next to Beth Nash is Dr. Janet Corrigan, President and CEO of the National Quality Forum.

And then all the way at the end of the table is Dr. Irene Fraser, Director of the Center for Delivery Organization and Markets at the Agency for Healthcare Research and Quality.

Paul Ginsburg will be joining us a little bit later today. He won’t be here probably until about 2:30 and his seat is next to Michael Barr’s over there on the right-hand side there.

On our agenda, we had John Richardson, also, from MEDPAC, who has taken ill and will be unable to join us this afternoon.

To get started, this morning we went through basically a needs analysis from the different perspectives, from the demand side whether they were the
consumer, the insurer or the employer or the physician in terms of what information makes a competitive difference to them.

This afternoon we would like to switch gears a little bit and turn to what are the barriers to greater competition based on quality.

To start that discussion off, Irene Fraser from AHRQ is going to give us her thoughts and then we can open up the discussion and we’ll go from there. Irene?

MS. FRASER: Well, good afternoon, everybody. I’m sorry if I’ve got my back to some of you. I’m so sorry I could not be here this morning. It looked like a wonderful, wonderful program.

I’m going to try to just kind of set the stage for this discussion. It is humbling to be in the presence of all of the other panelists here who will have a lot to say, I’m sure, about many of these topics. But I wanted to just kind of set a framework to get us started.

In trying to think about the use of competition as a way to improve quality, of course, this ties you back to the use of competition in general in our country, and, of course, we all know that that is not without its hurdles and without its problems. In the case of health care, it can be even more problematic in many ways.
So, some of the problems that you experience in other industries you see two or threefold in health care. That does not mean that it can’t be done, but it means that we have to be really mindful of the barriers. So, what I’m going to try to do is set the stage by talking about some of the barriers and also trying to set the stage for the following discussion by looking at those things that are being done now to start to surmount those barriers.

There are three paths that you can think about through which competition would improve quality in health care, and each of them faces similar, but not identical hurdles. It’s pretty much the same hurdles, but they play out in different ways depending on the path. This is probably something you all got to this morning in your discussions.

The first path would be that consumers of health care would choose higher quality providers. As a result of those choices, the addition of all those individual choices, those providers would then get more market share and potentially higher rewards. So, that would be one way that the market could play out.

A second way is that payers would make those same sorts of choices which would then cause more market share to the higher quality providers.
And a third path would be that the providers themselves are competing among themselves, and this is not necessarily directly for shares of the market, but for their own intrinsic reasons, because, for the most part, people who go into some of these professions, just like other professions, are, by nature, a competitive lot and are intrinsically motivated and want to do well and want to do well in the eyes of their peers. So, that generates some competition.

There are six hurdles that occur on each path, but as I mentioned, they tend to play out a little bit differently depending on which path you are talking about. There is, by the way, some evidence for each of these paths, probably the most at this stage for the path of the providers. But I think a growing amount of evidence that the other two paths can, in fact, work as long as they’re constructed ideally.

The first hurdle that I wanted to talk about briefly is awareness. Here the problem is that many consumers and some payers don’t really recognize that quality differences exist. Certainly, 10 years ago that was a huge issue, that was a huge hurdle. I think, increasingly, with the publication of the IOM report, “To Err Is Human,” and a few well-publicized horror stories, we’re beginning to change that and there is some growing
recognition that quality does differ from one provider to
another.

On the other hand, most people believe that
their own provider is good. So, it actually takes me
back to my days as a political scientist studying
political science. We were talking about this, actually,
a couple of us were earlier. This has been a truth since
way back when. That most people would say that Congress
is not great and probably their opinion of Congress has
declined at times. But they would say their own
Congressman is good. I think that we have a similar
kind of approach to providers, many do. So, that is a
bit of a hurdle because if you don’t know what the stakes
are, you are not likely to follow the other steps in the
path.

The second is measures. This probably, also, I
would imagine, came up this morning. But in order to
have really informed choice, you need valid uniform
measures that are relevant and credible to whoever of the
these three actors you’re talking about, the consumer,
the payer or the provider. And they have to not only be
valid, but be perceived to be valid and relevant. And,
so, that’s kind of a double hurdle.

The barriers to this is that, in some ways,
there are too many measures and in other ways there are
too few measures. In terms of measures that consumers, 
payers and providers really consider, boy, this really 
matters, this is valid, this resonates with me, there are 
probably too few. On the other hand, there are so many 
measures that it can get overwhelming. And trying to 
figure out how to deal with this challenge is a really 
major, major issue.

    Most of the measures are process- or diagnosis-
specific and that can be a problem because you can’t 
always predict what diagnosis is going to befall you, 
because process measures are not all that easily 
explained to consumers and often to payers. And 
different payers, as I’m sure you heard this morning, 
value different measures.

    There has been, in the last few years, an 
amazing amount of progress on this and I would say -- and 
you’ll, I’m sure, hear more about this from Janet -- some 
of the work that the NQF has done has really brought a 
lot of focus to our efforts in measurement and has 
created consensus around and agreement on a core set of 
measures. I’m sure nobody would say these are the very 
best measures one could come up with, given an infinite 
amount of time, but they are good and they are 
respectable and they are agreed upon, which gets rid of a 
lot of the issues.
Some of these measures increasingly are being adopted by Medicare and Medicaid and states and private payers, thereby leading to some of that uniformity. A lot more work to be done, but a lot of progress.

Just as one example, from my own home, the agency has developed a set of quality indicators and many of them have been accepted by NQF and are now in widespread use across the country. Right now, there are 12 states that are using many of these measures for public reporting. Many other states are in the wings. They have just been waiting for the NQF endorsement process to start doing this. So, this is comparative reporting for hospitals. CMS is going to be using nine of these under their new inpatient payment rule.

So, a third hurdle is data, because even though most of the attention goes to measurement, measures without data are really useless in the market. They’re interesting, they’re kind of amusing, but they don’t actually get you to where you need to go in a market system.

The other thing is that you need data at the market level, and a lot of the databases that exist right now in the United States are not at the market level. They can give you national data and, in some cases, state data, but they cannot give you data at the individual
provider level or at the market level. Or, on the other hand, you may have data that can give you the market level, but they don’t give you the national level.

You really need both, because, to some extent, showing that place A is better -- that provider A is better than provider B within the same market is useful and probably that’s sort of the basis of competition. But it’s helpful, also, to have some external benchmarks because you don’t really want them competing on mediocrity. That’s not the ultimate goal. So, having some national benchmarks and examples is a useful thing.

We know that measurements and data can improve with use. They tend to get better once people are being held accountable to certain measures. The data tend to improve or at least to change; in most cases, to improve. But even good measures with bad data, in the meantime, can create mischief. So, that’s really a complex issue.

Another issue is that data needs to be both good and cheap. There are a lot of places where there are trade-offs there. To get the really, really pristine data, it’s very, very costly. On the other hand, there’s other data that’s very readily available, but it is a bit too crude, at least in the eyes of some of the players, and, therefore, not valid enough to be making decisions within the marketplace.
There is no real gold standard here. Almost any kind of data has its pros and cons. Even the electronic health record, as much as some folks have been hoping that will provide a panacea, does not necessarily, because it may not include some of the very variables that are most needed.

There has been a good bit of progress in this area, and I’m going to speak now primarily about hospitals because that’s where much of my own work and much of the work of the agency has been done. There was a study that we commissioned a couple of years ago that has had several very significant findings in publications indicating that if you add a few fairly easily accessible -- this is all relative -- variables to claims data, and specifically if you add the patient’s existing conditions “present on admission” and laboratory values at admission, you can get quite close to the adequacy of chart review data.

Now, this is really huge because the gap in expense between claims data and chart review data is really immense. If there are some steps that you can take to add slightly to the cost, but add tremendously to the accuracy of this data, that is really huge.

Right now, because of changes in CMS regulations, states are in the process of adding
“present on admission” data. We are working with several states on some pilots to show proof of concept for adding laboratory values. In most hospitals, that is already -- the laboratory values are already electronic, and so, making that addition is not all that difficult.

So, as a result of all of this, states are building much improved all payer data systems and the measures that rely on these are becoming refined systems to include these measures as well. So, where we’re ending up, and this is something that AHRQ has been working very closely with others on, is toward a hybrid data strategy where down the road we won’t be thinking about claims data and electronic data: we will just be thinking about data because we will have merged the two.

And in other really good news, both for quality purposes and for cost purposes, it is really important to look not just provider by provider -- we do need to do that, because one way to improve quality and to reduce costs is to look at what an individual provider does. That should not be neglected. But if you are really going to improve quality, you also have to look at the transitions, the gaps, the unnecessary duplication of services between one provider and another. In other words, you have to look at whole episodes of care, and that is something that NQF and others have been
targeting, which is also excellent progress.

So, this is just kind of a summary of where I would see administrative and hybrid data in the future. Where we have, because of the union of clinical and claims data, we have much improved timeliness, we have both market level data and national data both on quality and cost. You have the clinical detail that’s needed. You have the outpatient reach. And you basically have -- you know, nationwide, you have data available that can help you both with measuring quality with quality improvement and with public reporting for competition on quality.

Good data are not enough, however. You really need to have customer-friendly tools. This is a picture of an inconvenience store. In other words, a 7-Eleven is designed by a researcher, where everything stays nicely aligned and clean and not messed up by the customer, but does not get a whole lot of use.

So, what that really means is that we need to make things into convenience stores for data. This is a place where things often really, really do fall apart. We have been seeing a tremendous growth in the use of quality reports over the last several years, but, frankly, most of them are not very good, if you think of “very good” meaning something that is credible,
actionable, usable by the person for whom it is intended or the organization for whom it’s intended. The information is not presented simply or effectively in the way the reader understands and cares about it.

This is something about which there can be a science base. One of the things that we often forget is there’s a potential science base around a lot of things that we don’t normally think of. There’s a science base on how to create incentives. There’s a science base on what kinds of payments are more effective, and there’s a science base potentially on what kind of public reporting is going to be useful.

There is a growing evidence base on this. In fact, for the quality indicators, Shoshanna Sofaer did a good bit of research, focus groups, et cetera, to create some public reports, report card kind of models that would provide a template for that, similarly with our CAHPS initiative. There’s going to be an NQF guidance on web-based comparative quality available soon. I’ve got a couple of links and aids for that.

So, the fifth barrier, after you get through all of those -- and these are somewhat sequential. On this one I found a wall rather than a barrier, because, in some instances, it can be a brick wall. These are kind of more physical barriers, if you will. You can
have all of the other things, but if you are in a one
hospital town, it’s pretty hard to compete on quality. I
can’t remember back, but back in my days when I was at
the AHA, it was about at least half of the towns in the
country had only one hospital. So, in those areas, under
normal circumstances, there’s not going to be a lot of
competition on quality.

Now, to some extent, purchasers have been
creating centers of excellence or whatever to kind of
transcend that, but for the most part you can’t really
have competition on quality in a place where there’s a
one-hospital town.

Similarly, many people have very limited
options for providers. So, for them, even if they’re
living in a two-hospital town, it’s, in fact, a one-
hospital town. They may lack money or insurance. In
other words, there is no demand. Economists use the
terms “demand” and “money” kind of interchangeably. But
demand is not the same as need. It’s need plus money.

So that if you don’t have need plus money,
you’re not in the market basically, at least not the
regular market. And time, there is no Web access in the
ambulance. Most of the measures and reports actually are
on conditions that you don’t really plan in advance.
They’re on things like heart attacks. They are not
things like normal delivery. And, so, that also creates a barrier.

And then, finally, there is a variety of other market realities that play in. One is that there are multiple markets in a way. As long as you are talking about making choices provider by provider, it matters less. Once you start trying to do it on a package basis, it will be more of an issue. But the hospital market and the physician market is not the same market if you were to draw a perimeter around that in any given area. Geographically, the physician market is a smaller space than the hospital market is, and long-term care has its own, et cetera.

There are also multiple product lines, and, actually, the correlation between your score within a hospital, say, on quality score on AMI and your score on pneumonia may be diametrically different. So, you don’t really choose a hospital; you choose a product line within a hospital.

There is also a great deal of market segmentation by payer source. That is sort of a fancy way to say that the people who are uninsured don’t go to the same hospitals that the people who have private insurance go to, and, in fact, even the people on Medicaid tend to go to different physicians and
providers. So, the market does not behave as you would expect if it were a single market for all payers.

There is a great deal of segmentation in that way. So, for example, studies that have tried to show a correlation between access to availability of primary care providers and quality of care or preventative care for Medicaid beneficiaries don’t take into account the fact that most of that primary care may not be available to those Medicaid beneficiaries. So, there’s a great deal of segmentation.

There are some factors that are starting to facilitate tearing down some of those barriers or surmounting them. Again, the use of the episode measures and cost-cutting measures, so if you have a cost-cutting measure of safety within a facility that says something regardless of what part of the facility, you’re going to, and, also, a good bit of payer cooperation on the measures. A good bit of cooperation between Medicare and private payers, for example.

And, then, the final challenge is that all of these barriers are existing at the same time. So, figuring out the right path to go from one to the next is a challenge. But, as I mentioned, I think we are coming up with tools to start to overcome some of those barriers. So, I look forward to hearing the discussion
of folks in this session and the next both about the
barriers and the tools.

MR. WROBLEWSKI: Thank you. Thank you, Irene,
for that comprehensive presentation.

What I would like to do is for the new folks
who have come in, if you would like to be recognized,
we’d just ask you to turn your name tag on its side and
we’ll call on you to add comments. But I would like to
turn to Richard and to Janet and to Karen for any
thoughts in terms of additional barriers, other than the
ones that Irene has mentioned, or to put some priorities
around which ones are the most significant barriers, even
though I know we’re, as Irene said, we’re addressing them
all at the same time. But which ones are the most
significant going forward? So, I’ll start with you.

MS. CORRIGAN: That was a great presentation,
Irene. I think one additional barrier that I would add
to this is the lack of evidence on effective care in many
cases. You’ve got to have evidence of what works if
you’re going to present information to consumers to make
rational choices for themselves or others.

Let me give you an example. The U.S. spends
$20 billion a year managing chronic wounds, like pressure
ulcers and diabetic ulcers, yet the recent evidence, a
review of the literature, found that a common treatment
called negative wound therapy, there were only six trials that had been done. All of them had major methodologic problems. Five of those clinical trials had fewer than 25 patients in them. Now, that’s a pretty lean evidence base for a $20 billion a year expenditure. So, it’s the kind of thing -- these gaps in evidence occur in many places in health care. We are not working from a solid evidence base.

I think one of the solutions to this -- I mean, part of it, it will always be there because health care is complicated. The evidence base grows so rapidly, the knowledge base and all the rest of it. But it doesn’t have to be nearly as bad as it is. And one of the solutions, I think, is that we need a formal feedback loop and communication from payers and consumers and others that discover these evidence gaps to those who build the NIH research agenda.

That research agenda, now a lot of it is generated by investigator-initiated projects. It isn’t necessarily responsive. The Federal Government pays for about half the clinical research, so there’s no reason that some of that couldn’t be more responsive to the needs of consumers and purchasers and others for this information. It’s also just critical needs for patient care.
I think a second barrier that we have on measure development, we now have a lot of different measure developers. There are a handful that account for a disproportionate share of measures. We call them the major measure developers, but there’s also probably over about 50 measure developers out there. And there has been a critical need to develop -- we’ve been working very -- we’ve made progress on this -- developing guidelines for how they specify their measures. So, every measure developer, you don’t want them to use different age breaks when they construct the measure. You don’t want them to exclude different things from the denominator.

Unless there are common conventions, two things happen. It’s hard to implement the measures and the providers who are trying to act on them can’t improve. They don’t understand the data. Everybody does things a little bit differently. So, you look at a health care card infection rate at the hospital and there’s different exclusions, different age breaks, different everything from the same kind of measures and the same factors that are at the physician level. Those should be common conventions. We should do things the same.

The other problem is if you don’t have common conventions, the EHR vendors that are trying to build
electronic health records can’t do it because they don’t
know what data to capture, and it is very complicated for
them to capture the necessary data and develop the
appropriate programming skills to generate all the
measures.

So, simplification and common conventions for
measure specification and development are critical to
addressing what I think is the third barrier, which
really is the data platform, which right now is limited.
We are moving on two parallel paths. We have a lot of
efforts in communities to develop these health
information exchanges, which is just another word for
pulling together the electronic data that you have in
different sources and trying to make it more useful for
secondary uses.

There’s another parallel path that’s going
along with that, which is the one we want to be longer
term, which is getting electronic health records and
personal health records in place that have connectivity.
We have to move in parallel paths. We have to be dealing
with both at the same time, even though sometimes it
diverts attention from the longer-term agenda, which is
the EHR/PHR agenda.

I think it is important to note with the data
platform, just about all of our efforts right now are
focused on data that resides within the health system, whether it’s claims data; sometimes it’s registry data on a particular condition. It’s laboratory results data. It’s pharmacy prescription data. But what’s really important to patients out there, I think, in making decisions is outcome data. It’s whether I got better. If I have the back surgery versus medical interventions and watchful waiting, am I any different six months later?

We now know, after spending a fortune in this country for 10 or 15 years on these two conditions that you’re not any different six months later. That’s an important choice for patients, and it shouldn’t have taken a decade or two to know that from a very slim set of studies. We should be getting information on an ongoing basis about patient outcomes, and it’s hard to capture. You need to get out to those patients, and somebody has to be following patients.

Right now, in our delivery system, nobody follows patients unless you happen to be in one of those prepaid health plans that are only a small fraction of the market. So, there’s no accountability for those patients over time in tracking and getting information whether it made a difference six months, 12 months down the road.
Two last things I’ll mention quickly. One, I think these data, also, as we begin to pull together and generate these reports at the community level, another area where we started to make some progress is, I think, for this data really -- this information, rather, to have real credibility with multiple audiences, we’ve got to have more developed auditing mechanisms in place so people know that what they’re looking at has been audited by a third party. They know it’s good. That’s important to both the clinicians and the hospitals that are being judged. They need to know that the data is good, that they are fair comparisons. It needs to have face validity to them to act on it. It’s also going to be important to consumers and payers and everybody else down the road.

In addition to that, I think reporting is a challenge, and one thing I would add to the other comments that have been made is that all consumers are not alike. We need to be segmenting the market. We know from Judy Hibbard’s work that people are very different and have a very different readiness to act on this kind of information. We need a lot more research in this area about how we segment the market, where people are at and how we tailor the information to them.

Right now, the data people get are old. It’s
given to them at the wrong time, when it’s not very
useful, not at the point where they’re making a decision.

And last, but not least, we’ve got to get a
systematic feedback loop in place because we aren’t going
to get this right the first time. We have been working
at it for 10, 15 years, and we haven’t gotten it right,
and we aren’t going to probably in the near future. This
is a learning process. We need a systematic feedback
loop from providers and from patients, payers and others
that are using this information.

I view clinicians as a really important
audience here. The person who helps me most when I’m a
patient is the doctor that gives me referrals to the
hospital, to the specialist and to others. They’re my
agent. So, provide them with the information, at least
they can start to help me if I’m a consumer that doesn’t
know how to interpret it or do it myself.

MR. WROBLEWSKI: Thank you. Richard or Karen?

MR. SORIAN: Thank you. I will try not to be
redundant. I think we have covered a lot of really key
issues. I’ll touch on two or three that I think can be
added to the group. One is we’ve talked about and I’m
sure you’ve talked earlier about the fact that there is
this feeling that we have too many measures, conflicting
measures, a lot of confusion. I don’t disagree, but I
think we have an impression that we measure much more than we actually do.

The NCQA is the home for HEDIS, the Healthcare Effectiveness and Data and Information Set, probably one of the longest standing sets of quality measures and a fairly comprehensive data set. In the most recent year that we collected that information, we were really happy that we exceeded 100 million Americans covered by HEDIS reporting. But that means 200 million Americans are not getting that kind of comprehensive information.

So, just to break it down quickly, a little less than half of the people with private, commercial health insurance in this country have that kind of information collected, reported and available to the public, a quarter of Medicaid beneficiaries and about a seventh of Medicare beneficiaries. So, there are lots of reasons for that, but there are huge gaps in the amount of information we have about the quality and performance of our health care systems. So, that’s one.

Two is our incentives are all skewed. I like to put it that way. That’s better.

(Laughter.)

MR. SORIAN: We don’t have payment systems, whether they’re public or private, that truly encourage improvement in quality. They certainly aren’t tied to
the performance of the health care system, whether it’s a hospital, a physician, a medical group, a nursing group, any of the -- there are great experiments that have been going around the country. Pay-for-performance is one category of those that have really shown some great promise. But we also have a lot of payment systems that are disincentives to quality and, actually, penalize more efficient and more effective health care provision. So, we need payment reform. I think that’s going to be a major piece of health reform in the next few years.

And, then, finally, as one of my favorite health services researchers would say, Paul Newman, we have a failure to communicate.

(Laughter.)

MR. SORIAN: Janet mentioned how little we spend on research and how to talk to consumers and patients and their family members about health care quality.

To be blunt, the AHRQ budget is a rounding error in the CMS budget, and that’s got to change. We can name the people who do research on this topic on one and maybe part of another hand. They are terrific, but they can’t do it alone. There is very little consistent funding for that.

Just to give one example and then I will pass
it to Karen, we’ve done a little bit of focus group research -- and we have kind of pulled the money from that from little corners of the budget, so it is not comprehensive. So, let me caveat that. But we have done some focus groups. For example, where we say value and efficiency, consumers hear cheap. We say quality, they hear cheap. We talk about a medical home and they think we’re going to put them in a nursing home.

(Laughter.)

MR. SORIAN: So, when we talk about quality to those who are listening -- and it’s unfortunately a declining percentage, according to the surveys, that are listening and using the information -- we’re saying one thing and they’re hearing another. I think we need a steady and consistent and bigger investment in research on how to effectively communicate.

Corporations that sell soap and other products around this country and around the world have put a lot of money into those kinds of things. Maybe we can get them and harness their brilliance on those kinds of things. It’s not always the government that has to do these things, but we have to figure out how to talk to consumers before we can expect them to use the information to improve the quality of their health. So, those are three items that I would add.
MR. WROBLEWSKI: Thank you.

MS. MILGATE: From my perspective as a staff of a purchaser, I would echo, I think, some of what Richard said in terms of the need for more demand for use of the measures. I guess it would be my observation that measures will continue to expand and improve. Presumably there would be, although I suppose this is maybe more of a presumption than it is the truth of it, more research when, in fact, the measures are used for more and more effective reasons; if there were incentives for patients to use them, if there was incentives for providers to use them. And, so, to me, it is a matter of just creating that demand even more.

I mean, sometimes I listen in meetings like this and others and I was just recently at a conference and there was a lot of really good discussion about how to improve the measures, how to get more information, and then when the question comes, but do consumers really use it, and I would put the CMS Web site in that same basket of, you know, well, do consumers really use it. There’s kind of this, well, we’ve done a little research, but we don’t really know.

I don’t have any specific suggestions for exactly how that happens, but it doesn’t seem like consumers are finding as much of a need for using it.
I’m not sure if providers are finding as much of a need
for using it as they should. So, I would just throw out
the use of what’s already built as one thing to add.

The other observation I would make -- and,
Irene, you did say this, I want to echo it, though --
I’ve been thinking a little bit about what is the right
unit of measurement, particularly when you get to
physician measurement. As anyone in this room knows,
it’s an extremely difficult place to try to attribute
accountability. So, is it right to attribute
accountability at the individual physician level, the
practice level, or what about the concept of some sort of
small region where there is some kind of joint
accountability among providers?

In thinking about that, I thought, you know, if
you are really looking for beneficiary, as I think about
it, or patient-focused measurement, what we are doing is
sort of slicing that patient up and we’re looking at,
okay, well, what happens here, what happens here, what
happens there. And when you’re looking at physicians in
the Medicare population, there’s multiple physicians.
It’s -- really attribution is an extremely difficult
concept and I’ve begun to wonder if, in fact, we’re
trying to fit something that just doesn’t fit.

So, I would throw out that I do think it’s
important for us to begin to examine and think about and
I think most people at this table have thought about
this, to some extent, episodes of care and coordination
of care across settings as a kind of a direction we need
to start thinking about how to head in. And that that
would be -- I don’t know if that’s more actionable, I
don’t know if that will mean that will encourage more
competition, but it seems to me that it would be at least
of more interest to the patient.

MR. WROBLEWSKI: That was a nice summary of
what we did this morning.

(Laughter.)

MR. WROBLEWSKI: Thank you. Nancy, you had a
comment probably on that last point.

MS. Foster: Actually, I thought all of our new
colleagues did a great job. Irene, I really want to
thank you for articulating -- I actually think I have one
that plays off of what Karen was just saying and maybe
one other to add.

The one that plays off of what Karen was just
saying is I hear from hospital leaders across the country
that they think we are not, in fact, measuring the right
things about hospitals. And I would agree with them.
That, in fact, they’re looking to us to be able to
describe for them what are the key elements of the
organization that is driving quality, safety, high-level performance, and start measuring those. We don’t have the evidence base to inform that discussion about how we create the measure, but we need it. Back to Janet’s point, we need much more evidence. But that, I think, would really have the capacity to drive quality forward enormously.

And the second one -- and I want to play off of something that Janet is doing or is leading through the National Quality Forum is one of the barriers that I think, at least that hospitals see, is that we don’t have enough focus. We are measuring a lot of little things all over the place, and different payers and different consumer groups and business coalitions and others are measuring different things. It just looks like a lot of noise to the providers. You can’t get a lot of traction behind engaging in real quality improvement if you’ve got all of that noise that you’re dealing with.

Janet and the National Quality Forum has convened a group of folks to bring more focus to that. Peter’s part of the group. There are folks from the AMA and CMS and other players at this table on that group. I certainly hope that has the kind of success that the energy involved in the National Priority Partners has suggested it would. But it would put us all on that same
page about what we want to drive and drive in the near
term.

MR. CORRIGAN: And we’ll be releasing them on

November 17th.

(Laughter.)

MR. WROBLEWSKI: Well, thanks. I had a
question -- actually, a very basic question kind of
getting back to first principles maybe here. In Irene’s
slides, the first slide, I guess, is the hurdle of
consumer awareness. Consumers have to understand that
there is a quality variation, and I guess getting back to
that, the basic problem here is what are the underlying
causes of this quality variation both in terms of, say,
pure quality, Dr. X has a lower mortality rate than Dr.
Y. And, also, sort of relatedly, in resource use, it’s
not correlated with quality outcomes.

Maybe I would throw that to Janet first, but
open it up to anyone else who may want to speak to that.

MS. CORRIGAN: I think there’s actually quite a
few variables or factors that contribute to variability.
Part of it is because our measurement systems have,
frankly, been so crude, and because they also are or tend
to be at a micro level, we measure little pieces of
things in one setting, in one aspect of care. The
providers can’t even see the larger picture.
It has really only been fairly recently -- well, we’ve had some variability -- we’ve had a lot of variability information across communities and geographic areas, but it’s only been fairly recent that we brought that down to show variability across hospitals and different diagnostic groups and physicians and, you know, where it really could be something a bit more meaningful and where we tied it to actual quality and outcomes. So, I think part of it is that I don’t think that the providers have appreciated how variable it is.

Another factor that influences variability, and probably one of the most important ones, though, that we just have to put on the table, and it’s that we have a payment system that drives towards volume. So, you see in communities, especially where the supply of providers, particularly specialists and hospital beds, is higher, each provider generates more units that bring in a fee. Hospitals drive towards filling up their beds and competing and trying to do that, and physicians want to fill up their schedule. If you have an excess supply of cardiac surgeons, you are going to have a lot of cardiac surgery in the community. We see dramatic variability depending upon the supply of providers and beds.

We have known that for decades. A guy named Milton Romer ages ago said, “Build a bed, fill a bed.”
It’s as true as it is. So, we have to -- it’s the payment system, I think, that drives a big piece of it. Others say that variability sometimes, too, may well be driven, to some extent, by consumer demand. But, once again, the supply has to be there really for the patients to get it. So, there’s various factors that contribute to it.

MR. WROBLEWSKI: Peter?

MS. CORRIGAN: But it’s only recently -- I’m sorry -- that we were able to demonstrate in the literature that when you reached a certain point of sort of excess supply and you see that volume of services go up high and the variability in the high ones, that you see a decrement in quality in those communities, and that is an important step for us. We finally got to the point of being able to demonstrate that because, prior to that, I think we were always sort of fighting this, well, my patients need it, you know, and there was pent-up demand and need for the services. Truly, a lot of it driven by supply.

MR. WROBLEWSKI: Peter?

MR. LEE: I will confess, I wasn’t going to answer your question. So, if others want to answer the question, I’ll pass and then come back. That’s my true confession point.
DR. BARR: I actually was going to react, but Janet took part of what I want to say, but if I could just echo that and then Peter can jump off on a different tangent. How does that sound?

(Laughter.)

DR. BARR: I was going to say another great presentation, but I was going to add another barrier to Irene and sort of Janet referred to the mixed incentives in the system we have now because people live on the volume. But let’s say we’re successful, you think with the end in mind, we’d get actually good measures and you drive. Well, okay, we identify the great quality physicians and now we’re going to drive more volume to those.

Well, from the primary care perspective, most of the primary care doctors I know don’t want more volume. So, they’re thank you very much. So, there’s that mixed incentive of about, okay, if I do well, I might get more. Really don’t do me any favors. I don’t need any more. So, we need to think about that.

The other thing is physicians are -- in the current market, are price takers. In a regular market, if you do better, you get to set your prices to some degree and maybe there’s a little wiggle room here. But in the current environment, you’re sort of a price taker.
So, you don’t really have the win on that end, even if you do take more volume without sort of pretty tough negotiations. If you’re a one or two-physician practice that builds a new medical home, puts infrastructure, does all the things right, there’s very little ability to negotiate that side of the equation.

MR. WROBLEWSKI: You know, we have been talking about payment reform and we talked about it a little bit, or at least some of the payment incentives, at the very end of the second morning session. And what are the barriers then to payment -- I mean, if it isn’t volume, if you’re saying that -- I mean, what are the other drivers that prevent payment reform from occurring at the private level -- the commercial level?

DR. BARR: Well, look what -- I mean, we’re not advocates of any -- but look what happens with boutique or concierge medicine. The way they set their prices, they step out of the whole system. All right? And they say, I’m going to build this, but that’s the kind of care -- when we talk about the medical home, that’s the kind of care we want to have for everybody and actually support it appropriately.

So, we talk about the principles and what it is about. And then we say, well, you can’t exist unless you do some of the changes. So, the barriers are you just
need to be creative and think about what’s the best way
to fund. We also have to prove the concept, and that’s
what all these demonstration projects kind of show,
whether we can reduce the variability, unwanted or
unnecessary care, reduce emergency department admissions,
those kinds of things.

MR. WROBLEWSKI: Vince or Elysa, do you have
any comments just on the last piece in terms of the
barriers for rewarding quality?

DR. KERR: I guess I have one or two comments.

In my household, my wife is the budget director. She has
finance training and it is very difficult to go back to
her and say, I really think I need a 20 percent increase
in the budget because I would look great in a red
Ferrari.

(Laughter.)

DR. KERR: We have a zero sum game. Unless
you’re going to add new dollars to the system and find
the support for that from Peter’s constituents or others
-- listen, I’ve got a great idea. I know we have a $2
trillion system, but I want to kick in an extra 400
billion bucks to the system to drive quality. We’re at
bail out levels. It might not take that much. I don’t
know what it would take. Somewhere between that, where
you’re dealing with sort of a zero sum game, and the
difficulty of re-rationing allocations the way they are already fixed in the system, that’s a Herculean task to take on. We know there are problems with that, with underfunding of primary care, for example, that haven’t been fixed for years.

There are ways of getting at it. They’re slow and they’re incremental. You can vary the rates of increase of the escalation in fee schedules and make those quality-sensitive.

We looked at our spend, along with another customer, a large customer, and I think this would be true almost anywhere, less than 1 percent of the spend in the U.S. is quality-sensitive. One percent of the dollars.

MR. LEE: I’ll jump in.

MR. WROBLEWSKI: Okay.

MR. LEE: I’ll respond to this one and then, also, pick up on my other line, if I could, which is commercial payers pay the vast majority on two dimensions now, only two, which is the volume and the unit price. Each of those are affected. Unit price, they try to squeeze down on the doctors and the hospitals, and the hospitals and the doctors try to consolidate and get better bargaining position to charge more, and volume is just gained by supply and other factors.
I mean, I thought Irene’s position was great, but it was absolutely the fact that the seventh hurdle is payment. All this issue about performance measurement, to have that be a factor in payment, is -- I’d be surprised if it’s 1 percent today. It depends on what you count it as. I think that is an incredibly important observation.

I want to jump to a couple other quick observations, if I could, that build on these other discussions that -- I saved my ask for the morning to the afternoon.

MR. WROBLEWSKI: Now, if they’re recommendations, we want them in the later session.

MR. LEE: Dammit. So, I’ve got to hold them again?

(Laughter.)

MR. WROBLEWSKI: We’re still talking barriers here.

MR. LEE: You know I have to leave a little bit early.

(Laughter.)

MR. LEE: Well, given that I will probably never speak again, I’ll --

(Laughter.)

MR. LEE: Those that know me laugh. First,
back to -- I really want to use Irene’s framing, which was so good for the remarks about the three paths -- I think when you keep on coming back to what a consumer wants versus what a payer wants versus what a provider wants is not the same thing. And it’s different at different points of time. We often get those confused, as well as that consumers are different.

So, I mean, I react to that. Boy, I want accountable cure organizations and people are more than their silo. But if I’m a diabetic that then gets diagnosed with cancer, I want to know my cancer treatment options and who does better for treating my cancer, even though I’m still diabetic. How do we both aggregate and disaggregate is one of the things about measures we need to think about.

But the other two on the measures issue -- and I want to reinforce the issues on prioritization. The priority partners will help that. I think it’s incredibly important. We don’t have prioritization. But the big piece here -- if we think about a competitive system is developing performance measures is developing the public good. And you think about to have a competitive system, right now, this is totally under-supported and almost unsupported.

So, the AMA chips in some money for PCPI. But,
you know, it’s tiny amounts of money compared to what we need for developing good performance measures. Everyone says we need better functional status measures, better outcomes measures. They don’t come cheap. So, when we think about the public good of developing those, I think it’s one of the things that it’s not just going to happen because we wish it were.

Finally, on the data element, using Irene’s hurdle number three, I want to do a second -- Vince’s earlier note around collaborative work also relies on sharing data, in particular, Medicare data. We have taken some micro steps in that direction, but having good ways to share Medicare data is critical.

But the other -- and this is a sort of story from the streets is that we have, in California, particular hospitals, as well as medical groups, that are saying your health plan cannot use our data to develop performance reporting because, not totally unreasonably, we don’t trust that you’re going to do it in just the right way. But they aren’t saying we’re going to negotiate around. They’re going to say, sorry, our data is only usable for X, which is for paying us. You can’t use it for other purposes.

So, we talk about the efforts to combine data and then we have, not unreasonably, providers saying, I
want data to be perfect, but all of a sudden we’re knee-capping efforts to actually use data together. That’s a huge constraint around the data hurdle. That’s another one that I don’t think people hear about because it happens out there in the streets, so to speak, where contracts are being written by those that have the power to write them and, in some cases, it’s a provider group, or it’s a hospital. In some cases, it’s the plan that has the power to write the contract.

So, people are saying whoever is in the dominant place will write contracts to say, you can’t tell a story about me about quality performance. That’s one of the other pro-competitive things that I worry about seeing being undercut.

MR. WROBLEWSKI: Jack, you had your --

MR. FOWLER: With all these wise payers sitting around the table, no one’s caught up on the point Janet was making, that if you put twice as many specialists in a place, you get twice as many specialist visits. If you build an MRI machine, then you get MRIs --

MR. WROBLEWSKI: Can you pull in the microphone?

MR. FOWLER: Oh, I’m sorry. So, the point was made that when the supply of medical resources of whatever sort gets used, and with all these smart people
around the room, I just wonder whether there are any
thoughts about how do you -- how do you address the fact
that in Miami, you know, you get many, many more test and
specialist visits than you do in Minnesota or San
Francisco or Tampa?
Is there no way you can intervene in that
process when there is pretty good evidence that there is
no medical benefit being generated from that extra use?
MS. CORRIGAN: I can quickly answer that, at
least tell you what efforts are underway to try to do
something about it. We did just receive some contracts
from CMS to try to identify and endorse measures of
overuse. We’re trying to get into the report cards
measures of overuse.
Now, as Richard and others can tell you, it’s a
lot easier to talk about constructing or building a
measure of overuse than it is to actually do it, because
you’ve got to be able to separate out. It’s not just a
measure of resources. You’ve got to separate out
appropriate from inappropriate use of it. That’s a bear
to do. It’s tough to do.
MR. WROBLEWSKI: Vince or Elysa, do you have
any reaction?
MR. FOWLER: Could I just say one thing?
MR. WROBLEWSKI: Okay, go ahead.
MR. FOWLER: One of the things, when we surveyed physicians in these different areas, you get things like how often do you see your hypertension patients back, and there’s no evidence that it matters whether you see them every three months, every six months, every nine months. But in the higher areas, I saw them every three months and in the low areas -- the low-cost areas I’d see them every nine months. They just made that up, you know. But it’s part of the medical culture in those areas.

DR. KERR: It’s not made up. You look ahead at your appointment log and you decide --

(Laughter.)

MR. WROBLEWSKI: I think we -- what are your thoughts on that issue?

(Laughter.)

DR. HOVEN: It is definitely not made up. Here we get into risk adjustment. And the thing we talk about, we use the term “risk adjustment” quite loosely, but I don’t think we’ve actually delved down into risk adjustment to look at the sickness of the patient. Those folks that are sick, you’re having trouble controlling their hypertension, they have renal disease associated with it, peripheral vascular disease, you have got to see them more frequently. You do not arbitrarily say,
they’ll come into the office every nine months, period.

So, we’ve got to be very careful how we look at this information. This goes right smack back to the quality stuff we were talking about this morning. If you don’t look at this and risk adjustment methodologies, you are going to screw up the system.

DR. KERR: So, as part of what makes medicine difficult to quantify in some areas because you are pegging it to a set of variables that are individual variables in terms of how compliant a patient is, how well they understand their medication, as well as the physiologic variables that you’re treating. All that aside, it is incredulous when you look at data, for large populations, without an explanation about some difference in the nascent severity of a given diagnosis, that there would be that kind of variation.

Over and over again in medicine, when we subject these kinds of things to scientific study, controlled study, we often find that what we think is necessary does not yield the benefit that we attribute to it.

MR. WROBLEWSKI: What are the barriers then -- and this follows up one of the things that we want to -- in terms of what are the barriers then to get that information? I mean, I’ll open it up. Go ahead.
MS. FERRARA: I want to actually address a number of the comments that were made here to your point about variations. I had been speaking on the break about bariatric surgery, and seeing in just one region of the country, including the bariatric surgery, and I can’t recall if it was 60 or 90 days post-surgical date. The variation in cost between 12 and $70,000 on average, per hospital. That is a huge sweeping variation. And the employer whose employees are primarily in the marketplace that’s dominated by the $70,000 procedures facility want change.

Now, is $12,000 the right price? Probably not. There’s probably an issue there, too, at the other end. But those are the kinds of variations when they translate into practice patterns that translate into dollars that have employers alarmed. These employers are seeing this because they have employees in Maine and New York and Virginia and California and they are demanding the information, and they’re saying, well, wait a minute, why am I paying -- and this is a discreet procedure, so, yes, there are certainly variations in risk associated with this. But for a discreet procedure within an eight state area, to have that kind of a variation is clearly going to be an employer red flag, and we need to do something differently.
So, then you get to the question of payment reform and, you know, what are the challenges. One interesting challenge that I’ve experienced -- we have pay-for-performance systems. All payers have pay-for-performance programs. We’ve had employers say to us stop. I think I spend too much already and you’re asking me to pay more because this hospital is safer than the average of 80 percent, or you’re asking me to pay more because they’re within 70 percent of meeting evidence-based standards of care. It’s really an interesting conversation that you have.

We believe in quality improvement. We want to reward the providers who invest. But we also have payers who say, I’m really -- I’m having a hard time wrapping my head around the idea that I have to pay more to come close to meeting the standard. So, I think these are some of the challenges and the conversations we have to have. One of the ways that we payers address that is we say, okay, get to a point and we retire a measure. So, you’re continuously improving.

The other thing is we’ve talked about high-performance provider networks. We also have high-performance provider initiatives, which is a little bit different. Those are gain-sharing initiatives where you find the creative providers. And, again, it’s not
specific to us. You do the same thing, and you innovate with them. So, they do look and they bring the docs to the table and a system, along with the health care -- with the radiology providers and along with the hospitals. And they look at their own data with us. They take our claims data as well. We work together and they figure out, gee, maybe there is a variation that we can reduce, and then you gain-share around it.

There are barriers to that. There are regulatory and other barriers related to that. And then in terms of payment reform, one of the biggest barriers is the complexity of the systems changes that are required in order to really launch global payment reform. And there’s a huge cost associated with that.

DR. KERR: I feel we didn’t answer Jack’s question, his initial question about dealing with the variation. We’ve described the problem.

MR. FOWLER: Yes. Are there any interventions?

DR. KERR: No.

(Laughter.)

DR. KERR: The truth is that, absent a measure that can get at what is overuse or something that can flag appropriateness, it is very difficult to do. What we have are crude measures, which are comparative and relative. So, in this market for this patient population
the best we can understand it, you are seeing similar
patients. Your rate of this is three times everyone else
in the community. Help us understand that. That is
about as scientific as it is right now.

MS. CORRIGAN: Could I add to that? I think
what we have to do -- one thing I want to point out is we
focused on overuse, but the evidence actually shows that
there’s a lot of underuse. The work at Rand shows that
when you -- you know, a typical consumer that goes into a
provider, you have only a little over a 50 percent
chance, a 52, 53 percent chance, of receiving the
services, the set of services from which you would likely
have benefitted. So, it’s really a flip of the coin when
you go in as to whether you’re going to get the ones that
you really would have benefitted from as well. It is
this underuse/overuse. So, what we’ve just got is a lot
of variability.

Now, what you would do in most sectors, I
think, or other industries when you have a lot of
variability, you standardize the process. You go in and
you analyze every step in the process, and you attempt to
standardize it and say what’s appropriate. And then you
monitor to make sure that you’re doing it exactly as it
is supposed to be done.

That is really hard to do in health care for a
whole lot of reasons. One of them, patients do vary.  
So, specialty societies develop practice guidelines, but, you know, you quickly get them out there in the field, and they apply to some patients and they don’t apply to other patients. But they try.

The second reason it’s really hard, though, is that the delivery system is so fragmented. Patients with diabetes or COPD or a common condition, they need to see multiple providers, multiple settings across time. Yet, we have basically organized as a cottage industry.

The third reason it’s hard really goes back to the earlier account about we need to move to a different unit of analysis here. It really should be the extended episode, the patient care episode. You know, if you’re diabetic, you want to know if you’re going to be -- how much is it going to cost and are you going to be better at the end of six months or 12 months or 18 months. But unlike producing cars, we can’t even figure out what the time period of time should be. And a piece of this is out of the control of the providers. It’s also in the control of the patients and how they behave.

MR. WROBLEWSKI: Barbara, did you have a comment?

MS. RABSON: Yes. I think there are some success stories on the interventions that you can have
for overuse. One of them I’ll mention is in Rochester with the Rochester IPA. Howard Beckman is the medical director of this group. And they really are looking at efficiency measures and why the variation within the Rochester community. And what they found was they drilled down to find what about those measures, like what -- not just that physicians were spending more, but what were they spending more on.

So, one of the examples is carpal tunnel surgery. And they had some that were using a local anesthesia and some that were using a general anesthesia. Same results, seemingly, and the expense was just, you know, three-fold different. Once you drill down to something very specific, then you can go back to the docs and say, why are you using this? And they say, I was trained this way. And you ask the other docs, why are you using this? And they say, I was trained this way. So, then you say, well, wait a minute, you know, as long as we can find that the outcomes aren’t different, then docs are very willing to change practice given the data and given this kind of thing.

So, I think that it’s a matter of drilling down into these communities. It’s labor-intensive, but you can get successes and then you can actually go to community guidelines.
Another way to address overuse is to say, okay, docs are always saying that I can explain to every patient why they shouldn’t go for this service, why they shouldn’t take this drug, but it takes me 15 minutes. If I’m not up for that, I’m just going to give them the referral. So, if there are community guidelines that say, you know, with patients with this condition, we send them there and everybody’s agreed to them, they say, these are community guidelines. You know, that what we, as a community, have decided, so that’s what we’re going to do with this.

While I have the mic, just one more point on payment reform and the idea of what the barriers are. I think, again, there are a number of local communities or regional collaboratives that have had some really successful quality improvement and payment reform initiatives, whether it be Pittsburgh or Minnesota or Massachusetts. One of the barriers is that you can get -- aggregate the commercial payers, get them all around the table to agree on a particular incentive or reimbursement plan, but then CMS doesn’t.

So, then you’ve got, within those practices, half the patients are reimbursed one way and the other half the other, and some of the doctors and hospitals throw up their hands and say, you know, I can’t do this.
We all have to be together because we sort of counter
each other out, and it’s too hard to do this.

MR. WROBLEWSKI: Let me go to Richard and then
I’ll go to Dr. Hoven.

MR. SORIAN: Just continuing a bit on the
payment reform. I mean, I really think payment reform
has to be the horse pulling the cart. We could spend
hours and hours talking about the cart. That’s what my
company does full-time.

(Laughter.)

MR. SORIAN: But if we don’t change the way we
pay for care, then the incentives are never going to be
there for people to make the hard choices that people are
talking about. What do we lack in terms of the ability
to make payment reform? We lack the will, whether you
want to call it political will or personal individual
will. But we, basically, have to have our backs against
the wall and then we really make changes.

If you look at the last major changes in ’81,
’82 when we went to DRGs and ’89, ’90 when we went to
RBRVS, certainly in the first case, there were some real
political and financial pressures going on. I think we
have all seen that there are some real political and
financial pressures going on right now.

(Laughter.)
MR. SORIAN: So, we have the opportunity to exert the will. Frankly, I believe, because of the way the system works, that Medicare does have to be sort of the canary -- a very large canary, that when Medicare changes the way it pays -- and Congress needs to do that, and I make that very clear -- then the commercial sector tends to follow. It doesn’t happen immediately. So, I think we do need to change the way Medicare pays for a whole lot of things.

I think that we have to keep the providers in the game because you hear very clear, whether it is pay-for-performance or gain-sharing, there has to be something in it for those who are delivering care in order for them to make the changes they need to make. Because you hear examples all the time about, yes, if I deliver more high-quality, efficient care in this area of care, I will get less revenue. So, my CFO is not going to be really happy with me. You know, Brent James from InnerMountain gives great examples of the losses that they incurred by changing some of their systems and such.

Back pain is a great example. We have a back pain recognition that basically rewards physicians for doing less. But the rewards are way less than the money they’re giving up by not doing x-rays and MRIs and all, not putting patients in the hospital, et cetera, et
cetera. So, there has to be some kind of system where they get bigger rewards, and some of the gain-sharing experiments have been promising in that area, but there are a lot of concerns, antitrust concerns and others, that need to be addressed. But the ideas are out there. We just really need to get moving on them.

MR. WROBLEWSKI: Dr. Hoven?

DR. HOVEN: Thank you. I’ve got several points I want to make and I wanted to do that before we ran out of time, so I appreciate it.

This morning we did talk about physician measurement reporting of our performance. I wanted to make it very clear, despite the conversation we had out there, there are issues going on at the ground level right now with physicians in which this information is not very clear. The methodologies are perceived as being black boxed. We don’t know what’s in them. The feedback issues are astronomical. We can’t do anything unless we get the right feedback and we know we are getting the right information. I cannot make that point any more forcefully.

Richard’s point about funding and that kind of thing leads me to the next one, which is the fact that we have got to have sustainable funding in order to support the physician’s abilities to engage in data gathering,
one of the hurdles you mentioned. Absent an HIT system that is interoperable, user-friendly, at point of care, real-time, we’re not going to be able to do this. There are huge issues out there -- Janet referred to them earlier -- about many of the guidelines and the principles and the standards that are going to have to be applied to this. But absent the funding, wherever it comes from, private payers, public payers, it’s going to have to be in place for us to get the data.

I don’t have an electronic medical record in my office. Would I like one? I would love it. That is a hurdle that we’re going to have to overcome. The example I use is if my BlackBerry is not in my pocket and I can’t Google something sitting in the office, I have to go out of the office with the patient, out of the exam room, down the hall, get online, look something up. I’ve wasted the patient’s time. I have taken time away from what I could be doing explaining something to the patient. So, this is a very crucial issue.

Thirdly, I want to talk about, since we’re sitting in this austere building, the emphasis of the Federal Trade Commission and its role in what physicians can and cannot do. Right now, the enforcement policy is an active barrier to physicians’ ability to participate in many, many ways. I can’t get together in my small
community where I practice with a one-doc practice or a
two-doc practice and us put together something that is
workable in terms of getting legitimate networks to look
at aggregation of our own data, what we’re doing, how we
can improve things. The Federal Trade Commission
prohibits us from doing that.

So, I think we’re going to have to look, going
forward, at a very large barrier that is going to allow
us to work together, to be collaborative. Right now,
we’re all kind of compartmentalized. We have to get rid
of this in order to make this happen.

MR. WROBLEWSKI: Thanks. Let me turn to
Michael Barr and then, Paul, welcome, and we’ll turn to
you to end up the session before we take a break.

DR. BARR: I’ll be brief, actually, because
Ardis picked up on the health information technology
question. I was going to actually turn the question to
Janet, because one of the concerns you raised, actually,
is the lack of measurements that are keyed up and ready
for implementation with health information technology.

Two questions. One, and Ardis already
addressed it, we desperately need health information
technology. It’s not going to solve everything by
itself, but it will contribute. The question is, do you
think it will contribute to sort of the reduced
variability once you start getting measures there and
then the actual work of the physicians is actually
contributing to the data collection that’s done so
automatically and fed back?

So, you get that feedback loop and the response
and the data collection at a different level. Because
there’s no way you’re going to get to the level of detail
right now to kind of answer some of the questions we’ve
been asking ourselves about how to improve the system.
So, the question is, do you think we’re getting there?
Will we get there?

MS. CORRIGAN: Yes, absolutely. I think that
there’s good evidence coming out on EHRs. We have
wonderful examples where we have been able to change
practices through collecting the right information,
clinically rich information. You can calculate measures
that are really meaningful, that take into account the
risk-adjustment issues that have been brought up. And
you can provide decision support, clinical decision
support to patients.

The world we want to be in is when we roll out
at the national level, you know, a new set of measures
that go into Medicare can pay or whatever condition, we
ought to have that teed up so that every one of those
electronic health records, it is capturing the right
information and it’s also providing the clinical decision support.

I mean, the measures and the decision support come off of the practice guidelines that come off of the evidence base. This is a supply chain. There’s the evidence, there’s the practice guidelines it gets translated into. Those turn into the measures, they turn into the clinical decision support. The EHRs get built to capture the right information to generate the measures and provide the prompts, the reminders and the other supports to the physicians and to generate the information to the public on the users.

MR. WROBLEWSKI: I understand that supply chain. But how does the -- when we were talking about outcomes earlier, if you are looking at a performance measure that shows that the recovery time for your hip surgery was much shorter and that is the outcome, how does that type of outcome fit in that chain that you just described? Because that’s not a practice guideline.

MS. CORRIGAN: That the recovery time or --

MR. WROBLEWSKI: You know, if you’re comparing, say, a redo rate, a readmission rate or an amount of recovery time, how does that fit into that supply chain that you just described in terms of the measure development?
MS. CORRIGAN: Well, we have to know that -- I mean, that’s part of the knowledge base, that it isn’t necessarily going to be embedded in the clinical record. But if we know that by doing certain things, the readmission rate will be less or the patient will get better outcomes, then you prompt and remind and encourage them to do whatever those things are that lead to it.

But the problem we have is we don’t capture that information in many cases on patients. We’re not picking up the outcome information. For many patients, they leave the hospital and we don’t know what happens to them. They may or may not have any follow-up. It never gets back. We don’t know what happens to them. So, there isn’t that.

So, I also want to emphasize it’s not only EHRs. We have to get to the personal health records. That is really important, especially as we move into health behavioral changes and all these chronic conditions. That’s all in the hands of the patient and the family care-giver. They deliver more care than professional health care providers do, patient and family care-giver.

MR. WROBLEWSKI: Dr. Chumbley?

DR. CHUMBLEY: Just a quick comment. We had talked earlier about payment reform, and if we want to
start with payment reform, I really encourage us to start
with the primary care physicians, you know. Twenty years
of leading physician groups, the neuro pathways are
different in primary care physicians from specialists.

(Laughter.)

DR. CHUMBLEY: And I really do believe it would
be a great deal easier if you started with just primary
care.

(Laughter.)

MR. WROBLEWSKI: Thank you for prioritizing the
significant barriers.

(Laughter.)

MS. CORRIGAN: If you don’t do it fast, there
won’t be any primary care physicians left

(Laughter.)

MS. CORRIGAN: It’s a dying breed.

MR. GINSBURG: Well, I’m going to live
dangerously by coming into the discussion toward the end
and take the chance that some of the things I say may,
you’ve already taken care of it before.

But two thoughts from what I’ve listened to
before. One is, I’ve just been doing a lot of site
visits, and when it comes to the quality improvement
area, when asking about how organizations motivate their
physicians to improve their quality, it is almost all
facilitated and driven by what they can measure. So, in a sense the measurement is really important not so much for the consumers or the public, but just to be used within organizations so they can identify which physicians can do better and learn from others.

The other comment I wanted to make is just after I came in, Richard Sorian was talking about the payment reform is the horse, and I agree with that. He was talking about the political will. My sense is that what needs to be done in payment reform may not be that difficult politically, but we need some development work to be there so that it can be pushed across.

Now, when I think of payment, you know, the first thing -- and this is mostly in physician payment, we did it in hospital payment, even if the problem wasn’t as severe, is just getting our current payment system, the relative values, the structure correct, more accurate and more accurately reflecting costs. Because there are many examples of attempts to re-engineer delivery, like what Virginia Mason Medical Center did where, you know, fee-for-service wasn’t great. But what really killed them was their distortions in fee-for-service payment, the fact that rationalizing re-engineering care for those conditions meant cutting back on the very profitable procedures, and it just made it not viable.
I think that that’s stuff we are really ready to do. I don’t think we need a lot of development. But to start paying on the basis of multi-provider, acute episodes and capitation-like payments for a chronic disease -- in fact, I worry about all the focus on the medical home. That’s such a baby step toward the broader thing of using capitation, that I think the bottleneck is developments, that we need more technical tools as how to do it.

I don’t know that it will be that difficult politically if it can be pulled off. And I agree with Richard that Medicare has to be the leader because, otherwise, payers are too fragmented to really have an impact.

MR. WROBLEWSKI: Okay, thank you. With that, we’ll take maybe a 10-minute break. We’ll start at 20 after 3:00 for the last session of the day. Thank you.

(Session concluded.)
POLICIES TO FACILITATE QUALITY INFORMATION MEASURING, COLLECTION AND REPORTING

MR. WROBLEWSKI: Why don’t we get started on our last session for this afternoon. We are very grateful that Karen Milgate from CMS will be able to give a brief presentation on some of the initiatives that CMS is undertaking in terms of quality improvement. Thank you. Karen?

MS. MILGATE: Sure. Let me start off by just giving a brief non-political statement. I don’t know if you all focus on it as much as we do because our bosses are about to change next week, but the current administration has been a very strong proponent of transparency and has really pushed all parts of the agency, particularly at HHS, to use its information as much as possible, to try to make it available. I think AHRQ has felt this. Certainly, we at CMS have felt this.

Having said that, sometimes they, I think, like to take credit for more of the progress than maybe that’s due to them because it was really possible to push forward in part because there was a very strong foundation built in previous administrations. As those that have been around a while know, there was a lot that happened, also, in previous Democratic administrations.
All that is to say that I think this work will continue, and so, pressing forward, at least, I’m not nervous that this kind of push will end. So, I would hope that others would have the same feeling that I do, and I don’t think it is a partisan issue. So, we’ll continue forward with trying to get as many and as good quality measures as we can.

I wanted to just make a comment off of what Richard said, because at least in the Medicare realm -- and I know it’s true for private payers as well -- we really do have our backs up against the wall situation in terms of funding. I give a whole presentation on this, and I won’t do that at all. But the reality is the Medicare cost growth is really higher than can be sustained, and the problem is even greater because we are going to have a large number of retirees in the next few years. So, we have more people. We have cost growth so that it’s higher than we can afford. And at the same time, we will have fewer workers to support the beneficiaries that come onto our program. So, we have a real cost problem in the Medicare program.

I throw that out here in, you know, a group of folks that are looking primarily at quality information in part because I think there are really two very significant needs for quality information in this kind of
scenario. One is it can help us actually design rational policies for identifying care and trying to put incentives in the system to actually encourage the greater use of efficient care, and that could be incentives by providers. It would also be incentives for patients.

Two, though, I think is an area that we have to just keep in mind that if there is a decision by Congress to actually try to push for greater cost containment, it could be done less or more rationally. And if it’s not done rationally, it could actually harm the quality of care. Therefore, it means that it’s really critical that we have good measures so that we have a good measure of if a certain type of policy has gone too far or cut too deep or that kind of thing.

So, I just want to suggest that, at least, as I’ve evolved over my time in Washington working on policy issues, I used to think of myself as sort of a -- more of a pure quality person. But as time has gone on and the cost issues have become more and more paramount, I guess I’ve seen that quality information is even more and more important and it’s not just necessarily in and of itself.

So, having said that, I’m going to now talk about what I’ll characterize -- and Richard and I can argue about it later -- is, in part, the 93 percent of
Medicare beneficiaries that don’t have comprehensive health information. I would suggest that, in fact, there’s pretty good information for fee-for-service beneficiaries, whether it is perfect or not.

So, the three things I’m going to talk about, the first is just kind of a framework for how to think about using Medicare information, and it’s very similar to what others have talked about. Second, just go over CMS initiatives to make Medicare information available. Here, I’d like you to think about, because we try to -- are beginning to think more about how the information we have on Medicare beneficiaries is actually helpful not only to Medicare beneficiaries, but could also be used by others. So, private sector payers, for example, for states. Others can use the information that is on our Web site beyond beneficiaries.

And then also talk a bit about something that I think will probably generate some conversation, which is some of the challenges to using Medicare claims data. I want to make a distinction between Medicare data generally, which I’m not sure what anyone would define as that. There’s a lot of Medicare data. But a lot of what we get asked for is Medicare claims data and talk a little bit about the legal challenges that we have. So, I think this has been talked about before
by several speakers and really that there’s three different audiences for quality and price information to foster more informed decision-making. There’s providers to support quality assessment and improve efforts; consumers to support decision-making about plans, providers and treatments; and then purchasers to support the alignment of incentives for high-value health care.

For consumers -- and I want to just drill just a little bit here because our Web sites really focus particularly on the top two. First of all, there are choices where consumers have to make about which health plan to choose. So, from a Medicare perspective, there’s several different choices that are made that we provide information on. One is whether you want to be in a prepaid health plan or a Medicare Advantage plan or whether you want to be in the fee-for-service part of the Medicare program.

In addition, the Medicare Part D, prescription drug benefit, was designed so that beneficiaries have to, again, make another choice about a health plan and there’s two options there. One is you can be a part of a comprehensive plan that is a Medicare Advantage plan with drug coverage or you can choose one of many other private plans and still stay in the fee-for-service program. So, there is a lot of choice there, there’s a lot of
different aspects of choice, and we try to provide information to help beneficiaries make those choices.

Providers are clearly -- it’s been said before, there’s many different providers that beneficiaries need to make choices about, and, of course, it depends upon what their needs are as to what they -- you know, when they would look at a Web site on a provider.

Treatments, I think that’s kind of a next frontier so to speak, certainly for Medicare. We’ve had a lot of internal debates about how we even want to move into the space or if it’s something that is appropriate for a public payer. There is a Web site called MyMedicare.gov, where beneficiaries are signed up automatically when they enter the program. And we have actually been considering giving prevention alerts so that we can track claims to see if a particular beneficiary is eligible or due for a particular preventive service. There have been other suggestions for how we might be able to use Medicare claims, and so some of the pushing out of messages that other health plans do.

We also have some research underway on personal health records and what the role might be in the Medicare population for personal health records, whether that would be something where we would just kind of be a
portal to commercial offerings, not thinking that necessarily the government would be the best developer and maintainer of a personal health record or would we have one vendor. So, there’s a lot of questions how that might work in the Medicare program. But discussion is under way.

The next slide is just a list of our various compare Web sites. So, this is the homepage of www.medicare.gov. This gives you kind of a sense of the kinds of Web sites that are on the -- these are the types of Web sites that are on the CMS overall Web site. I will go in more detail so you don’t have to look through each of those arrows. But you can pull up one page and then just choose one that you want to go to.

This is to give you a sense of the types of Web sites that are up there, but also these are the number of hits or page views that occurred in one month, in September 2008. So, at least when we’re looking at these in the agency, it gives us some interesting information on how many people seem to be going to those Web sites. They’re probably not all beneficiaries. I certainly go to those Web sites sometimes and others in this room probably have, too. Some are better than others.

But the two that I find, I guess, most interesting are, one, the physician directory because
people say, oh, you don’t have any information on physicians, and we don’t have really performance information on physicians. But there is a Web site called the physician and other non-physician provider directory that has information for people who are looking for a physician by zip code. It has kind of the health plan information on address and zip code and phone number and I think where they went to school, that kind of thing. People certainly seem to be using it.

The other one and the one that’s used the most is the health and drug plan finder. In part, that’s because that’s such a critical choice for beneficiaries, but I also think, in part, because it’s one of our better Web sites.

The bottom line best feature on that Web site is you can actually plug in your drugs and your zip code and you can plug in a couple of other factors as well, but it will calculate from a cost-sharing perspective what the best plan for you would be, taking into consideration premiums, deductibles, their copay policies, making sure that the drugs that you have are on the formulary.

So, that’s, I think, a really good example of a tool that combines both access to necessary drugs, which I guess I would call at least some type of a quality
indicator with the dollars at a very personal level.

Now, of course, it has its problems. You can’t always anticipate what drugs you’ll need or what conditions you’ll have. But it gets about as specific as you can in that kind of Web site.

So, this is -- I think I probably shouldn’t characterize our Web sites as some better than others, but our Hospital Compare is certainly one of the older ones that have been up there and these are the kind of measures. As Nancy characterized, perhaps it’s too many different types of measures, but these are the variety that there is. So, beneficiaries can go on it and look in a variety of different ways. You can plug in your condition and get scores, for example, if you -- I said -- well, I don’t suppose you would know. An AMI is -- Irene said ahead of time -- but there is CHF, for example, you can plug in and get whatever measures apply to that.

It has patient experience of care. So, that’s the results from CAHPS surveys. There is also -- we have just put together the information on quality with also some of the volume of services so you can look at which hospitals have a higher number of procedures that are performed at that hospital. And you can see down at the bottom bullet that it’s searchable by a variety of ways.
You can look at hospital name, zip code, city, county or state.

We also have some -- and I would call this definitely a baby step -- provider reimbursement information. So, this does not tell the beneficiary what he or she will have to pay. This just looks at what the Medicare program pays. So, there is a Web site for looking at common and elective hospital inpatient procedures, outpatient procedures, the same things that are done in physician offices and ambulatory surgery centers. So, these are not the same procedures across all these settings. We look for, basically, the top in each of those settings and then you can look at in your area generally what the Medicare reimbursement is for those services in your area.

The second large bullet there is just where you go to look at that. And then the third is just to kind of transition into the next slide a bit. We are beginning to focus a lot more energy on episodes of care and how you might look at episodes of care across settings of care and actually measure the resources for that. We haven’t even really begun the discussion of whether you would somehow post that information publicly. We are really just trying to figure out how to measure it at this point in time, which I think is where a lot of
other initiatives are as well.

I talked about this a little earlier, but the plan finder Web sites are very well used and, in part, because there’s a pretty serious cost differential for beneficiaries. So, this helps beneficiaries choose Medicare Advantage plans or prescription drug plans and there’s quality information, cost information and coverage-specific information so that beneficiaries can actually compare and decide which plan best meets their needs.

This is just a shot of the plan finder tool. So, you can see here, for example, that in this particular beneficiaries area, Aetna is a possibility. You can see whether there’s any coverage in the gap. I won’t go into gory details of what the gap is. But there’s a certain gap in coverage in the Medicare prescription drug benefit that leaves a beneficiary fully exposed if they don’t have some coverage. What the premium, the deductible, what kind of cost sharing there is.

Then we also have -- are going to, before open enrollment occurs, put up some summary rating of prescription drug plan quality, which is primarily looking at sort of access to appeals and -- yeah, it’s service quality: it’s not clinical quality.
So, the hardest nut to crack, so to speak, has really been looking at physician quality and price information. There are three initiatives I want to talk a bit about. Many in the room know about some of these, but I don’t know if everyone knows about all of them. So, I’ll try to give sort of an overview of the three bullets there.

The Physician Quality Reporting Initiative or PQRI is where the physician self reports on a variety of different measures through codes that they basically define the population to which the measures would apply and then suggest whether they gave the necessary interventions. There is also some intermediate outcomes in that as well.

Currently, these are not the performance measures nor whether physicians are participating in the initiative is not publicly reported. However, MIPPA, this summer, the new Medicare law did require CMS to, beginning in 2009, report on physician participation in PQRI. There is also a bonus that’s paid to physicians who report successfully in this program of, I believe, 1.5 percent.

The Better Quality Information for Medicare Beneficiaries Project, I would describe as a research project. It was really intended to look at how Medicare
data could be used alongside private sector data at the local level, under the auspices of the QIO Program -- and I say that just because it sort of was a legal constraint. It allowed us to do something that we couldn’t otherwise do in terms of giving out individually identifiable information to external organizations. So, there were several local organizations that became subcontractors to a QIO and they actually got Medicare data.

There were some interesting findings from that. I don’t know if the report is up yet, but there’s a final report in progress right now and I think it would be fascinating reading for anyone who’s interested in the data issues. But two issues I would highlight. One, it became apparent that it is very difficult to actually mingle together the actual claims level information; that while there may be ways of putting together the information at a little higher level, but actual claims is hard because they are just different. They are not standardized.

And the other thing that I think doesn’t necessarily have to do with Medicare data or other data, specifically, is it’s very difficult to identify the physician. UPINs and TPINs just even technically are difficult to figure out exactly which to use. A TPIN is
a group number; a UPIN is an individual number. Now, we have the NPIs in the Medicare program. And the other issue is the more qualitative issue of attribution. I mean, who really is the appropriate provider to hold accountable for a measure?

The third bullet is -- I’m going to try to summarize this quickly, but I don’t know -- we just may need to discuss it. The GEM Project, the Generating Medicare Performance Results Project, is a project that grew out of BQIs. The concept from Secretary Levitt’s point of view was he really believes in national standardization and local action. So, he really wanted more organizations at the regional level to come together to look at quality information and then to use that information either for public reporting or working with providers. So, he wanted to make it possible for Medicare data to be used for this purpose.

So, the strategy that was devised was to -- because it’s difficult, again, to actually release individual physician-specific or individually beneficiary identifiable information, was to calculate the scores. So, you would have ratios for we did it at the physician practice level, again, to keep it a little bit away from getting down to the decisions about the individual physician and, so, give ratios to the chartered value
exchanges, which was the name of the local organizations. And the hope was that then they could calculate ratios and be able to put the information together.

   It’s just begun. The information -- actually, we calculated the information and it is up on our Web site for -- nationally -- well, I’m not sure if it’s up nationally, but it’s up there for all the states that have chartered value exchanges for them to be able to use at the taxpayer ID level. So, that’s a model of using Medicare information that I would be glad to talk more about because there’s lots of back and forth on that as you can imagine.

   I think I’ve said a little bit already about the challenges with physician-specific information. The other area that we’re doing a lot of work on is trying to figure out how to measure physician resource use. A few years ago, MEDPAC recommended that Medicare go ahead and do some physician resource use measurement and provide it confidentially to physicians. MIPPA, again, this summer required the agency to do that beginning -- or to put a plan in place to start doing that in January 2009.

   We do have a contractor in place to try to create some of those reports. We’ve done a lot of research on what is the best way to give those reports, what’s the best way to define an episode. I would not
suggest that we think that we’ve found a really great method, but we are continuing to work at improving the tool at the same time that we intend on using the tool for confidential feedback. So, you’ll see more on that as time goes on.

So, on an ongoing basis, we continue to update and expand our quality and price transparency Web sites and our various initiatives. The thing I want to talk about here, though, now more than what we have put out in terms of information is the difficulty that the Medicare program has with balancing the legal requirements to protect beneficiary and individual physician information with a need for more information on quality and efficiency. And I guess the next bullet -- that’s what I want to talk about next the most -- the rest of this presentation.

But we have also, just recently, for those that are interested in prescription drug information, released a regulation earlier this summer that made it possible for researchers and others to actually use our Part D data now, which is a huge addition to the potential for looking at quality measures because now you can actually use prescription drug data. It’s not out there all on the street yet. I think it will be, probably for researchers, available December or January next year for
2006. But it will be available on an ongoing basis after that.

We also were mandated by Congress to put together a warehouse of information that identified people and linked information for A and B for those with chronic conditions. So, there’s a chronic conditions warehouse that researchers can also access to do research on beneficiaries with chronic conditions.

So, when we are looking at Medicare data -- and here I should probably have labeled this claims because this is really -- I mean, actually, some of this applies to data more generally. But I think the real issue and the real rub comes when you are looking at claims.

There are really four laws that govern the use of our data. One is the Social Security Act, and I’m going to tell you a little bit more in detail about what it authorizes us to do and not do. And that law authorizes CMS to release data for a limited set of purposes. The other is HIPAA, and I’m embarrassed, there’s two Ps. I’ve made it my pride not to have two Ps in HIPAA, but now MIPPA came along, which does have two Ps. So, it’s very confusing for policy people in Washington. So, I just hate it when there’s two Ps in HIPAA.

But, anyway, so, that protects patient
identifiable health information. So, we clearly have that in our claims. And then the Privacy Act of 1974 is something that the private sector doesn’t have. I guess I would say the private sector probably has something called contracts which at least does some of the same thing, which is it protects individually identifiable information, both patients and physicians. So, it’s not just protecting, you know, whether you can identify the patient, but it also protects the physician.

   And then FISMA is the new and very expensive kid on the block. This is a law that was passed that was passed to require that anyone who uses, and CMS itself, to put in place certain security requirements for use and release of individually identifiable information. If you want to strike terror in the heart of anyone who is interested in information inside CMS, you say, if you do that, it will bring in FISMA. Because we’re told by our Office of Information Services that it’s an extremely expensive, although necessary, set of rules around the level of security you have to have around your systems to actually be able to use individually identifiable Medicare data. So, this applies both to us and anyone with whom we contract.

   So, if someone says, well, why don’t you just contract with us to do X, well, if that’s a purpose we
would want a contract with you to do, we could give you
individually identifiable information for that purpose,
but you would have to meet this FISMA requirements. So,
that’s another law that governs the use of our
information.

The next slide is the list of the statutorily
allowed authorized purposes. So, this is where the
Social Security Act comes in. We can use our data for
payment; we can use individually identifiable information
for research. So, we have a whole contractor called
RESDAC that handles our data for those purposes and we
have a privacy board that reviews any requests. We can
use it for demonstrations. The quality improvement
organizations actually have a separate section in the
statute that allows them to use the information.

We have just this year -- I’m particularly
proud of this because my office really made this happen
in part -- we figured out a way so that Medicaid programs
could use our data that they currently use for
coordination of benefits with Medicaid for a little bit
of a broader purpose. So, you can also look at care
coordination for duals populations, and we included in
some of that language quality improvement.

So, they can use the information on the duals
population, which is the population that’s eligible for
both Medicare and Medicaid, for purposes beyond just payment. We found that states were building these great databases using their Medicaid data and trying to really use it more broadly. So, this was something that we were able to get done this year.

The other way it can be used is through patient consent, which people don’t like to do. It’s hard, it’s cumbersome. But, in fact, that is probably the most straightforward way of informing a beneficiary that, in fact, you would like to use their identifiable information.

This slide is really just to provide some Web sites for people to go and look around if they want to. And then that really concludes my presentation. I was hoping that you would take from this presentation that there is a wide variety of information on the Web site. Some of it, for example, the hospital information, except for some of the claims-based measures, is on all the patients in a hospital.

So, I encourage any local initiatives to link to that Web site because then you don’t have to build your own and hospitals don’t have to report twice, and those are measures that, in fact, have endorsed at the national level. So, except for the claims based measure, that’s true there. Nursing homes, it’s the same thing.
Health plans, of course, are specific to Medicare only. So, we put a fair amount of information on our Web site for beneficiaries that could be useful to others. We are exploring different ways to try to have our information used without having to actually give claims databases away. And the other concept that I think could bear some fruit if we got creative about it are public use files. Those are files -- we just create them for the purpose of the public using them. There may be some ways we could strip some of the identifiers or do some analyses ahead of time that would provide some useful data.

MR. WROBLEWSKI: Thank you, Karen. I would like to start off and maybe segue from Karen’s last point, in terms of -- the purpose of this part of the discussion is really to look at those policies that would overcome some of the barriers that we have talked about and to get to the needs that we discussed earlier this morning. I love the way Irene set it up in terms of the six hurdles. We probably got up to 11 by the time we ended up adding more.

(Laughter.)

MR. WROBLEWSKI: But, you know, what Karen was just talking about in terms of CMS data -- and I know Vince had mentioned it earlier, so I wanted to talk and
fit in with the data in terms of getting the data. We can talk about policies regarding that. Then I have some other questions about going through the hurdles that Irene had set up initially. So, if you wanted to talk about just in terms of how you want to use the CMS data, and if it can’t be done now, that’s fine. You know, that’s point of making a list of what our asks would be.

DR. KERR: Yeah, I think, which is probably obvious to you, there’s great value just from the volume of claims data. But to get the maximum utility out of it, you would need to have an identifier. It doesn’t have to be personally identifiable to an individual, but something that you can track claims to a unique individual, and it would have to be identifiable for a physician to be able to do the kind of performance measurement.

The question would be, how do we get there? And you listed some tantalizing possibilities. It isn’t clear that the release of data wouldn’t be neutered through most of those. But how do we get there? Does it require a statutory change to allow you to do that? Is there a safe haven, an expansion under the QIO that could do that, or could Medicare receive commercial data and produce the performance information that way? You’ve chosen not to do it with the data you have at a physician
MS. MILGATE: We haven’t chosen not to, but --

(Laughter.)

MS. MILGATE: I have to say we have -- myself and another colleague have really thought long and hard and really tried to figure out how to do it. I mean, you raise an interesting one that I will just expand upon. Let me just give a couple of observations from trying to actually put together a legislative proposal. Like what would the proposal be, right?

You end up exempting physicians from the Privacy Act for these purposes, which, you know, it is possible to do, but I think you’d probably get some pushback on that. But you can’t really exempt anyone from the HIPAA Act, right? That’s kind of a pretty basic protection for individually identifiable information. And, so, there you either end up -- and I agree, you do need individual identifiable information to link to get that score. But I would suggest to you that our beneficiaries don’t have to link with your people because they are not the same people.

DR. KERR: Right.

MS. MILGATE: So, the physician is the key. If you really think -- this is the other thing that I would just challenge some assumptions on this. I mean, I know
that some physicians see both Medicare beneficiaries and
under 65. But there are probably also plenty of
physicians that don’t overlap. And, so, I don’t even
know if you--

DR. KERR: No.

MS. MILGATE: No? So, all physicians see both?

DR. KERR: If they want to make a living.

Pediatricians don’t see a lot.

(Laughter.)

MS. MILGATE: My point in saying that--and
perhaps that was a less well-informed statement--but
when we’re looking at sample size in the Medicare
population, we have a heck of a time getting enough
sample size for adequate measurement just like you. I
know you find that surprising, but we do. And, in part,
it’s because there seem to be a fair number of physicians
-- and I don’t know, you can probably comment on this or
not -- that don’t see -- that see small numbers.

So, you will see a fairly significant number--
I mean, this is like one state numbers. This is not any
kind of statistically significant statement. But, you
know, we looked in a couple different states, getting
sample size on certain conditions, and we ended up, after
we excluded -- for example, we can’t do Medicare
Advantage. I mean, there’s a lot of exclusions you have
to get to actually get a good sample size. I don’t know. It was certainly under 50 percent of physicians had a sufficient sample size, even if we used really loose standards.

So, I don’t know. I’m just not sure what it gets us. I’m wondering if, in fact, we calculated some scores, if you calculated some scores, and then we put the scores together, we wouldn’t really get to the same end without having to have individually identifiable. You would have to have the physicians linked, I suppose. But what if you had a physician score for Medicare and a physician score for private sector? Is that really the worst thing?

DR. KERR: If you could marry up the methodology so the scores would be --

MS. MILGATE: Right, right.

DR. KERR: Yes.

MS. MILGATE: I mean, some people in this room probably know about the AHIP Foundation work. That’s what they’re trying to do is get the health plans to calculate their scores generally the same way we are, and then they would have scores. But I find it interesting because they’re having a heck of a time trying to get plans to give them the information. I think it’s some of the same reasons we’ve had a hard time because of the
protections on individually identifiable information.

MR. WROBLEWSKI: Barbara, you had a comment.

MS. RABSON: Sure. As a BQI pilot in a chartered value exchange, I’ll tell you how we see the world, sort of this issue with Medicare and CMS. The BQI pilots, there are six of them and they spent two years and we each got over a million dollars to work on this data aggregation with commercial payers and Medicare and we learned a tremendous amount. I think our perception was that CMS couldn’t wait for this contract to end. Part of it was because it was tied to the QIO eighth scope of work.

So, I mean, there’s a legitimacy -- I certainly understand from CMS, it was like the eighth scope of work ends, this project shuts down exactly Friday, this Friday, and so it was like closure. All of us could have used at least an unfunded time to actually really mine the data to get the wealth of information out.

There were lots of delays in the project and there’s been a sense of frustration that there’s so much to learn, why turn off the lights now and is there any way to sort of keep that going just to gather up the information so that we can apply it towards the next phase, because we know that with the chartered value exchange and the GEM project and the AHIP project, under
the GEM project, and you’ve alluded to this, the data
that’s being put on the Web site at the Tax ID level is
not an accurate way to group physicians and the BQI
projects have all proved, and it’s just because they’re
using administrative data which is available, which is
all you had to use.

MS. MILGATE: We have UPINs. We could have
used UPINs. It was a decision to actually use TPINs
because we find them much more stable in our data. You
would say a conclusion from the BQIs is UPINs are better
than TPINs?

MS. RABSON: No, I’m saying that you cannot
accurately group physicians using administrative data at
this time. Not reliably use it.

MS. MILGATE: Well, but you can’t accurately
identify physicians using UPINs. I mean, sometimes they
use group UPINs, sometimes they -- I mean, we found it
the better of two evils.

MS. RABSON: Okay, I hear you. I mean, this is
not the place to argue about this. But I guess the point
is that there’s some unfinished business and some
learning that could be used going forward and -- with the
GEM project, for example, MHQP cannot use that data for
anything because we don’t know what physicians are in it
and we don’t group physicians by Tax ID number.
We have an internal process where we reach out to physicians and do all the groupings. So, we have really reliable groups. So, there’s not a meshing. So, I guess the issue is, going forward, if we want to get to a place where we’re actually succeeding in what we’re trying to do with CMS and making this data available, there is just more work that needs to be done, and we’ve got a platform of research based on the BQI projects that we could use. I think that’s the plea, is to go back to that.

MS. MILGATE: I mean, I can’t disagree with you. I was in a meeting recently where they were talking about you guys having to destroy or give back the data. I’m like, what does that mean, they have to take it out of their databases? It was a sad moment, I have to say, because we do recognize the research capacity and the problem is it was in the eighth scope in the QIO program. And for reasons that are beyond me, I don’t know if it was asked for or what the discussion was, it’s not in the ninth scope, and that scope does -- yeah, it ends on the 31st.

I think that maybe part of the feeling you have gotten from it is I think everyone knew how like kind of unique this was. I mean, you really came at a very unique period of time and people really turned themselves
into pretzels to figure out how that data could be used.

    MS. RABSON: I appreciate that, yeah.

    MS. MILGATE: And that’s why it was through the QIO program as you probably know. I think there was some fear that once it was out, people would want to continue to use it. So, I’m sure that’s some of the emotion you heard from people, because we do recognize how useful it is.

    Having said that, I don’t know -- I mean, it could be turned into a research project, and I’m sure you have been told that. So, that’s the other way to do it, is to do it through a research project. But I do understand what you are saying.

    MR. WROBLEWSKI: Peter.

    MR. LEE: PBG is partners of one of the other BQIs. So, we actually have three of the six along here and so, we are also -- right now, most of my staff are at home shredding right now.

    (Laughter.)

    MR. LEE: You know, little scissors, cutting up all the status. But it’s very compliant with FISMA. I don’t want to get into the --

    MS. MILGATE: Well, let’s not talk about FISMA in this context then, huh?

    (Laughter.)
MR. LEE: Just a couple of observations. One is, I think, Karen’s note is an incredibly important one. For a lot of folks there are huge learnings that will be public soon that these six pilots have submitted, and they’re different, because some of the sites really focused on Wisconsin driving information out of medical groups to populate, which is a different strategy, and others, Massachusetts, focused more on group than PBGH, and the California Cooperative Healthcare Reporting Initiative trying to get more at the individual level, et cetera.

But a few observations that I’d note is, first, the Medicare data is incredibly important. One of the things across the board is that the richness of that data cannot be understated. If we compared it to the richness of the data of a commercial enrollee, you know, one Medicare enrollee is worth about seven or eight commercial because they are older and sicker. So, they have more hits. So, the value -- it’s a terrible way to say it. It’s not really crass.

(Laughter.)

MR. LEE: But it really is the richness of Medicare data, doing something and saying, let the commercial do it without Medicare, really makes it virtually impossible. So, that’s one observation.
The second is -- I think, Karen, your point about even with Medicare data, which is richer, can you get to all doctors? Absolutely not. If you look at -- on page 432 of this report, you’ll see the California section, which has some charts that notes that for a number of the I think 12 measures -- there might have been 16 measures used, a number could only identify 50 percent of the Medicare physicians for particular scores, but that represented, in some cases, 80 percent of the Medicare enrollees for whom that score was relevant.

So, in some cases, it may not be talking about all of the doctors, but it may be getting the 80/20 rule of the majority of the doctors that are seeing patients in a particular type. So, that’s just an observation about we want everyone, but we also want those for whom patients are seeing most of them.

The last is -- and I think there’s a lot of good reasons to look at different work-arounds for the information being shared. I think one of the things that I think we need to look at -- now, this is not my BQI hat. I’ll take it off and throw it to the side. Being very careful about where CMS serves as the moderator and definer of here’s the right way to present the information as opposed to letting the market do that with the pressures that come on that through things like the
patient charter. And I’ll note as an example of that concern is the hospital reports that come out of Hospital Compare show -- and Nancy may be really glad her flag is up now -- but it shows very, very small variation. It shows that of 4,500 hospitals, for some of the scores, there are 20 that are at average. If you would put the same data in the market and say let’s look at a 95 percent confidence interval, other ways to weight it, you might see, God forbid, 300 hospitals that are at average. And that’s -- when you talk about -- we were talking this morning about showing variation and performance where there’s real variation. Some of that is scientific and some of it is actually a value statement of how much uncertainty you’re ready to have. Does it need to be right 99 percent of the time or 95 percent of the time? Those issues then really mean something different for consumers.

So, I think one of the challenges for letting the Medicare data be merged with and used with is to have the numerators and denominators be used that then would still allow for some of that value application of where do you draw the cut points. I think that’s some of the next discussion that we should be having as the data gets out there.

MR. WROBLEWSKI: Thank you. We have been
talking all about combining payer data. One of the interesting things about Wisconsin was that it was provider reported. So, I wonder what people’s suggestions were in terms of engaging medical societies to being the repository so that it would be provider reported so that you wouldn’t have this problem of -- regardless of who the payer is, what initiatives would be a way to get around the whole issue of the combination, which seems to be a tough nut to crack.

(Laughter.)

MR. WROBLEWSKI: I just wondered whether that makes sense in some areas. So, Michael and Peter put their tents up. And Nancy.

MS. Foster: No, please, physicians first.

(Laughter.)

DR. BARR: Wow, I don’t get that treatment at home, right?

(Laughter.)

DR. BARR: I would say from the perspective of the physician, I think there is a strong interest in looking at my practice data. I think that -- not from different streams. I don’t have that and I don’t have United. I have my practice data. The source of the data is my practice. That’s why I asked Janet earlier about the health information technology and the resource. So
if you’re able to suck the data right out of a practice
and reflect it back in a usable way, then all this sort
of aggregation is less important and it represents my
data.

Now, it needs to be standardized. You need to
evaluate it in the same way. I mean, all those caveats
agreed. But it takes away some of the mistrust factor
when it goes over to Vince’s shop and then comes back to
me or to Aetna. I think there is -- but that
infrastructure doesn’t exist. So, jumping ahead to the
asks later, I think investment in health information
technology to get us to the point where some of this
becomes more of a reality is a very key ask. I think
most of us would probably agree with that if not all of
us. But it has to be done in the right way, not just for
technology’s sake. It’s got to be able to deliver the
kinds of things that we’ve been talking about.

MR. WROBLEWSKI: Nancy?

MS. Foster: Sure, and I’ll tie my response to
your question to a comment I was going to make about
something CMS has done well. That is, while I understand
the thought about having physician registry data,
essentially specialty-specific data, it depends on what
you’re collecting and how you’re collecting it, because
while I could understand that from, say, the private
physician office, as soon as you go to the hospital and say, you have 125 different specialists and each one of them has its own reporting system, now you have to report to all of those and you have to report to the 125 organizations that are asking you, the hospital, for your specific data. Sorry, it’s not 125, it’s actually about 50 in most states. You have just augmented the measurement blizzard to a point where we will never dig out.

It’s just overwhelming and you have convinced hospitals you really aren’t serious about improvement, you’re only serious about data collection. Because they don’t have any capacity to do the improvement that would go along with it, you’ve now sucked all of that resource into the data collection. So, reasonable to think about what use physician registries, reasonable also to say, but you really have to do it with caution.

And the other point I want to make is as soon as you start collecting data in a wide variety of places, one might presume that there would be measures of care that are similar, maybe even addressing similar patient populations. When those measures change, as they inevitably will, someone has to decide -- sorry, when the science changes as it inevitably will, someone has to decide what changes need to be made to the measures and
when.

CMS, on hospital measures, along with the Joint Commission, have come together and created a single measurement manual. Yes, I would like to think the fact that we were screaming for that had some influence on their decision to do that. But it really has been a marvelous thing. They have stayed together. The measurement descriptions are identical. Data collected for one organization goes to the other, no problem. That has been an enormous stride forward, as small as that might sound to some people. But that has been an enormous stride forward. I don’t know how you stay on that same pathway if you have data being collected on basically the same kinds of patients in a wider variety of locations.

And, then, I want to just raise an issue we can come back to, which Karen alluded to the data display and Peter talked about what role CMS in some of this -- I think it may be time to ask the question, you know, what does CMS or other parts of the Federal Government do best and how can it more successfully partner with other parts of the health care delivery system to take advantage of what they do best?

MR. WROBLEWSKI: What would your suggestions be in terms of what they do best?
MS. Foster: I would say that the aggregation -- I’ll speak only for hospital data. The aggregation of hospital data that is done there, all payer data whenever possible, has been an extraordinary step forward.

What they don’t do best, as much as I know they have tried and invested hard in doing it right, is a data display on hospital data. Hospital Compare is overwhelming and my guess is that 1.2 million people was actually me going there most of the time.

(Laughter.)

MS. Foster: But we take the data and rejigger it and display it and send it back to the hospitals to share with their boards. A number of state organizations rejigger it and make it useful to their state population because we can take that overwhelming amount of data and cull it down to exactly what you want to display. That may be just a wholesale versus retail kind of model that works extraordinarily well in other locations as well.

MS. MILGATE: I would say that’s probably what it does -- I mean, that means that the information is there, and I don’t know how complicated it is to take it and use it, although at MEDPAC we didn’t reanalyze the heck out of it.

So, the question would be would you prefer that
we did that and, so, therefore, it might be more useful for a consumer, but would not have all the details behind it? Is it the display or is it the amount of information, there’s so much information you’re not quite sure how to use it? Because I guess the goal would be to have both, right? The goal would be to have a high-level summary that would be useful to someone, but I guess one of the problems is that there’s so much customization that’s necessary for each beneficiary, I’m not sure what the --

MS. Foster: My personal suggestion would be that there continue to be the ability to download the data, the entire file, and use it as you see fit for your patient -- for your populations, whomever you’re trying to reach, which there are a couple of tweaks that could improve that capacity. But that’s basically done fairly well.

I don’t see a way, given the constraints that there are on federal Web sites, the formatting and so forth of federal Web sites, I’m not sure there is a way for CMS to actually display that amount of information in a useful format. But others -- Consumer Reports, specific business -- I’m embarrassed by the way we display it when I look at how others are able to display it.
DR. KERR: Have you seen the USA Today compilation of Hospital Compare?

MS. Foster: Yes.

DR. KERR: On the interactive side, it is actually quite consumer-friendly.

MS. Foster: They only do three of the measures.

DR. KERR: But they only do three, right.

MR. WROBLEWSKI: Dr. Hoven?

DR. HOVEN: Yeah, I’m not a data-wonk, so please accept my language here as being confusing. Michael, when you said medical societies I thought you had lost your mind.

(Laughter.)

MR. WROBLEWSKI: Specialty societies. ABMS is what I’m thinking of.

DR. HOVEN: Okay.

MR. WROBLEWSKI: I’m sorry if I mis-spoke. I was thinking ABMS.

DR. HOVEN: Having heard you say that, I’m sitting here thinking. And, you know, most health care is local. In fact, my data in my clinic, my state collaborative, my state, in fact, is a venue that we don’t often talk about as being a vehicle for doing some of this aggregation of information. To do data
collection comparative work looking at this stuff may not be such a wild idea after all. Maybe there is some plausibility instead of all of this being done at the federal level, that more of this is taking place in Wisconsin, in Massachusetts where these partnerships are already taking place, and perhaps that’s what we need to be talking about.

DR. CHUMBLEY: I might just say that in the collaborative, as I said when we began the day, we have about 50 percent of the physicians and we have partnered with the medical society, the state medical society, as a vehicle to approach the other 50 percent. We’re not there yet, but we felt that they actually might do it. So, when you said that, I said we’ve already had that idea.

MR. WROBLEWSKI: What I would like to do, if possible, Irene had listed six barriers and we’ve talked about that a little bit in terms of a solution, in terms of combining -- on the data barrier. But we had five other ones, and I know we don’t have -- time isn’t unlimited. So, I would like to go through some of the other ones to see what the role of public policy is. I will start first with awareness. That was the first one Irene talked about in terms of the awareness of variation.
So, I have one specific question for Karen because this may be -- well, I’ll open this up to the group and then I have a specific data question if you have an answer. What should be the public role to educate consumers and the providers about the variation and the differences in quality?

And to that end, I wondered how successful -- and I don’t even know if you can make this public, in terms of the ad campaign that CMS had run on Hospital Compare, where they took out a number of large-scale ads saying in your hospital -- in New York City, these three -- you know, had the hospitals listed and had a couple of their criteria. And I didn’t know, was that in the 1.2 month or was that -- didn’t know if that made a difference.

MS. MILGATE: It did make a difference. It wasn’t in the 1.2 million month. But there was a significant spike in the use of Hospital Compares after those ads were out. As you may have read, there was also -- well, I’m sure you probably don’t capture newspaper articles from across the country on Hospital Compare, but there continued to be actually quite a bit of interest in news reports across the country.

I think that -- I can’t remember if that was added when we added the mortality measures or -- do you
remember, Nancy?

MR. WROBLEWSKI: It was the patient experience measures.

MS. MILGATE: Yeah, when we added the HCAHPS. The other thing that, as some know, has captured all kinds of interest is the policy on hospital acquired infections -- conditions, sorry, excuse me. It’s more than infection, it includes infection.

So, I don’t know if that’s another -- you know, I wasn’t saying -- throwing that out to think, well, that may have -- you know, it generated an interest in variation, but I think it certainly generated an interest in that concept and that there are such things that occur in hospitals.

But that was a payment policy. That wasn’t -- and we didn’t say there was different -- we just said some hospitals are better than others on that.

MR. WROBLEWSKI: Paul?

MR. GINSBURG: I wanted to make a comment about this discussion. We usually talk about data being for consumers. But, you know, I think these days, the people really making use of the data are providers. I think it’s very important that the data ought to be accessible to providers in forms that they can use because they are primed to respond to it. Whether it’s thinking down the
road that consumers might use it some day or just
strictly professionalism. That should probably be our
top priority now.

When I think about the consumers, I think the
government is not well-positioned to do the final -- the
actual consumer-friendly data. It is probably best to
plan on Consumers Union for-profit vendors often hired by
insurers to use the raw data that they get from Medicare
and other sources and let them compete on making it
usable and valuable to consumers. But let’s not lose
sight of the fact that for the next few years, at least,
the biggest value for society is going to be to get
valuable data into providers’ hands because they’re
primed right now to respond to it.

MR. WROBLEWSKI: And how do we go about doing
that?

MR. GINSBURG: Well, when Nancy was talking
about what the American Hospital Association does with
Medicare Compare to transform it into a way that they
believe is useful to individual hospitals. So, I think
the key thing for the government is to make the raw data,
to the degree they can, available to others who will
massage it for different markets, different audiences.
Rather than trying to plan at a very high level, you
know, make compromising so that this data is useful both
to consumers and to providers of different types.

MR. WROBLEWSKI: Richard?

MR. SORIAN: It’s interesting. I think Vince mentioned the USA Today. There is a reason that their information was more interesting and more useful. That’s what they do for a living is communicate to consumers and they understand, just one example. But if you think back to when they started, the little silly graphs and stuff, now everybody’s doing that because they do research and they actually look into it.

I worry about -- it’s the massaging that I worry about. I don’t mean to cast any aspersions. But if the party that’s being measured is massaging the data to then communicate it to others, there’s always a chance that it gets massaged in a way that kind of changes the message.

I think the media can serve in a very powerful way. We’ve worked with U.S. News and World Report. Now, for years, we’ve done report cards and we always stopped short of ranking health plans because they would scream at us. U.S. News and World Report said, we’re going to rank them and we need your data, and we worked out a formula with them. So, they ranked them and it will be out in a couple weeks for this year. But the use of that has been sky high, much higher than anyone ever came to
the NCQA report card because it didn’t make them do all the work of this, well, this star plus these stars, plus this and that.

So, it becomes more simplistic which makes a lot of us nervous. But the simpler the message, the easier it is to use, the more graphic it is, people are much more likely to use it.

The problem is with hospitals -- and we talked earlier, again, I think it was in Irene’s presentation -- there are a whole lot of hospitals that are basically captive of -- that have the market captured. So, you get information about your hospital kind of not being the best hospital in the world, but you can’t go anywhere. So, there has to be other uses of the data where the payers start saying we’re going to do something, but they don’t have as much power when the hospital has the whole market.

Using the data to actually affect change is often the missing piece. We collect a lot of data that we don’t do a lot with. In the private sector, employers are much better at that. But Medicare -- and I love Medicare --

(Laughter.)

MS. MILGATE: You will later.

(Laughter.)
MR. SORIAN: I’m getting closer every day.
They collect all the data. Every Medicare health plan --
almost all of them and it will be all of them in 2010 are
required to report a very significant amount of
information. But other than putting it up on the Web in
a form that doesn’t get people upset, so it doesn’t
inform, that’s it.

Just one example, the State of Michigan’s
Medicaid program -- I know it’s not Medicare, but
Medicaid program in Michigan, they standardize all their
payments to the plans using an actuarial formula so that
there’s no bidding and arguing about that. They decide
what plans get into the program based on their quality
scores. And there’s a cut-off. Last year, they cut two
plans of the program including one that had been in the
Medicaid program in Michigan since almost the inception
of the program, but their quality had fallen below the
threshold. That’s a very clear message that quality
actually matters.

MR. WROBLEWSKI: Thank you. Irene, you wanted
to add something?

MS. FRASER: Yes, I wanted to add something to
this last discussion that also harkens back to the
discussion about the data.

Two things. One is this issue of reporting at
the local level and getting data to the point where it’s useful to particular audiences. One of the things that we’ve been working on, and it’s showing really great promise, is a portal through which we are going to be able to take all of the software that we use to do analyses of hospital data at the national level, applying them to the quality indicators and other things that we do on our Web site. All we can report on our Web site is national data or at the state level, but we don’t do any reporting at the hospital level even though we have that data. But that’s part of our agreement with hospitals.

But localities, who may also have that same data and want to do reporting at a local level with their own data, would be able to use our software through this portal that they could import and do all of the different kinds of analyses that we do. So, for example, if we do stat briefs on certain things at the national level with breakouts by states, they can use all of the same methodology and software to do that at the local level and, similarly, for reporting or tracking potentially preventable admissions, et cetera. So, I’m thinking that might be a model for other things as well.

We’re starting out just with our hospital data, but we are, this year, expanding it and thinking that we can add other kinds of data elements in. It came out as
part of our discussions with the chartered value exchanges and providing technical assistance to them. But, also, provide our local state hospital association and data organizations that use the same data. So that might be kind of a vehicle for that.

I wanted to make one comment on this question of using providers as the collection points versus payers as the collection points for data. That’s the way it’s done with hospitals, but, obviously, hospitals are an easier unit than individual physician practices, many of which don’t have the capacity. But I think in some ways, the technical problems of doing it, physician group by physician group, are easier or more surmountable than the problems of doing it payer by a payer. I think there are some strong reasons to do it, one of which is that if you go payer by payer, for one thing, you don’t get the uninsured, which is a growing number. So, that is one reason. Plus people move in and out of insurance status, et cetera.

So, I think if we could -- I mean, there are technical and financial problems with going physician by physician group. But it would really be nice if we could think about ways to do that. And maybe what we do is just -- what it’s going to require is having some kind of standardization within electronic health records so that
as soon as something changes it can click and make it easier. I mean, it’s not easy, but I’m just saying I think the problems are more surmountable than the problems of going payer by a payer.

DR. KERR: I don’t know who had it up first. But this relates to your comments. So, you’ve kept mine from being out of sequence.

(Laughter.)

DR. KERR: And that’s just one caveat with rolling up data at the physician level. To the extent you want to view an episode of care, you will have difficulty doing that. That’s the view that may not be supplied by --

MR. WROBLEWSKI: Michael?

DR. BARR: Can I just react to that because I wanted to comment on Nancy and then you changed topics. I want to amend my comment actually to say that it’s important to look to the patient sector and talk about what information is about the patient, wherever the patient goes, but reflected -- you know, I mean, you need the whole practice data there. It’s very distracting when the physicians get information from all the different places. But I think one of the most important ones would be from the hospital, because if we get to any sort of shared savings models or work together on the
transitions of care, we really need to be looking at each other’s data and contributing to the same pool in the same way.

So, that was the only comment I was going to make earlier.

MR. WROBLEWSKI: Thank you. Dr. Hoven -- oh, and Elysa. Go ahead. I’ll come back to you.

MS. FERRARA: I think that what I’ve heard today is, you know, we’ve heard talk about elements of what we’re talking about as a public good. And you asked us about CMS and CMS’s role. So, what parts of this are a public good?

We know that creating standardized measures, defining those measures, putting standards around how the data can and should be used and shared are all public good. The investment in evidence-based medicine in determining new measures that drive from the pathway we’ve already heard discussed. Those are public goods. Maybe even the methodologies for attribution are something that should be standardized. I’m not sure that they should, but maybe.

But then you get to a point where you sort of come full circle to what’s the purpose of this discussion. It’s about competition. And I think what we’re hearing is that the marketplace has found much more
creative ways to use that data where it gets to the place
where we want it to go because we’re really not creating
measures and data for measures and data’s sake. It’s for
two audiences, providers so they have actionable
information because they want to make a change and the
consumers because we want to engage them with more than
just plan design to make a difference in the way they
behave.

So, I think what we’re saying is we want the
UPINs, we want the TINs. We build something, I hate to
admit it, called a POIN and a POIN is an IPA. You know,
so they’re not really TINs, they’re 50 TINs. Right?
Because if you have an IPA in Rochester, you have 2,200
physicians under 175 TINs working together. So, I had to
have a way to aggregate and generate data down at that
IPA level. So, we invented something, and that’s what we
use. But, you know, you have Consumer Reports, you have

Whether we love it or we don’t love it, we are
saying that if the public good could invest in the
standardization, if groups like NCQA can give us PHQ
standards that say if you’re going to publish data or if
CMS is going to release this data file to you, these are
the standards you have to meet for how you use it. I
can’t just put NCQA’s seal of approval on Aetna any way I
I’ve got really strict standards for how I can represent that. The same thing with CMS. They can create the standards for how it’s used and then let it out in the marketplace and let us use it.

MR. WROBLEWSKI: Dr. Hoven?

DR. HOVEN: Thank you. I want to go back to measurements and reporting methodologies once more. The point I want to reiterate is that they have got to be linked to actionable strategies. It’s got to be real-time and it’s got to be a point of care. We can collect data until hell freezes over, but unless we move this bus down the road, we’re not going to get to where we need to be in doing what we’ve all been talking about today.

MR. WROBLEWSKI: How do we do that?

DR. HOVEN: I was afraid you were going to ask me that.

(Laughter.)

DR. HOVEN: Well, let me back up. PCPI, for example, is now beginning to look at composite measures and continuum of care measures. And one of the issues that was made a few minutes ago was that you can’t do that kind of thing because it’s too -- probably too diffuse.

But, in reality, I think we can do that. I think we’ve got to make the motions, we’ve got to get
started trying to get this sort of thing done. I think we’re going to have to talk about this going forward. I don’t have the answers right now, but, clearly, it is an impediment to what, I think, is happening out there right now.

You have to have the data, as Dr. Ginsberg said. Doctors are going to respond to information. We love numbers. We like to see how we compare. All we want is that data to be methodologically sound, transparent and usable. Right now, we are having to get stuff out of a lot of different pots and isn’t working. So, I think going forward, that’s something from a policy standpoint that we need to prioritize and make --

MR. WROBLEWSKI: When you say you’re getting information from different pots, you’re thinking of is there a -- I mean, we’ve been talking about ways to combine the public data with private data. Are you saying that we need also to think of ways to combine private data -- so, you have a larger -- so you’re not pulling from multiple pots and so there are more -- you know, you’re pulling the Aetna and the United data together from a methodological point of view and a data point of view? Is that you’re talking about?

DR. HOVEN: Yeah. I mean, I’m talking about everything’s got to be standardized. When I look at my
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report from Aetna or my report from United, it’s giving me -- it’s all apples. It’s not apples, oranges; it’s peanuts, pretzels, you know, and the cut-offs are different and it’s uninterpretable because I’m going to ditch it. That’s the kind of message that I think we need to listen to out there.

    DR. WROBLEWSKI: Okay.
    DR. NASH: Are you saying you’re not getting the apples to apples right now?
    DR. HOVEN: Right.
    MR. WROBLEWSKI: Right. Elysa, you wanted to add something to that?
    MS. FERRARA: Yes. And, actually, it’s a semi-related topic. I think that we are all interested in multi-payer collaborators and the idea that the power of the N is very important.

    I will say that with the CVE development, when I went to the first CVE, that we’re a member of, and they had the roll-outs in the markets and this great media event and I saw the maps for the plans of CVEs, which you’ve all seen, it was very frightening to me because there are CVEs that have really done a great job and there are others who spend a lot of time inventing new measures and asking health plans to invest in providing multi-payer data, measured a different way for each
county. They are not statewide collaborative. And we have states with 50 CVEs they want us to engage in.

There are two concerns I have. One, we can’t afford the investment. The blizzard of measures -- the blizzard of not only measures, but methods of measures and methods of aggregations and different vendors that they’re hiring who have different approaches. In one state alone, we had about 10 different hired vendors by a CVE and a lot of public money to invent new ways to aggregate data and new methods for attribution.

So, I think we’ve got to be really cautious that we have to find the blend of local, but responsible local, so that we’re not investing so much in measurements. Someone made the point, there’s nothing left to affect change with. So, I think that’s been one of our big concerns about the CVE movement and the need to really be prudent about what we’re doing in this area.

MR. WROBLEWSKI: You know, the one thing that we haven’t talked about in terms of -- really all this discussion has been about provider information and we haven’t talked about, in terms of the solutions, comparative effectiveness. Jack, I’ll turn to you and to Beth and Kristin if you’d like to follow up on that.

MR. FOWLER: Do you want to talk about comparative effectiveness?
MR. WROBLEWSKI: In terms of what would be the -- I mean, we heard there was a lack of evidence in Janet’s flowchart of what is it that’s the public good, so to speak, that creates the foundation on which competition could then occur?

MR. FOWLER: Certainly, the plea that we need to give somebody a whole bunch more money to do more studies because the percentage of medical care that doesn’t have a good evidence base is way too high. I don’t think there’s any doubt about that. But there are some things where we do have quite a bit of evidence and the problem there is packaging it.

Just like the inattention to the fact that there’s not a lot of public awareness and running to a Web site where you just put things there for when they want to choose a hospital or when they want to pick a doctor. Most people don’t spend their time thinking about how to manage their health and you kind of deal with health problems when an event happens or you’ve got a problem. But I can’t afford to have a liver plan at the moment, I mean, for what I’m going to do about my -- I mean, I can’t have one for all of these different things that could happen to me.

So, you have to kind of wait until something happens. Then you may not know -- have at your
fingertips where all the resources are and where things are. So, you’ve got to build it into the system.

I agree with Richard that the provider shouldn’t be organizing the data. That’s the wrong way to have it. But having the providers or somebody who is involved in the care system be the trigger to say, here’s where you can get the information and here it’s organized in a reliable, credible way makes more sense because the positions, and maybe the health plans, are the people who think about this stuff all the time. They have a liver plan and a foot plan and a knee plant and a heart plan because they think about those problems. Patients are not going to be ready to do that.

So, I think having people that they’re likely to come in contact with and know at the time that they’re about to have to cope with this thing is really an important part to getting information to patients. I don’t think you can rely on them.

We studied 10 decisions that people made, three meds and three cancer screening tests and four surgeries. The Internet was a tiny part of the decision-making process for people. It was 20 to 30 percent max who said they checked the Internet at all about these decisions, because they happen fast. If somebody says, you know, you want to take a med, you know, I think you should take
a med, they took a med. So, there’s not a window, there’s not a period. You don’t even know sometimes that there’s a decision to be made which people were talking about.

So, I think somehow building it into the system so that the people who are contacted have the triggers and then give you reliable information has got to be the case. Just sticking it up on a Web site and assuming somebody will Google it and get to the right place will not work.

MR. WROBLEWSKI: Thank you. Beth?

DR. NASH: Just one quick comment. There’s been a lot of discussion about how we need more research and, of course, we do. But even if we were to start today, it will be decades before we have all the answers that we need.

So, on the data front, first of all, I think if we had more physician level data, we’d also have more answers. So, it wouldn’t be randomized, controlled trials. But, you know, you have to use what you’ve got and you have to understand that it’s registry data or observational data and use it appropriately, but it’s better than no data.

And then the second thing is that, you know, maybe we do need to think about other ways of collecting
important data. So, I do think that systematic collection of patient data is also really interesting. It’s something that Al Mulley has worked on. It is an interesting concept and one we should think about, again, in the absence of the best quality data that we’re all looking for.

MS. MADISON: I really just want to reiterate what Jack Fowler said and to say that I think it’s important and we’ve talked before about what consumers know about what data is out there to take advantage of the resources we do have, which includes both physicians and health plans in publicizing the existence of reliable data sources to help sort through some of the stuff that is on the Internet.

I also think that surveys have shown that it depends on what population you’re talking to how willing and ready they are to do things like search the Internet. Certainly, my students, that is the first thing they do. That is absolutely the first thing they do is go online and that’s partly because they’re young, it’s partly because they’re well-educated. That differentiates them from a lot of other patient populations. But as we all get older, I think the number of people who are willing to do that will be increasing.

And, also, to reiterate something that was said
before about the importance of doing research on making these sites much more usable, I think the Wisconsin site, for example, is actually quite good in terms of usability. So is the Massachusetts one. There are a lot of other sites that aren’t so good. The other thing that I’ve had trouble with is actually finding these Web sites. I’ve looked, at this point, probably at 100 different Web sites. I know they’re out there, and despite knowing that they’re there, I have a hard time finding them.

So, Pennsylvania, I have spent 10 minutes on Google trying to find that wonderful Pennsylvania Web site that gives all of these good quality measures. I end up having to put Pennsylvania Health Care Cost Containment Council or PHCCCC to actually pull it up, which is absurd, right? You need to put in best hospitals Philadelphia and be able to pull that up.

So, I think there are still a lot of unanswered questions about design in order to make these things useful for consumers.

MR. WROBLEWSKI: Thanks. Nancy, I’m going to call on you, but I also have one quick question because it’s a point that you had brought up earlier. You had said that in terms of quality of care we need to break down the silos. Maybe I’m stealing your thunder, but how
do we do that?

MS. Foster: Thanks, Michael. I do believe that. I think when I made the remark I meant in terms of looking at data across the continuum, as a number of us have spoken about. That really requires, I think, that we have a common vision of what an episode of care -- how we’re going to choose to define it because that really is sort of a policy decision, that there are not clear boundaries on a lot of episodes. Choose it, define what we’re going to think of as the critical pieces to measure, measure those, and share the information among all of the interested parties. That would be my ideal vision. That’s not an easy thing to do and there are lots of boundaries we’ve just talked about.

But related to that is the point I wanted to make, and I’ll come to that in just a moment, I promise. But, Richard, I wanted to assure you when I talked about the AHA sharing data, I neither think we should be the organization that shares it publicly nor should be the organization that, in and of itself, decides what measures should be included because we would have some of the very same challenges you alluded to with the health plans and your data collection, which is things that we might ought to be pushed to measure might fall off the agenda. If we were trying to dictate this for our own
membership, it poses some internal challenges.

So, my belief is that we have another barrier we have not yet talked about, and that barrier I would call branding. That, in fact, a lot of organizations have invested a lot of resources and dollars and so forth in creating their own data display, their own data collection, their own -- and we heard some of that from our health plan friends. That’s, in part, what they share as the value to the employer groups they’re trying to market to. I know we have done the same thing and others have done the same thing.

We’re never going to get there. We have proven that already, I think, that we’re not going to get to where we need to be if we continue to develop all these little individual silos of data. We need to come together as common stakeholders in a common purpose. That will be tough for a number of us who want to say, gee, it’s the AHA’s data collection or AHA is leading the way, but we’re going to have to get over that because we won’t get there. Quite frankly, it’s also been a challenge for us with some of our federal partners who clearly have a reason, just like the rest of us, for touting the CMS data.

My challenge with that around the hospital data is it has made people think it is Medicare-only data when
it’s not. I think we kind of step all over our own messages when we don’t do it right. So, my policy lever there is that there’s got to be federal legislation that furthers the opportunity for the federal agencies to work collaboratively as a multi-stakeholder group in achieving this common goal.

MR. WROBLEWSKI: Thank you. We’re kind of out of time, but I did want to do one thing and I know this is a rather -- I want to give everyone a last chance to say something. What I would love it to be is kind of a -- what’s a real quick fix? If you have one thing that you’d like to see done in the short term, what would it be? One quick -- it could be a small thing. And then a longer thing, a longer-term item in terms of a policy recommendation to address some of the issues that we’ve done today. I will start with anybody who wants to start.

(Laughter.)

MR. WROBLEWSKI: Dr. Hoven, go ahead.

DR. HOVEN: Build the HIT infrastructure.

DR. BARR: That’s your short or your long-term?

DR. HOVEN: That’s my short-term.

DR. BARR: Well, if that’s the guide, then we can actually go further than that. I was going to say a short-term, I think because it’s relative to what Ardis
has suggested and it’s less expensive, is the whole education. I was with a group of physicians who had not heard about Wennberg’s data or the variability and the difference between their practices, and I don’t know that that’s terribly uncommon. So, I think -- in the short term, I think we can all do a lot to educate people through different venues.

Long-term, support primary care. I think the evidence is in that if we have a good, robust, well-supported primary care system with the aligned incentives so there’s shared information, shared incentives around there with the right reimbursement system, we’ll start to generate the kind of patient-centered care that we’re all looking for. And the other would be the HIT infrastructure. I think that’s a -- it’s not sufficient, but it’s necessary to get us to where we need to be.

MR. WROBLEWSKI: Okay. Nancy?

MS. Foster: Short-term, I would suggest that we take the tool that has just been adopted by the National Quality Forum for data collection on disparities and push it out to begin to look at that. We haven’t really talked about disparities except for one mention this morning. But we need to get a handle on where we stand with care for people of different races and ethnic backgrounds in this country. We won’t be happy with the
picture it paints. That’s clear.

Long-term, I am for building this multi-dimensional stakeholder organization to really push quality.

MR. WROBLEWSKI: Okay. Richard?

MR. SORIAN: Short-term, establish what I would think is a two-year period of increasingly tightening the current warped payment system so that in two to three years, at the most, everybody is clamoring for real payment reform that will actually start doing some of the things we discussed today. It’s the model that worked in DRGs in ‘81, ‘82, and I think it’s time for it to happen again.

MR. WROBLEWSKI: Long-term?

MR. SORIAN: The long-term is permanent -- semi-permanent. Nothing’s permanent. But is the comprehensive payment reform that actually reflects all of the values stuff that we talked about probably earlier today as well.

MR. WROBLEWSKI: Sure. Jack?

MR. FOWLER: I think I’ve got three, but I don’t know whether they’re long, short or medium. But as we talked about -- with different areas we have evidence -- I mean, we have information about hospitals, we have information about individual providers or teams and we
have information about comparative effectiveness and the pros and cons of options and things like that.

I think we really need three different things. I think, one, the problem of the variety of not so credible sources of information seems like a big problem to me. I think maybe the federal government or Medicare or somebody has to take that on as a certifying. I don’t think they should make all the data, but I think maybe they should be in the business of saying this is a credible source of data and it meets some set of standards. It would be efficient to have one group do this rather than having ten, which we already have and it doesn’t work.

Second, I think that, incrementally, Medicare first and I think then others would have to follow along and should start thinking about requiring that patients be given this information or be exposed or have someone say that you should get this information before certain choices are made, whether it’s choosing a hospital to intervene in your heart or -- I’m not sure, we’d have to make a list and the list could grow over time as the data became available and as we identified the choices.

MR. WROBLEWSKI: And this data would be the quality data?

MR. FOWLER: You’d have to have certified
quality data before you say somebody ought to see it, and
then you say somebody ought to see this data when they
are faced at certain points in the clinical pathways and
it should be required to pay for someone to make sure
that they see the data and maybe talk to them about it
before a choice is made. I think you need something like
that to structure informing people about all these
decisions. Each one has its own special features. But
that’s what I’d like to see.

MR. WROBLEWSKI: Okay. Paul?

MR. GINSBURG: Well, I really like many of the
ideas that I’ve heard, so I won’t repeat them. But I was
just thinking about the FTC with your mission about
promoting competition.

It seems that one of the summary things from
this discussion is that if the FTC really wants to help
consumers through competitive mechanisms, it has to
recognize that a lot of this competition will take place
far away from consumers. It’s going to be
cardiовascular surgeons competing for better results on
bypass graft surgery and hospitals competing and insurers
competing. And, in many ways, the consumer, of course,
is going to be the ultimate beneficiary of this, but may
not really be involved in a lot of the competition

But, yet, I think that the FTC or government in
general can do a lot by fostering competition it
considers to be productive even if it doesn’t really
involve consumers. It should focus the tools and the
steps on the people who could really use the data. To
me, consumers are very far down on that list.

MR. WROBLEWSKI: Thank you. To finish off this
side.

MS. FERRARA: Short-term, going in a different
direction we haven’t talked about, I think a very short-
term thing we could do is CPT-2 coding. There’s 132
codes out there ready to be introduced for measurement
purposes. We just need to have it reported. It’s
reported for some sectors, it’s not reported for all.

Adverse event reporting, it’s something that’s
captured a lot of interest. We’ve all talked about it
tangentially. There are payers, there are employers who
think there’s a lot of money to be had out there. There
is a lot of hospitals who think there’s not a lot of
money, you know. We have to put some reality around it,
you know, some real reality testing around it.

And then, of course, I have to agree, the work
on disparities reporting is so pivotal. We’ve invested a
lot of effort into it.

And, then, long-term, again, I hate to be
redundant, but public-private partnership. What’s so
interesting about health care is we have to have
competition and cooperation at the same time. The
organizations that sit around this table for the most
part are private-sector organizations, and so, that
partnership is pivotal. And you can hear that when you
go sit in a room and have plan sponsors, payers and
physicians and hospitals in a room together, we really
all have the same goals. We really do, in fact.

And, then, payment reform. which is a piece of
that.

MR. WROBLEWSKI: Kristin?

MS. MADISON: I will reiterate the HIT point is
just critical to make this whole process cheaper, better
quality, better risk-adjustment. Making the data
available at the point of care. There’s so many ways in
which I think that would help the process. I would also
push for more development of broader health care outcome
measures because I don’t think we have enough and I think
that it is possible to develop some more.

MR. WROBLEWSKI: Why don’t we start on this
end. Vince, do you want to go first?

DR. KERR: Oh, why not. I’m still awake right
now.

(Laughter.)

DR. KERR: I think there are two things that we
can do. Actually, the ideas have been fantastic. As I get older, usually my conclusion is if you wait long enough, you will hear the thing that you were going to say anyway.

So, two things that I didn’t hear. To support payment reform, one of the things we lack is data on how that should be done. So, what I would encourage short-term -- and it may be CMS -- to do a structured way of understanding what is most effective in terms of how you structure payment and do three or four different pilots and look at the behavior change in the marketplace. So, we need to have that information. That’s antecedent to your idea, which I like.

And, then, the second, which is also short-term -- I’m a very short-term thinker, I guess -- would be -- it’s on us, the insurance sector, to think through, like many other sectors in this country have, what are industry utilities versus what are -- I think you were saying this actually -- versus what are truly differentiators. We haven’t come to -- I mean, just imagine if Wal-Mart was a leader in getting to UPC coding, if everyone thought -- and it had great advantages for controlling inventory and, clearly, had a business advantage to doing it. But if everyone took a different tact at doing that, it would have failed.
So, they were willing to give up some of
business advantage to create something that actually
moved the entire industry forward and from which everyone
-- and what I typically see happening in our sector is we
haven’t decided where that line is. We really believe so
many things fit on the competitive differentiator’s side
and they really don’t.

MR. WROBLEWSKI: Irene, go ahead.

MS. FRASER: I think I’m going to say for long
and short-term, payment and payment. The reason I say
that is I think we’ve been trying, through a variety of
means, to kind of use measurements and data tail to wag
the dog. And competition, therefore, is part of that. I
think if the ultimate goal is quality, we’ve got to have
the payment piece in there because we’re sort of using
measurement and data to try to cajole people into
behaving against what is presently their interest. Until
the payment changes, that’s a real uphill battle.

In order for any payment change to affect
action, though, in a real way, it has to have a certain
market share. We don’t know quite what that market share
is, but it’s not small.

So, I think in the short-term I think what we
need are some demonstrations whether that be private
sector or Medicare. It’s most likely to be private
sector. In fact, there’s some with Prometheus going on right now and other gain-sharing experiments and so forth.

I think in the short-term we need that and we need evaluations of those efforts. It’s very hard for CMS to jump in on some of these kinds of demonstrations in a big way without having evidence on what works. So, in the short-term, we also need evidence on what works and that means systematic evaluations that cross payers and can’t be just CMS specific or private sector specific. Then, so, for the long-term, we need payment reform that’s based on that evidence.

MR. WROBLEWSKI: Thank you. Dr. Chumbley?

DR. CHUMBLEY: I think both in the short term and the long term it would be nice if government agencies made it a little easier for not-for-profit systems to work with independent physicians to create some accountable health system, accountable care systems so that we could do some of this reporting.

I guess in the long term just don’t make it any harder.

(Laughter.)

MR. WROBLEWSKI: Beth, go ahead.

DR. NASH: I’ll be very brief. I really like the education idea in the short term. I really do agree
that I don’t think doctors really get it and, so, I think there’s a huge opportunity there. Low-hanging fruit. And I think educating the public will go a long way as well.

And in the long term, I got to believe that there is a way to collect data at the physician level, even independent of information systems. The cardiac surgeons have been doing it for decades. So, I would like to see, again, a broad-based coalition of people coming together to try to figure out how to get physicians to collect that data. Of course, we have to deal with the episode of care issue, but I think it’s solvable.

MR. WROBLEWSKI: Okay, thank you. Paul, you had one last comment.

MR. GINSBURG: I just have one last thought. I certainly support all of the pleas for payment reform as a critical thing. I also heard the word “demonstration,” the word “pilots,” and I just wanted to give a reaction to that. The way we’ve done demonstrations, you know, with the way CMS has done it, they take years and we don’t learn that much. We don’t learn that much because you don’t expect providers to behave the same way in a demonstration, particularly when it takes investments, as they would when they know the policy has changed or the
payment system.

So, let’s get bolder and let’s -- maybe we’ll call them pilots, but pilot just means we’re going to do this and we know we’re going to change it. The most important changes in payments in our history have not been demonstrations, were not preceded by demonstrations. We just did them and we fixed them as we went on.

MR. WROBLEWSKI: Okay.

DR. KERR: Okay, regional roll-outs then.

(Laughter.)

MR. WROBLEWSKI: Okay. With that, it has been a great day. I appreciate all of your stamina for staying with us for eight hours. It is our objective to produce a white paper report that summarizes what we have discussed, as well as lays out the pros and cons of the likely effects. Thank you very much.

(Roundtable concluded.)
CERTIFICATION OF REPORTER

MATTER NUMBER: P083901

CASE TITLE: ROUNDTABLE ON THE COMPETITIVE SIGNIFICANCE OF HEALTHCARE PROVIDER QUALITY INFORMATION

DATE: OCTOBER 30, 2008

I HEREBY CERTIFY that the transcript contained herein is a full and accurate transcript of the notes taken by me at the hearing on the above cause before the FEDERAL TRADE COMMISSION to the best of my knowledge and belief.

DATED: NOVEMBER 18, 2008

______________________________
ROBIN BOGGESS

CERTIFICATION OF PROOFREADER

I HEREBY CERTIFY that I proofread the transcript for accuracy in spelling, hyphenation, punctuation and format.

______________________________
ELIZABETH M. FARRELL