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Health Journalism 2008 – Day 3
How Valid are Ratings of Doctors, Hospitals and Health Plans?
Association of Health Care Journalists
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TRUDY LIEBERMAN: I think we'll get started because this is late in the afternoon. And I don't know whether we've lost people to the cherry blossoms or the run or what.

But anyway, I'm Trudy Lieberman. And this is a panel on health care ratings, health care broadly defined. I want to give you a little bit of background about ratings and kind of how they came to be. And then I think you can understand the context of ratings and where they're headed and what our panelists have to say about them.

The panelists that I have assembled are people, for the most part, that I've worked with for a number of years. We have Peggy O'Kane from NCQA, Joe Martin from Pennsylvania Health Care Cost Containment Commission, Bob Berenson from the Urban Institute, and Dr. Richard Goldberg from Georgetown University. I have not worked with Dr. Goldberg, but I've worked with everybody else through the years on this ratings monster, because that's what it's turning into.

The ratings basically started with *Consumer Reports* in 1992. I think we were the first ones to rate health plans. And the way these ratings came about is that one of our statisticians and we met each other in a corridor one day and I said, "What do you think about rating HMOs?" He said, "I think that would be a great idea. Let me do a little preliminary testing to see if it's going to be possible." And he

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definitely found that it was going to be possible. So our first ratings project was born.

And after that, everybody else in the world decided they could start doing ratings, too. The government started putting money into it. And it just sort of burgeoned after that. So in some ways I consider myself the mother of all of this stuff. And so, as the mother of health care ratings, I think it's time to take a look and see exactly what all of this has meant for consumers and patients, whatever word you want to use. And that's the object of the panel today.

I just want to give you a couple of really interesting examples of what's happened to health care ratings and how many people are now in this market. Angie's List, any of you know about Angie's List? They rate all kinds of things, from plumbers to roofer and what have you. They have now decided that they're going to get into the game of rating all kinds of health care entities, because they believe that there is a huge market for this.

And this was a story on the Internet just in the last couple of days. And this woman from Deloitte Consulting is quoted, and she says, "It's a great extension of the consumer movement and more evidence of that in health care," said Linda Heitzman, Director of Life Science and Health Practice at Deloitte Consulting. "We are really making the shift from patient to consumer."

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Then, the latest issue of the *Washingtonian*, we have Top Doctors. Many of you are familiar with these kinds of ratings in most of the city magazines. They also decided that they could get into this ratings game after *Consumer Reports* came out with ratings in '92. And so we have all kinds of doctors being rated on all kinds of different criteria.

I want to share with you a couple of statistics that might be very interesting as you hear the panelists. We now have at least 220 rating schemes. I say at least because I don't think anyone is exactly sure how many are out there. There are 86 ratings of health plans, 81 ratings of hospitals, 26 different rating schemes for medical groups, 12 for individual physicians, 12 for nursing homes, two for home health agencies, one for dialysis providers and one for managed behavioral health. So you can see, and a lot of people see, that there's a whole lot of money to be made in ratings, or money, prestige, market share, whatever you want to use as your metric.

The reasons for ratings are really twofold, or at least that was the theoretical reason for ratings. One was to help patients, otherwise known as health care consumers now, to be good health care consumers. The second was to monitor the marketplace. And the theory was that if there was a bad doctor or a bad hospital or a bad HMO, the marketplace would win out. People would know that they're bad because they would see a

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rating. They would have information just the way they have information if they're going to buy a car, like the Edsel, if you remember that car. People didn't buy it after a while and it went away. So, what was going to happen in health care ratings is that people were just going to vote with their feet, as I've heard it explained so many times from people who are selling these ratings, that we're going to be able to have a wonderful marketplace and the bad apples, so to speak, would disappear. So the panel this afternoon is going to discuss and evaluate those two premises.

So, to begin, I would like to start with Peggy O'Kane from NCQA. And NCQA has now entered the rating space with its ratings of HMOs using HEDIS data. NCQA, they came out after us. So, Peggy, do you want to start?

MARGARET O'KANE, M.A.: Well, it took us a while to collect the data. My point is not going to be to say ratings are fabulous. I think that ratings have brought a lot of interesting side effects. I don't think the side effect that we were looking for has come, which is to make the market work, as Trudy was pointing out.

So, let me just start by introducing NCQA. We're a private, independent, non-profit quality organization. We were founded in 1990. Our mission is to improve the quality of health care. And we do that through measurement, transparency and accountability. And we have a multiple stakeholder board,

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one health plan, lots of famous public citizens and so forth, consumer organizations that work with us. We were I think best known for accreditation of health plans. Two thirds of the HMOs in the country are NCQA accredited. And we're also accrediting a large number of PPOs now. We also have programs for physicians that are completely voluntary. They're called physician recognition programs. And we have one for diabetes, one for heart and stroke care, one for back pain, and one that really assesses whether you have the kind of systems in your practice, you know, a 21st century information-based practice needs.

It's been a very interesting journey for me, because when I started in this field and there wasn't even a field when I started we kind of used to tell ourselves that we had the best quality in the world. Measurement was kind of something that you read about in the *New England Journal* or the *Journal of the American Medical Association* or more obscure journals. There really was no consensus about how to do it.

And so I think our launch of HEDIS as the first nationwide system of rating that was looking at both patient satisfaction and clinical performance was really a breakthrough. What I think this revealed was absolutely shocking to everybody, which was that there were tremendous performance gaps, and that quality was not at all what we had thought it was. And I think for a while people said, "Well,

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that's those HMOs. They're substandard care." But as we've kind of moved this out into the larger delivery system, I think we've found quality gaps enormously everywhere we look.

And I actually think that the kind of transparency that we've brought about through this kind of rating, and I agree that it's kind of a Tower of Babel out there, but I think that this is going to have a transformational effect on health care that we don't even begin to grasp. I sit on the board of the American Board of Medical Specialties, which is all the certifying boards for the different specialty areas for physicians. I also sit on the board of the National Board of Medical Examiners. And I can tell you that we have got their attention with these ratings. They are all in a period of soul searching about how can they do ratings that are actually relevant and that measure how effectively you perform your job, not whether you passed the test 20 or 30 years ago. So I think there are many, many side effects here that are positive. There are probably many others that are negative.

Our system is called HEDIS, the Health Effectiveness Data and Information Set. We measure high consensus areas of medial care: preventive services, treatment of common chronic conditions like diabetes, asthma, heart disease and so forth. And then we also use the standardized satisfaction survey called CAPS. And you probably saw, if you saw the *New York Times* today, that the government has published for the first

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time the hospital CAPS report, which is really I think a tremendous breakthrough, reporting on how patients perceive the quality of care and their experience in the hospital. So these are really good things.

You know, it was interesting to reflect back on the politics of what we did. We came along at a moment when the idea of the accountable health plan was really rising. And really, the Clinton plan came along just as we were starting to do our work. And that gave us a tremendous boost. I mean, the fact that nobody trusted health plans actually made our job a little bit easier, because the employers who were buying them really were demanding this. And there were no two ways about it. You really had to do it.

Now, that reporting, it's kind of a mixed story, because I think if you look at what's happened with health plans, the quality of what we measure has really gone up, and just enormously in many cases. So those plans that have been reporting to us, and they are not the whole market, obviously they've really improved the quality of care. But at the same time, I think that the market hasn't bought on quality. And so we have HMOs losing market share for many other complicated reasons as well, the fact that people hate them among the others.

So I think the idea that the market is going to work the way it works with cars I think is insane, actually. When I

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was in graduate school, I took health economics. And what they teach you in health economics in graduate school is that you have basically almost none of the conditions for a market in health care. And just having one of the conditions for a market, transparent information, as limited as it is today, doesn't get you where you need to go. You really need to take it and do things with it. And just throwing it out there and expecting consumers to use it appropriately when they actually have a choice, I think it doesn't really work.

On the other hand, I think it has raised consciousness about quality. As I said, the kind of official world of quality in health care, of physicians and hospitals, are all very much moving towards performance-based evaluation as opposed to whether you have certain processes in place. And so I think that's all to the good.

We have another phenomenon, which is pay for performance. I think, again, you know, I just wish we would stop looking for the silver bullet. But we seem to always look for the silver bullet in health care. Is pay for performance the answer? Well, I think pay for performance sends a signal, at least, that there are differences in quality. It does reward people who go to the effort of doing the right thing. But simply grafting pay for performance onto our current payment system is not going to transform everything overnight. So, there is actually fundamental payment reform that we need.

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And I think we need that coupled with a lot more information on how effectively different providers are performing. So, again, the glass is sort of half full, or maybe a quarter full, depending on how you look at it.

Another issue is what's the right unit to measure. You've read a lot in the papers about individual physician measurement. It turns out to be really very tricky business. If you've heard about Andrew Cuomo's actions in New York State, a number of the plans got in serious hot water with him. We actually a few years ago realized that as plans were moving into the business of rating physicians, somebody needed to be playing umpire. And we developed standards for plans that were doing it. These are voluntary standards, but they basically try to set the kind of rules for fair rating, like you don't just rate cost. You have to have adequate sample size. You should be using standardized measures where they exist and so forth. So we are actually playing an interesting role in New York State in the resolution of that whole how am I doing on time?

TRUDY LIEBERMAN: Three minutes.

MARGARET O'KANE, M.A.: Okay. So, I think, again, my message is that transparency really I think offers many, many opportunities, but we shouldn't think that we're going to be delivered from the complexity of health care by any kind of simple answer. So the question is not whether we measure, I

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think, going forward, it's how we do it. We want to make sure we do it fairly. We want to make sure we don't punish the providers that take care of, for example, poor people or people with less education. It turns out that the patient also has something to do with how well the performance measures go. If the patients are compliant, which highly educated people typically are more so, you will get better performance. So we have to be careful as we're doing these things not to punish those that are kind of already disadvantaged.

But I think as we go forward, we need to get to the right entity to measure. And it really needs to be something that's bigger than the individual doctor. That works in California, that works in Minnesota, where you have organized medical groups. It doesn't really work in other places.

Personally, I think this ought to be much more collaborative between plans and those providers that are willing to cooperate and put their data forward. I just think strategically if you've made an enemy of the doctors, you're really going to have a problem. So, that's my personal point of view, and I'm not speaking for NCQA.

You know, we ought to be measuring how well people keep populations healthy. And I think there are enormous challenges in that. But remember that the purpose of health care is health. I think there are also, among the rating schemes, one of the problems is that, for example, if you're rating the

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outcomes of bypass surgery and you have a lot of people who shouldn't have had the surgery in the first place because they were pretty much on the healthy end of coronary artery disease, you will have better outcomes. And yet the people aren't better off. So, this is a tremendously tricky business, and we need to be very thoughtful as we roll it forward.

Thank you very much for your attention.

JOE MARTIN: Good afternoon. I'm Joe Martin. I'm with the Pennsylvania Health Care Cost Containment Council. I've been with PHC4 for almost 18 years. So I've seen it go through all the various generations of methodology in reporting that have gone on there. We're an independent state agency, which means we're not under the jurisdiction of the governor or the general assembly, which is very important, although we do go through the same state appropriation process for our budget as every other state agency does.

When I say we're independent, we are run by a board of 24 people. These are appointed volunteers that represent various constituencies in the health care community in one form or another. These positions are dictated in the statute under which we operate. And 12 of those 24 come from the business community or organized labor. And so there was an intention, when the law was established, to stack the board in favor of those who purchased health care benefits on behalf of lots of other people. There are doctors on the board and

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hospitals, and the representatives of other agencies that deal with health care. I don't want to go into all the numbers there.

But suffice it to say that that coalition of business and labor has been crucial for us being able to do what we do in Pennsylvania. And we get calls all the time from other states, asking us, "How do we do it? How do you kind of keep the providers at bay and keep the providers from weakening what you're doing? How did you get that law passed at all?" stems back to that unique coalition of business and labor. And anyone familiar with labor management history in Pennsylvania would know that that is quite a unique situation, for those two groups to be speaking with one voice on this particular issue.

We're a soft regulatory agency. We can't tell hospitals or doctors or insurance companies what to do, how to practice or anything like that. The only thing we can tell them to do is to submit data. That's what they have to do under the law. If they don't, they can be fined up to \$10,000 a day for every day that they are not compliant with the law. We have never had to use that penalty. They could also face five years in jail under criminal penalties in the state. We have never put a CEO of a hospital in jail in Pennsylvania. But those are the penalties that we can kind of hang over people's heads. Usually it takes one letter from our attorney and people come around. And most people are usually not

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compliant for things like a key person in a small hospital went out on maternity leave and they weren't able to replace them, and those kinds of things. So we have pretty good compliance with our law in Pennsylvania. It's gotten better over the years.

That is changing a little bit because of the proliferation of small outpatient facilities, where you have kind of almost mom and pop shops being operated, and particularly where physicians don't feel that it's appropriate for them to comply with the state law. So that's one area that we're struggling with a little bit.

We publish a lot of reports for the public. They're free. A hospital performance report, which looks at mortality rates, complication rates, readmission rates, lengths of stay, all risk-adjusted information I'll get to that in a moment as well as the average charge for the hospital stay for 50 different surgical and medical categories. We publish a guide to commercial HMOs in the state, and one for Medicare HMOs as well. We publish a report on coronary artery bypass surgery.

We were the first state to publish a report on physician performance. And I say we were the first state to do it proactively. And some of you may know that New York did it a year before that. We don't quite recognize that in our own internal dialogue, because they only published it because David Zinman from *Newsday* sued them under the Freedom of Information

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Act in New York and forced the health department in New York to release those ratings.

So we do it as a matter of mission. We've been doing that since 1992. We were the first state to publish a hospital-specific hospital-acquired infection law as well. So those are some of the flagship reports. We also publish a lot of financial data about hospitals and outpatient surgery centers.

Let me come back to the methods for a minute, because that I think underpins a lot of what we're talking about here today. Almost all of our data as it related to quality and patient outcomes are severity-adjusted or risk-adjusted. We use a fairly complicated system, which requires hospitals to collect patient-level clinical data from the medical charts. It's all confidential. That information is essentially designed to identify abhorrent key clinical findings. Those are lab results, EKG, pathology, potentially hundreds of those types of things, blood pressure readings.

That all gets rolled up mathematically, so that each patient in the end is assigned a severity of illness score from 0 to 4. If you have a 0, you're not that sick. If you have a 4, you're almost dead. And that is all based on these data collected at the time of admission to the hospital. So you have a benchmark. How sick was the patient, and what were their key risk factors at play, age, gender, other things,

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diabetes when they were admitted to the hospital? So then you can measure what happened to them after they were admitted to the hospital.

And then we look at, given the illness of the patient when they were admitted, how many deaths can you expect hospital A to have in a treatment of heart attack compared to hospital B. And because you have risk adjusted all this data, you've put all the hospitals on an apples to apples basis. You've equalized risk across all hospitals. So it's as if they are all treating the same kind of patient. That enables us to avoid unfairly categorizing or criticizing hospitals that legitimately are treating a larger proportion of sicker patients. They get extra credit in our system, similar to a diving competition where a diver gets extra credit for attempting more difficult dives. That's how our system works.

And almost all of the outcomes data is adjusted for that, with one exception, hospital acquired infection rates. Our board has taken the position that with some exceptions, the issue of risk adjustment is not appropriate when you are trying to determine the rates of hospital-acquired infections. And the scientific evidence on this is slim on both sides. Providers will argue that you are at more risk to get a hospital-acquired infection if you have diabetes or you're obese or if you have cancer or if you have immunity compromised situations. That's often true. But that doesn't mean that

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patients who are getting hospital-acquired infections because people didn't wash their hands or because pneumonia patients weren't elevated or walked, or because catheters were dropped on the floor and immediately put back into use. It doesn't matter whether you're obese. It doesn't matter whether you have diabetes.

All of those things are true. But we have seen some studies that look at diabetes patients. And you see that, yes, patients that are older and sicker get more hospital-acquired infections than patients that are younger and healthier. But patients who are older and sicker and diabetics, over here, in this bucket, don't necessarily get more hospital-acquired infections than diabetes patients who are older and sicker over in this bucket. It is not correlated. So that is the one exception. And we have quite an argument going with at least some of the providers in Pennsylvania and nationally about this issue of risk adjustment as it relates to infections. We think infections are an equal-opportunity afflicter.

Users, I'll just talk about that briefly. And it comes to the issue of market impact a little bit. We have a lot of people who use our data in Pennsylvania. Mack Truck, for example, every time we release one of the coronary reports, they send 7,000 copies out to all of their employees. People use them in negotiations. They use them for a lot of different reasons. The state of Pennsylvania announced recently this was

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national news that they were going to stop paying for medical mistakes in the state's Medicaid program. And my guess is the state employees benefit program will not be far behind on that, as soon as they work out the politics, probably with the contracts and the union and so forth, although I know there is no philosophical disagreement with that from the unions in Pennsylvania that represent state employees.

A lot of our data was used in the construction of that program of not paying for medical mistakes, particularly our data on what are called, interestingly in medical jargon, medical misadventures. It reminds me of kind of *Gilligan's Island*. You go off on a three hour tour, you have a little misadventure, and then you get saved. That refers to a doctor leaving a glove in the patient and forgetting to retrieve it, or a lot of little needles that get left behind, or what are called accidental punctures and lacerations, as opposed to intentional ones, I suppose. But there are thousands of these that occur all the time that are just kind of considered to be part of the game. They are just part of the practice of medicine. This is part of what happens. And those are a lot of the things, including now some infections are being worked into that, that the state of Pennsylvania is going to refuse to pay for anymore. And we're seeing that on the federal level as well now as Medicare is starting to move in that direction, which is a good thing.

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Some of the impact of what we're doing when we started to issue the hospital performance reports about 12 years ago, the overall inpatient mortality rates in the state of Pennsylvania were significantly higher than national figures. Today, they are statistically significantly lower than national figures. We don't think our activities are the only reason for that, but that's what different in Pennsylvania, its aggressive public reporting process. On coronary bypass surgery, the rates are down 51-percent over the life of the bypass-reporting project, which began in 1992.

Now, some physicians will argue that bypass mortality rates are down everywhere, and that's true. But there are studies that have been done, notably by Hannon, Ed Hannon out of New York, which also has done very aggressive work on this, that show that the rates are down everywhere but they are down much more aggressively in states that have public reporting programs like New York, New Jersey and Pennsylvania, or have private activity but it is very aggressive quality-improvement activity, like the Northern New England Heart Consortium. So there's a big difference there that can be measured.

Judy Hibbard, and this doesn't relate to Pennsylvania, but Judy Hibbard out of the University of Oregon has studied this issue in Wisconsin hospitals. And the evidence there is clear that hospitals that are part of a public reporting process do conduct enormously more

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aggressive quality improvement activities internally, devote a lot more resources to them, a lot more executive leadership than hospitals in the second group, which get private reporting back, and certainly more than hospitals in the third group that get no reporting back at all.

Just a little bit on the market issue and I'll wrap up. We also started with the premise that people would vote with their feet at some point. It's not really clear that that's happening. I still think there are enormous barriers to overcome for consumers before that will occur, and for purchasers. Purchasers are beholden to the third party insurers that stand between them and providers, and are usually not able to move those insurers in an aggressive direction, because many insurers do not really consider purchasers, businesses or labor unions, as their primary customers. They consider hospitals and doctors as their primary customers.

And consumers, I can tell you from personal experience I'm pretty well informed, I'm very aggressive and it is very difficult to sit in a doctor's office and confront them about their own statistics, especially when you're dealing with a difficult health situation of your own. Have a person with you is my - and I'll just stop with that. We can talk a little bit more about the politics in Pennsylvania I think if you'd like, which are interesting.

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TRUDY LIEBERMAN: Okay. We've heard from two organizations that produce ratings and evaluations. The third panelist is Dr. Goldberg from Georgetown. And he's going to speak in the capacity of a doctor and a hospital, someone who is rated. And we will get the point of view of somebody who is a recipient of the ratings and how they believe these things are being conducted.

RICHARD GOLDBERG, M.D.: I guess I'm here as the victim, the man in the trenches. Just to tell you a little bit about myself, I'm the Vice-President of Medical Affairs at Georgetown University Hospital. Prior to taking that role, I was the chair of the Department of Psychiatry. But all of my professional career, I've been involved in work with various medical specialties, and certainly in the administrative position of vice-president of Medical Affairs that's the case.

My journey in medicine began about 35 years ago. And I was thinking about this as I came to the panel. At that time, there were no computers. There were no CT scans, PET scans. There were no automated labs. And there were no managed care companies. It was a completely different landscape in terms of the field of medicine.

And I think that things have changed, changed for the better. Technological advances have produced a plethora of data. That data has been able to be analyzed, studied very

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carefully and produce a great deal of evidence-based medicine. And based on evidence-based medicine, the result is standards of care that can be measured now. And I think the result of that is really an increase in the quality and safety that patients receive in hospitals and from their physicians.

I think that the reporting of quality data is something that is exceedingly important. The transparency that's occurred to the public, to hospitals, to physicians really acts synergistically. It's helped hospitals a great deal in having an added reason for following measures that have to do with quality and safety, and potentially really offers the consumer of care a great deal of opportunity to no longer be a patient, to be just that patient in waiting, but really to be an active collaborator in their medical care, both in the choice of it and their collaboration with their health care providers.

There are two types of quality data, boiling it down in my mind. One is processed data. These are data that are put together to evaluate processes, such as are we administering the right medication in the right time to a patient for a particular disorder. And, as some of our panelists have mentioned, there are outcome data. And this data really demonstrates what's the outcome of a particular procedure for a particular disease for patients. And I think

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this is important to keep in mind.

I think that even the best of rating scales have their nuances to them. The nuances are the devil in the detail, if you will, in the interpretation of data. I think there are a few things worth keeping in mind as journalists as you all interpret reports of quality on websites and the rest. One is what is the currency of the data? Frequently, data that's up on various websites are not current data. They are not real time. And hospitals are used to, as well as physicians, moving rapidly in a health care climate. And usually, by the time data has gone up on a website, hospitals have responded by putting into action their own performance-improvement plans. So I think it's very wise that when you view this data, if you have questions about particular hospitals and so forth, to actually inquire with the hospitals/providers themselves, to see what they have done in responding to the data that's up there, what improvements have been put into place and what their current data might be.

Another thing to keep in mind is that evidence-based medicine, which is the basis of these standards of care, which is the basis of the data, also is an evolving field. And evidence-based medicine changes. I give you an example. In the criteria for measuring the successfulness of giving an antibiotic to a patient with community-acquired pneumonia

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when they come into the emergency department the former standard was that that had to be delivered within four hours of time. That's now been expanded to six hours of time. So, hospitals which months ago may have seemed as if they were not responding well to this particular criteria now may be doing well within the confines of the six hours. So, keep in mind evidence-based medicine changes.

Also, from looking at scores in discrete quality categories of care for particular treatment issues, like acute myocardial infarction or congestive heart failure or other areas that are cited in some of the best work of core measures, et cetera, I think it's important to keep in mind that you can't draw conclusions about an institution's overall quality from its performance in specific categories. Also, it's very difficult to compare hospital A and hospital B within particular categories, because any difference in score, it's hard to determine what difference does that actually make in the quality of care rendered patients. Is it really a significant difference, a significant difference in quality?

And also, as Joe has mentioned and his work has done fine work in this area it's very important when looking at outcome data to be knowledgeable about how that outcome is adjusted. Is it adjusted well for severity of illness? Is it adjusted for other factors that are important? So that

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you know that you are comparing apples and oranges.

I think finally I'd say that comparing scores across reporting systems is a very difficult thing to do. So comparing, for example, CMS core measures and trying to compare it with *US News & World Report's* rating of hospitals, or HealthGrades' ratings, et cetera, is a very difficult thing to do, because often these reporting systems use different methodology in terms of analyzing their data and obtaining their data. And in some cases, they refuse to actually publish what their methodology is, claiming it's proprietary. So it's a very tricky thing to do that.

Let me just turn very briefly to how useful and how effective in my mind are these report cards to a variety of folks. Hospitals I believe really get these measures. Most hospitals are not only measuring core measures, if you will, that are common in some of the rating scales, but will rate a host of measures. Georgetown will rate over 90 measures in quarterly periods to see what our performance is. They understand that this is important for measuring quality and safety and putting into place a culture of quality and safety in their hospitals.

They also get that there are extreme penalties for not doing well in some of these rating systems. One is in the area of accreditation by JCAHO and other organizations. And the other is the financial implications in soon to be pay

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for performance. So I think hospitals really understand as entities the importance of rating scales to the public and to themselves.

Physicians, I think it's another matter. Physicians are, I have found, natural challengers of data. They hone in like a missile on flaws in data and will argue endlessly about the significance of data. Also, I think for physicians, pay for performance has a less imminent subjective, anxiety-provoking fact than it does for hospitals. Physicians are also certified by specialty boards. And these specialty boards, although they're changing, these specialty boards really evaluate physicians on knowledge and skills, and do not now currently evaluate people on terms of quality and safety.

And, finally, one of the things that is a complete abhorrence to physicians are sort of the Zagat-type rating scales that are up there, where anonymous people can go to a rating scale and give a rating just like they would to a restaurant. And who knows who's rating you, and rating you on access and communication and the like? And physicians hone in on the bias of that sample extremely well.

Consumers, I believe at this particular point in time, consumers still seek their medical providers by word of mouth recommendation by the location of their providers, by the convenience of the care that their providers offer. I

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believe that more and more consumers are accessing report card systems online, and more and more are not understanding what they access. It's sometimes very, very difficult for consumers to understand this. And the whole process, even though there are a plethora of these rating scales, is still a work in progress.

I just want to mention that there are possible unintended consequences of rating scales. Just like with any other standards of measure which create rules for games, there's the possibility of gaming. There's a possibility of providers excluding from care more severely ill patients to demonstrate better outcomes. There's the possibility of hiding data, because you know it's going to be reported. There's the possibility of trying to target process measures by giving medications broadly to people, or vaccinations broadly to people who ought not receive it, but you can still hit your targets very well.

So, despite the caveats and nuances I've mentioned, I do think the transparency of public quality reporting has a very important influence on safety and quality, and I think down the line will indeed lead to an enhanced consumerism on the part of patients in the future. And it's important to remember the whole process, even though it's been around for a decade, is still indeed a work in progress. But I do believe the old dictum stands, that if you measure it, it

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will improve.

ROBERT BERENSON, M.D.: Thank you. Also a brief background about myself: I practiced medicine for 20 years, internal medicine in Washington, DC, and made a couple of those *Washingtonian*-type best doctors, for whatever that's worth. I don't think a lot. But I was a decent doc. But in recent years, I've become a policy person. I worked at CMS for three years as a senior political appointee, and for the last years I've been sort of more of a policy wonk at the Urban Institute.

And I guess what I'm going to say on this topic you'll see that I, well, normally I would use the word schizophrenic, but I have a psychiatrist sitting next to me, so I'll say ambivalent is the way I feel about this topic. And I'll go back and forth between being a policy wonk and being sort of remembering what it was when I was a physician and reacting to some of what's going on here.

But first I'm going to start, because it just came up again. Almost every couple of months I will be at a policy discussion and will hear about Bill Clinton and measures. Bill Clinton, according to a lot of people out there, did not go to the report card that said where he should not have gone to have his heart bypass. And, in fact, Alain Enthoven wrote about this in the Health Affairs article, and others have commented on it. And at least some people think that because

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Columbia Presbyterian, by New York State's very good standards, risk-adjusted mortality, three years previously had been statistically significant outlier in mortality rates, although that was representative of about a 1-percent deviation in mortality, that he sort of blew it by not doing that.

And I guess my reaction has always been if there was a fault, it wasn't there, that your cardiologist is telling you that you've got a life-threatening illness. He's recommending an urgent transfer to a facility well known, one of the best known facilities in the country to have heart surgery. It seems to me you don't start pulling out the book and looking at mortality measures. If there's a fault I'm not sure there was a fault, but if there's a fault, it's the cardiologist who was referring him there.

So, just a couple of points on that one, which is, in fact I agree with what Joe said earlier, that these measurements, when done well, have a positive impact. But the impact may be more on the supply side, on the providers, on the administrators and chiefs of service within the hospital who say, "Why aren't we getting a good result here compared to our peers?" and getting improvement there, and not expecting this information, in most cases, to be used to promote sort of a consumer choice, turn patients into consumers and have them be robust readers of report cards.

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I still remember a statement made by David Lansky, who used to head something called the Foundation for Accountability and has just recently been named as the new president of the Pacific Business Group on Health. But in his former life, that organization really tried to understand what patients and consumers wanted in terms of health care. And referenced specifically to measures based on some focus groups they did, he said at a conference, "Patients don't want that information to change their doctors. They want their doctors to do better."

And I think that's a significant thing to keep in mind about the role of all of this stuff. Which doesn't mean that in some circumstances, I mean, when you've got a purely elective procedure or a recent diagnosis, a new diagnosis of cancer, if there were objective information about where to go, or more importantly who to ask about where to go, that would be very useful. So, multiple purposes for this information, and in my own view and I'm going to get back to this in a second the more important one may not be to move to a consumer-directed choice system, but rather to, as we just heard here, the hospital itself uses the information to try to improve itself.

Now I'll wear my physician hat. And I actually agree with Dr. Goldberg. I was going to make a very similar point. The fact that it seems to be robustly working and important

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in hospitals doesn't mean you can simply say, "Okay, now we're going to roll it out and roll it over doctors."

Hospitals are organizations. They have particular purposes in life, to take care of specific illnesses, generally. Physicians are professionals. We typically do not rate professional activities. We do a similar kind of silliness with lawyers. Last week in my insert in the *Washington Post*, I got a list of the best lawyers in town. It's all sort of reputational and I'm not sure how useful it is. I know where I can go spend a lot of money if I wanted to get a lawyer.

It is very hard, I would submit and I am wearing a little defensively a physician hat right now to objectively measure what physicians do. Now, it varies somewhat by specialty. But I jotted down sort of different domains or different attributes that I think a good primary care doc should have. And I'm sure I'm missing some, but, you know, we have a time problems. Skills in diagnosing a range of conditions, bedside manner I think that's still the best term for what we're talking about. I think people know what that is, but that should include some compassion. A professional commitment to act in the best interest of the patient a lot of docs aren't doing that. They're sort of in bed with pharma or things like that. But that's a professional attribute.

And I distinguish that from this other one, because I

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wasn't always very good at this other one, which is being a very strong advocate for a patient in crisis, a patient in trouble who need help, making sure they're getting to the right care immediately and you are there for the patient no matter what time of day or night. Aid in navigating a very complicated health care system, clinical management skills especially the challenge increasingly now is for patients with multiple chronic conditions, patients with six or eight or 10 chronic conditions who probably have 10 or 12 medications, are seeing six or eight different physicians. That's a management challenge. It doesn't matter what you learned in medical school or what you know about treating a disease. It's a specific set of skills.

And then population and preventive health, being able to make sure the population of patients you're caring for are getting the preventive care they need, et cetera, surveillance kinds of activities. And I'd say finally, and this has now been included in official definitions of professionalism is parsimonious use of health resources, not overdoing it with the resources. That's also a skill I think we should value.

It is very hard, I would argue, to measure at least some of those activities. Now, I think what's most important actually is the patient evaluation. That's what we should get, and I think the CAPS kind of activity, the consumer

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assessment one, is the most important. But when I say now that I react a little defensively, you know, there are now measures CMS now has a set of physician performance measures. And I looked at the ones for internal medicine. And so there were sort of three conditions represented, and I think one for each one of those of things that I should be doing on which I would be submitting data and ultimately being measured.

Now, first of all, there's some recent data from MedPAC, the advisory commission to Congress that said that on average an internist 82, I think it was, 82 conditions makes up 80-percent of what an internist sees. And now we have three measures, three conditions, and one measure for three conditions, one of which was whether you do an EKG for a patient with chest pain. And if anything a doctor doesn't need to be told and to be measured at, it's doing unnecessary EKGs for patients with chest pain, it's the need for having quality controls in what we're rolling out here.

But the point is, it is inevitable and I'm not even practicing; I'm more than a decade away for physicians to act defensively about, "You're going to measure my performance on this tiny little snapshot of activity?" Again, I think it's more difficult than with hospitals. And Dr. Goldberg said even there, you can't take a couple of conditions and assume that that's how the hospital is going to be doing on other

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conditions.

For physicians, these various domains of activity, some measurable, some not measurable at all I would argue, there's inevitably going to be a problem of you're under the streetlight you've lost the keys in the bushes, but you're under the streetlight looking there because that's what you can measure. It doesn't mean we shouldn't do it. I'm just saying we have to be a little cautious about what we think we're getting in terms of the validity of what we are looking for.

So, let me finish with just, since I'll now wear my policy wonk hat, I have two concerns about measurement. And I think the work in Pennsylvania is great. I think what NCQA is doing is exactly right. I have two concerns. One is that the limitations are ignored, and we use the whole sort of concept of transparency and measurement to endorse a vision of health care which is around consumer-directed care, which is unwarranted and won't work. In other words, we understand there are limits to the use of these measurements, but we're going to pretend that we have robust information for consumers to make choices in a consumer-directed world. And so I think that some people use it as a smokescreen for pushing a political agenda.

And I'll tell a brief story here. A few years ago I was at an AARP-sponsored event on long-term care in Japan. I

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don't know why I went to a meeting on long-term care in Japan. But the American expert on nursing homes in Japan, a Professor Campbell, was recounting sort of what they're doing in nursing homes, and basically made the point that they're not measuring quality in those nursing homes. And this was just at the time that CMS was doing nursing home compare, and had identified I think nine things like the presence of decubitus ulcers, falls out of bed, things that shouldn't happen. And he said, "They're not doing that in Japan." And the audience sort of gasped, like, "My god, they're not measuring?"

Well, he then sort of was taken aback. He said, "Why are you all gasping?" He then sort of got it and said, "It's because in Japan they have such a reverence for old folks that they have nurse's aides or the equivalent of nurse's aides. They pay them three times as much as we do here. They would not ever allow a patient to have a decubitus ulcer." In other words, it's a different policy approach. It wasn't based on measure. Maybe they should be measuring. Maybe there are a few hospitals that don't do well. They have taken a different policy choice. They're paying a lot of money to a certain segment of health care workers, and that's a different way to get good nursing home care.

And so I think we sometimes ignore the opportunity. And that's the second and final point I want to make.

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There's this sort of opportunity cost problem, which is that everybody is going to meetings all over the country. Peggy and I were at one a couple of weeks ago. I was stunned by how many people were there. It was a pay for performance meeting hundreds of people working really hard, conscientiously. I applaud what they are doing, to try to figure out how to reward doctors with an extra 2-percent of what we would like doctors to be doing. And when there are meetings about how we pay doctors that 100-percent, nobody shows up.

We have a basic crisis in this country. We're not going to have any primary care doctors in about five to 10 years. We have a payment system that is wildly tilted in favor of procedures and tests and not for spending time with patients. I could go on and on about that. And we are sort of, I think, fiddling with some of this stuff. Again, I'm glad it's happening. And that's why I'm ambivalent. I'm glad it's happening. But I think actually, let me ask. How many meetings did you go to here about the disappearing primary care workforce? Were there any? Oh, okay, that's good. I'm glad there is.

My point is only that one, which is that this is important stuff. But I think if misused sort of obscures lots of other important stuff. And I think measurement is tough. I think there are other ways to get quality

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improvement. Some of it includes measure.

And let me finish with this one. It is often said that you can't improve what you don't measure. I don't agree with that. I think you can improve a lot of things that you don't necessarily measure. I think there's plenty of opportunity to improve our health care system. Measurement is one of many tools that we should be using.

TRUDY LIEBERMAN: That was a very provocative presentation from all of our panelists. And Bob wanted to have the last word, so that we could use his remarks as a basis for asking questions. So, why don't we queue up at the microphone? And our panelists will take questions and maybe even have a discussion among themselves.

ANN WLAZELEK: My name is Ann Wlazelek, and I work for *The Morning Call* newspaper in Allentown, Pennsylvania. Hello, Joseph. I deal with him a lot on stories.

I wondered if some of you touched on the fact that there are different ways to measure by different groups. How is the public supposed to interpret all of that? How do we get to maybe a single standard? Is that the game plan?

MARGARET O'KANE, M.A.: Well, when NCQA was started in 1990, it was because health plans were going crazy with all the different measures that were being thrown at them. There seems to be no way to stop this. I mean, there are just a lot of entrepreneurs out there. There are people who

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think, "Well, my people are different, and your measures are fine for whatever, but not for my people." There are consultants that make more money by having more complicated measurement and so forth. It's really one of the fundamental problems that we have. And for the poor doctor and hospital that are trying to deal with all of these different things, especially when they're measuring the same thing 12 different ways, it's pretty much insane.

There is a group called the National Quality Forum that is trying to become an endorser of measures. I think, you know, there's limited I don't think anybody will ever stop people from doing this. But I think at least within the sort of house of medicine and the more official organizations, there is a feeling that we need to cooperate. And there is a committee that I co-chair with Don Berwick, who runs a thing called the Institute for Health Care Improvement that has all of the major the medical boards, the Joint Commission, many of the major quality organizations on it. And I think we're all expecting to hold each other to some kind of order, to try to create some coherence. But that doesn't mean that there won't be Angie's Lists springing up and everybody else. But it's a real problem.

JOE MARTIN: I agree. I think it's confusing. And I'm not sure what you can do about it, since the market it going to operate the way it's going to operate. And I know

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in our case, we're concerned about national standards, because in our view, what often happens is you regress to the least common denominator. And so states that are out there pushing the envelope, at least the attempt is to try to force them backwards politically.

And there's a lot of resistance in our organization to that. We don't disagree with what other people are doing. We think, you know, you get as far as you can get. In some states, politically all you can get is volume-based data, like the Leapfrog data. We have no quarrel with the Leapfrog data. We think if that's all you can get, then that's better than what you didn't have before. And there are certain circumstances where volume is really the critical issue. There isn't a lot of mortality. There aren't a lot of other types of quality things.

So that's our concern. That's where our kind of radar goes up, when we start talking about uniform standards and how can we live with different results in Ohio than in Pennsylvania. Well, Pennsylvania residents don't care how hospitals are rated in Ohio. They care about what's happening where they go. So I'm not sure what we can do about all these different groups, but we do have concerns about this, the national activity.

RICHARD GOLDBERG, M.D.: Yeah. I think it's very difficult to get hands around, because these private, if you

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will, rating systems are big business. They make money from the number of hits on their websites, just like popular websites do. They frequently have proprietary methodology, which they don't disclose. And if a hospital does well on their rating system and the hospital wants to bear this as part of their banner, they're charged huge fees to do that. It seems like there's some conflict of interest in that. So I think there's money in this, and when there's money in it, I think it will augment.

ROBERT BERENSON, M.D.: I would just say I spent some time doing interviews around the country for an organization called the Center for Studying Health System Change, and interviewed hospital chief medical officers and all. And I would just share Dr. Goldberg's most recent remarks about the concern about the private ratings systems, which have black boxes, that are asking the hospitals to sort of pay in. And they give different findings. There's a problem there. I'm much happier with, as difficult as it is, the Pennsylvania/New York kind of public domain, where you can kick the tires and see what they're doing, or CMS, you can kick the tires and see what they're doing. I have a real problem with these private black box approaches.

LOLA BUTCHER: Lola Butcher, freelance. I'm interested in the observations that hospital executives are pretty much on board with measurement. They see it as their

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self-interest. But physicians are much more skeptical, both of the things that are being measured and even the propriety of being measured in this way. Could any of you, but particularly the two physicians speak about what that means for hospital-physician relations when the hospital measures are dependent on some cases on what the physician does or documents.

And also, as hospitals really put a lot of energy into both improving and getting their processes down, what's to keep hospitals from getting their processes down, double-checking, making sure all the data, the documentation and everything is right, so that eventually they're all 100-percent, because there's a person whose job it is to make sure that all the scores are-

RICHARD GOLDBERG, M.D.: Yes. It depends on how the hospital is structured. I think it's much more difficult in community hospitals that rely on voluntary staff and that may not have electronic medical records, to get compliance from their staff to fulfill the data reporting that's necessary for coming out and scoring well on some of these things. And it's easier for some university hospitals in some respects, easier in this way, that these are employed physicians, and often they move a little bit more in alignment with the hospital's goals, although university physicians are usually professors and philosopher kings and able to point out also

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to errors in data and standards. So you have a downside there as well.

You're exactly right, that this is enormously costly for hospitals. And essentially down the line that cost will be passed on to probably the consumer in some ways. Quality and safety initiatives, gathering quality and safety data is a very costly, resource-rich enterprise. Frequently, to change a culture you have to drive it through what I call the eye of the needle, the gatekeeper who actually owns a particular process and monitors it and checks it and adjusts it, rather than driving it through hundreds of people. So it's a very, very costly affair for hospitals.

ROBERT BERENSON, M.D.: Yeah, just a couple of observations also about four years ago now, I guess it was, that I was in a debate, taking the pro side of should we have pay for performance in the health system. And in particular, we were focusing on hospitals. I said, "Yes, we should." And the person taking the con was Bruce Vladeck, the former CMS administrator. And he actually raised a couple of very interesting arguments, which I think still have to be discussed, such that I remain ambivalent about all of this.

And that was that depending on how you would measure and reward, but in particular reward, you might be promoting or exacerbating tiering of hospitals, that hospitals who already are pretty well heeled have positive margins, a fair

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amount of money, are in a better position to invest in the infrastructure, the technology, the computer systems, having people to call the doctor saying, "You have to come in and sign your note or order the thing" I mean, that's a lot of what goes on and that this poor hospital that's serving an inner-city population won't be able to do it.

And then, lo and behold, I went on site visits again with a health system change, and went to a hospital in an inner city I can't be too specific about this because of confidentiality in which they were responding to the CMS measures with a nurse in the basement with a stack of charts. And then I went 27 minutes to a very rich suburb, where they had a team of 10 or 12 people responding to the CMS measures, and saw the potential for exacerbating tiering. That gets into, then, design on how these things can happen. Should you reward improvement, perhaps, and maybe not have everybody in the same standard? It's of issue just in terms of evaluating performance. Are the rich going to get richer and poor get poorer?

Having said all of that, I also learned on those interviews that the hospital staff was pretty positive about what it does to the hospital culture. They basically said, "This gives us an opportunity to show data to doctors." And one thing doctors will react to as data. I mean, as Richie Goldberg said, they may try to poke holes in it, but if it

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holds up, they will respond to it. They say, "Even if the first few measures out of the box may not be the most important, it sets a culture change, that we are not reviewing data, that doctors, data can be reviewed, that we have a quality improvement environment around here."

And so I think in general that it has been a pretty positive response, the CMS measures, in that sense. The issue of physicians themselves, you and I could talk afterwards about that one.

MARGARET O'KANE, M.A.: This issue about the expense of doing this I think Bob is absolutely right that the poorest hospitals are in no way equipped to do this. And you do worry about further increasing the disparities among these providers.

But I think we have to also realize that poor quality brings its own costs. And while we're going through an awkward period right now of additional costs for measurement and so on, ultimately, if people can really reengineer their processes so that everybody knows what their job is and I've seen this in some of the best hospitals it's absolutely transformational. You know, nurses wind up having really completely different jobs. They're not where the buck stops all the time because processes are organized, aides know what they're supposed to be doing and so on.

I think the problem that this does bring up, though, is that often this saves money for the payers, but then the

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hospitals lose money because they've created more efficiency. So, again, it goes to this inadequate payment system that we have and the need to kind of look at it again.

JAMES GUTMAN: Hi. I'm Jim Gutman of Atlantic Information Services. One of our subscription newsletters is Health Plan Week. And I have a question for Peggy O'Kane based on what I've seen through that. And that is, it seems like health plan performance depends in large part on the characteristics of the areas where the health plans operate. And maybe one reason that Massachusetts health plans fare so well in these absolute ratings is more of a function of what buyers are demanding, what the providers are capable of doing, than the characteristics of the plans themselves.

MARGARET O'KANE, M.A.: Yeah. It's a great question.

JAMES GUTMAN: And how do you adjust in that when you're trying to do an-

MARGARET O'KANE, M.A.: Well, we don't adjust for it. We recognize, though, that how plans do is a reflection of both what the plan is doing and who they're dealing with at the delivery system level. New England, obviously, is way ahead of everybody on quality. But we've had cooperative ventures in New England for I'd say 15 years around quality, where all the plans got aligned on their quality measurement, and the providers actually got aligned, too. And they've formed groups, because of accidents of history, of Harvard Community

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Health Plan up there and so forth.

So, you're right. But I think they are basically competing within their markets. It probably is somewhat unfair to compare a plan in Mississippi with a plan in Boston, because we have chronically poor performance in Mississippi, for example.

But we also see that there are really exceptions in each region, too. So you may have a region that's very mediocre, and one plan will really stand out. So the plans can do quite a bit, going directly to patients with chronic illnesses with reminders about preventive services and so forth. They can do quite a bit, and also by rewarding at the delivery system level.

So it's a great question. But you're right. It depends on what you're dealing with.

ROBERT BERENSON, M.D.: I was just going to say that the Urban Institute and NCQA have teamed up to try to sort this out. We actually have a research project to try to figure out to what extent to geographic variations are plan responsibility and how much represents the underlying performance of the providers in the market. And it's not easy research. But we understand the importance of that question and we're trying to do it.

JULIUS KARASH: Julius Karash, Kansas City Star.

There's been some controversy in recent years on managed care

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companies, such as United Health Care, rating doctors on cost and efficiency. Do you feel like there's a conflict of interest there?

MARGARET O'KANE, M.A.: Well, I think they've gotten a very strong signal back in a number of cases. I mean, there have been debacles in St. Louis and North Carolina, latest in New York. I mean, I think they hear I just talked to somebody from there, and I think they're getting it. I don't agree with the strategy, so what can I say? They have learned, they are saying they're going to do it differently. They're planning to go through out Physician and Hospital Quality Standards Review and so forth.

But I just, well, I shouldn't comment but I think people have to be more strategic about how to get to where they want to go, I think in general. And there's a lot of room for collaboration in this marketplace. If we can get more cooperation, there are economies of scale that can happen. There's cooperation that can happen. Our recognition programs, for example, are completely voluntary. And some plans reward people for doing it. I'm not here to shill for my programs.

But I think there are many different ways to skin a cat, and that people really have had a sort of single, pointed way of trying to get the doctors to improve performance. And it hasn't been working, to be honest with you. So-

TRUDY LIEBERMAN: Okay. Anybody want the last word?

¹ kaisernetwork.org makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material and the deadlines involved, they may contain errors or incomplete content. We apologize for any inaccuracies.

Well, thank you very much. My thanks to the panel. I think this has really been very interesting. And we'll continue the conversation.

[Applause]

[END RECORDING]