

Press Conference: 2004 State of Health Care Quality Report: September 23, 2004

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MARGARET E. O'KANE: First of all, I want to thank everyone for coming. We're very excited to be here. I think we have a very good set of announcements to make today. I also want to thank the Kaiser Network, which is web casting this at kaisernetwork.org. And let's take a moment to see who we have with us by phone. All around systems failure, I guess.

My name is Peggy O'Kane and I'm the President of NCQA and while we're waiting I'm going to acknowledge the staff who worked on this, our research and development department, our data collection department and communications, but really this represents the culmination of the efforts of NCQA staff over the year and so I can't possibly name everyone.

We are expecting Mark McClellan this morning. The last time we heard he was planning to stop by here and make some remarks. So we're not positive exactly what time he'll be coming in, but anyway. I'm going to introduce the panelists. First we have Senator David Durenberger, Chairman and CEO of the National Institute of Health Policy and obviously somebody who needs no introduction. Peter Lee, President and CEO of the Pacific Business Group on Health. Ellen Stovall from the President and CEO of the National Coalition for Cancer Survivorship. Allen Schaffer, Dr. Allen Schaffer, Senior Vice President and Chief Medical Officer, CIGNA Health Care. And Charlie Baker, President and CEO of Harvard Pilgrim Health

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Care. I want to welcome everybody and they'll all be making remarks. Thank goodness we've got our video. Now what about the people on the phone? Are we ready to? Okay, welcome if you're on the phone and if you're not on the phone, I guess then. And Senator Durenberger is going to have to leave early for another engagement, so.

All right, so this is a really good news story, but it also I think represents a lot of progress and gives us a sense of unfulfilled potential of our overall health care system. So let me just launch into it.

We're going to talk today about a way of thinking about health care quality, a year of record gains for the accountable health plans that have been reporting to us for a number of years, some important new measures that we're constantly moving the HEDIS agenda to be broader. We're going to talk about some persistent quality gaps and solutions because if our strong point of view, the transparency and accountability that this project represents that is the path forward for our health care system, and so I really want to make sure that you all get that message because it's a complicated message. So really excellent among accountable health plans year over year and a solution or a road map, I think, for the rest of the system.

Okay, this is a schematic that was developed by George Halverson and George Eisham at Health Partners. George Halverson now being the head of Kaiser. Dr. McClellan, welcome.

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We saved a seat for you up there. Actually I'm going to, since Dr. McClellan only has a few minutes I'm going to just go through this slide because I think it's a great way to think about quality and then I'm going to bring him up here. Just think about a population of the United States, the Medicare population, at any given time there is a large number of people that are healthy and low risk, but as people age, as they have unhealthy behaviors, as things happen they move into at risk, high risk, early symptoms, and if we don't do something into active disease. And what is the purpose of health care? It's to move or to exert pressure back towards the healthy end of the spectrum. So if you think about it, everything that we're talking about today and we're going to be alluding to this picture over and over again, the goal is to heal, to keep people as healthy as possible, to find disease early and so forth. And so I just want you to put that in the back of your minds and then I'm going to bring Dr. McClellan up since he's only got a few minutes, so Mark. I also want to say, please, congratulations. I think CMS is really moving the ball and has really exerted a lot of leadership in the system and I think a lot of credit goes to this man who I think we all, those of us that knew him before were just delighted when he took the job. Thank you very much.

MARK MCCLELLAN, MD: Thanks, Peggy. It's my pleasure to be here with you all this morning for this very important

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report. There are so many partners in the NCQA's efforts that you see represented up here. I have to tell you that we've been able to make progress because of the strong commitment of a very broad range of health care stake holders as reflected by people like Ellen Stovall and many patient advocacy organizations and Peter Lee and purchasers and payers for health care who are working harder to make sure that they're spending the money wisely, Senator Durenberger, health policy experts who have long been involved in finding better ways to improve the health care delivery in this country, Allen Schaffer, Charlie Baker, people who are actually out there in the field making sure that we're improving quality and that patients receive in their individual interactions with doctors all over this country. So it's a real privilege to be here with the National Committee for Quality Assurance who is working so diligently, every day on improving the quality of America's health care system. Thanks to the efforts of the NCQA and of Medicare quality initiatives, including our quality reporting and quality improvement activities and thanks to the real commitment of many health professionals all over this country, we've made a lot of progress towards a higher quality health care system. The report that NCQA is releasing today recognizes that quality improvements have been realized. For example, for the third consecutive year we're very pleased that Medicare health plans have shown significant gains in the management of

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cholesterol and thus in the reduction of the burden of heart disease in the Medicare population, which still remains the leading cause of death. But as the report also shows, we still have a long way to go. It's just not acceptable to have quality problems that cause between 40,000 and 80,000 deaths each year as well as additional hospitalizations and much higher health care costs. Dealing with this problem has never been more important. We've got the potential right now more than ever to bring better treatments to patients from genomics to nanotechnology, many other new applications from new life sciences, treatments that can turn many fatal and debilitating diseases and end you up at the right side of that slide that can turn these fatal and debilitating diseases into manageable chronic conditions or that can prevent them in the first place, but we need to bring these treatments to patients at a much lower cost if we're going to be able to afford them in this country.

And so to get both better innovative treatments and to keep medical care affordable, we need to transform our health care system. We need to measure performance and help patients and doctors use this information to choose better care for their personal needs. We need to provide technical help and better support, a better environment for health care providers to improve quality, and we need to do more to reward quality so that health professionals who want to do a better job of

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keeping patients well and out of the hospital, and even out of the doctor's office won't be swimming against the financial tide. The good news is we've got better opportunities than ever to get much better health care.

First of all, NCQA's efforts have gone a long way to help develop valid standard performance measures. In addition to the HEDIS measures that NCQA provides for Medicare Advantage plans, NCQA has worked closely with Medicare and Medicaid, with CMS on the development of a standardized set of measures for physician services as well. Second, thanks to the Medicare Modernization Act we have the best opportunities ever to encourage the use of these and other quality measures to help our beneficiaries get higher quality care and avoid unnecessary medical costs. This includes modern health care coverage. In January, Medicare will have new preventive benefits to help beneficiaries avoid complications. That's a hallmark of high quality care. And preventive benefits don't need to cost a tremendous amount to still have a big impact on the health of our population. Up until recently, Medicare has been all about the right hand side of that chart. Almost all of our spending has gone to treating active diseases and the complications of chronic diseases. We have not had preventive benefits that can help keep people healthy, that can help keep our health care system oriented to the left side of that chart where it should be. That has now changed with the addition of a screening

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physical exam when people come in to Medicare, with new screening tests for heart disease and diabetes added to all of the other preventive benefits that Medicare has put into the program in the last few years screening for cancer, screening for many other types of diseases, we now can make our Medicare program prevention oriented. That is a fundamental shift in Medicare and it is going to be reflected, I predict, over time in more of our dollars going where they should to keeping people well rather than dealing with the very costly complications from potentially preventable illnesses and their complications.

We're also adding new drug coverage. Medicare is already lowering drug costs through the drug card and we're going to provide much more help with the drug benefit in 2006. With modern medicine it is very hard to keep people healthy and to avoid complications of diseases without drug coverage and a health insurance plan. That's one of the key ways that modern technology is helping us keep people out of the hospital and out of the doctor's office and that's changing in Medicare as well.

And finally, the new Medicare law takes many steps towards paying not for more care, but for better care. One of these initiatives is hospital quality reporting and that's a priority that I share with both Secretary Thompson and the Congress. The new Medicare law provides a full hospital

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inflation update only for hospitals that participate in a voluntary reporting program. That is currently 10 measures, but that we're working to expand. And you know what? These financial incentives work. Virtually every hospital in the country is now going to be reporting quality measures for the first time ever.

CMS and the Joint Commission on the Accreditation of Health Care Organizations recently issued a technical manual for hospital quality measures that provides common definitions for each of the quality measures that are being collected and reported that has a scope that goes much beyond the 10 measures that are currently used. Hospitals will use these standard definitions to report on quality for both the national voluntary hospital reporting initiative that CMS has helped lead, and for JACO accreditation beginning with January, 2005 discharges. I think this is really important. We're committed to the goal of moving toward a single comprehensive set of validated quality measures that can be used by all stakeholders, and it reflects the input and the values of all the stakeholders in our health care system. And we can do this by working together. This agreement between CMS and JACO with the support of a broad range of stakeholder organizations in our quality improvement initiative to adopt identical measures is an important step, an important example of what we can do when we work together and work hard.

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The importance of this information is clear. The effort to promote public reporting quality measures is designed to help hospitals improve the quality of care they provide and allow patient and their families to make more informed decisions about hospital care. We need to do this in other settings too and we look forward to working with NCQA to build on the collaborative efforts that we're undertaking there, including physician quality measures.

In addition to our commitment in the hospital setting, we're also working in a number of other settings as well as I just mentioned. We've started an expanded program for home health agencies, we are expanding and improving and updating our nursing home compare web site for quality measures on nursing homes, we've enhanced chronic care quality measures on the nursing home web site and we've reworked their presentation to make the data more consumer friendly, and while millions of people have already looked at these data we know that the quality measures have other uses besides for the most informed consumers. For example, by health care providers working to improve their performance and by our quality improvement organizations that are working with health care providers in every state in the country to improve performance on these and other measures.

Another key opportunity provided by the Medicare Modernization Act is big steps toward broader use of paying for

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performance. This is really important as well. It includes our voluntary chronic care improvement program, which will soon start providing education support for Medicare beneficiaries with some of the chronic conditions that right now account for the majority of our costs in Medicare, congestive heart failure, complex diabetes, chronic lung disease. The chronic care improvement organizations that are participating in this program will support patients and their doctors in improving care for these conditions. They will only get paid if they reduce Medicare costs and improve clinical outcomes and measures of patient satisfaction. We can do both. We've got a lot of bids in to participate in this program already. We are in the process of finalizing the selection of the entities that are actually going to be providing these services who have put together some very impressive programs that are intended to achieve both lower costs and better quality. We can do it and we're going to do it. Starting soon, this year, as many as 300,000 beneficiaries in fee for service Medicare will begin getting assistance through this program.

We're also conducting a pay for performance demonstration program for hospitals and will be starting one soon for physicians in 4 states, so that doctors and other health professionals can get rewarded when they do what they should be doing best, providing better care and getting better health outcomes as a result. And we're pushing for earlier

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adoption of electronic prescribing and electronic record systems to better support quality care. And we're working to develop better evidence on which treatments are best for our beneficiaries. So we look forward to continuing to collaborate with partners like the NCQA in this critical area to identify effective performance measures, which enable public reporting and pay for performance, which foster accountability and which eliminate gaps in the health care quality that are too big and too costly to be ignored.

So thanks to better science of quality improvement, better opportunities to use this science as a result of the Medicare Modernization Act, we've got the best chance ever to make real progress on the challenge of providing more portable, but also high quality medical care across the board to Medicare and Medicaid beneficiaries. We've made some important progress, but we've got to do more in order to get high quality, affordable care. Measuring performance is allowing us to do this. It's allowing us to inform consumer choice, to reward quality, to identify areas for improvement and to make those improvements. There is enormous potential in these activities to drive improvement and without measurement you can't do any of them. Medicare is fully committed to continuing our partnership with NCQA in these activities, as well as with other stakeholders in our health care system and we are 100% committed to moving toward pay for performance. Thank you all

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very much for taking a few minutes to listen to me this morning and it's a real pleasure to be here with so many people who have made such a contribution to improving our health care system. Thank you.

MARGARET O'KANE: It is such a thrill, I think, to have the largest payer in the country really grab this ball and run with it and I just want to thank you so much for those of us that have been spending our careers trying to put quality on the map, there's nothing more improvement than your strong support for this agenda. Thank you.

So let's move on to the next slide. Just for those of you that are not health care experts, I just want to go back to the slide about how to keep people healthy and just talk about some of the ways and I'm going to have to gloss over this very quickly. To keep people healthy plans do things like making sure doctors are advising smokers to quit, so there are programs for wellness and prevention. Screening and secondary prevention, PAP smears for women, mammography, colorectal cancer screening which is one of our new measures this years, for high risk patients, patients that already have disease we have disease management for single diseases, broader disease management for people with multiple diseases and case management. People that are actively sick, I mean there's an awful lot that can be done both to improve the quality of their care and to make the care more rational through complex case

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management programs, palliative care programs, complex disease programs like for people with AIDS and hospital pay for performance. So what Mark was talking about, about this hospital quality that is very, very important and yet not particularly well articulated yet, part of the agenda. Because once you're in the hospital there are very many risks that bad things could happen and that's one of the reasons that costs are so high at that end of the spectrum.

So let me go back to that for one second. There's one nuance I want to point out. There's no one size fits all approach to who needs what. Some people need active intervention, they need health coaches and so on. Other people just need to get a reminder. They need to get an e-mail and technology is now possible, or a telephone call. So part of the art of getting a good quality health care product for health plans is to understand exactly who needs what and make sure that they get it.

So some interventions are patient focused, reminding patients, bringing them in, using health coaches for people that really need that kind of support, and some are physician and provider focused. So plans have been giving physicians information at the point of care. Mrs. Jones is coming in today because she has a sore foot, but she hasn't had her mammogram. Reminders and alerts for physicians. We see that Mrs. Smith has gotten 2 drugs that really shouldn't be given at the same time.

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Can you take care of that? And then pay for performance, which you've heard a lot about and which Peter Lee is going to talk about, a very promising initiative in California as well. So again there are many, many different ways of approaching this, but I just wanted to give you some sense of what the plans have been doing.

Edith, I'm going to skip over this but I'm going to just say it's a very rigorously specified measurement system. Performance measures are a piece of a system that needs to include validation, benchmarking, and making sure that the way you're collecting the data, that you can compare organization A with organization B in a way that is fair. How do we pick the measures? One of the reasons that you see the large number of deaths could be prevented is because we shoot for very important conditions in terms of the health of the American public, so they are highly prevalent. A lot of people have them. They have a high impact on health. And health care can make a difference. So we really measure things where health care if it's given right can prevent illness and death. And so that's why it's so important to make sure that these things are happening.

So let's go to the plans and I think they deserve, I think, the most credit of all because I think it's not been a friendly environment and year over year we want to see them getting rewarded for this important progress that they are

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making, because they are truly, they have really staked out a roadmap for the rest of the system. So this year 41 of 43 measures improved, seven by 4 points or more. In Medicare we had strong gains on cardiac and diabetes measures, which are very, very important in the Medicare population. In Medicaid and I think that is probably the most challenging program of all in the 54 programs in the 50 states and territories, we see real gains in prenatal care, in blood pressure, and in chlamydia screening, and in fact I should point out that Medicaid plans actually do better than anybody else in the country on chlamydia screening. And that's a very important issue.

I just wanted to show you a way to think about what plans do when they embrace this accountability agenda. So if you look across we have the national baseline and I should say that this is our best estimate based on public sources of data from the Centers for Disease Control and other trusted sources. So controlling high blood pressure, high blood pressure is a huge problem. It has tremendous ramifications in terms of heart attacks, strokes, kidney failure, and so forth. There's probably no more important issue that we're looking at. The national baseline, we get it right about half the time. Now we've been publicly reporting this since 2000 and if you look at how those plans are pulling away from the national baseline, this is something that really needs to be rewarded, and please,

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those of you in the press I hope you're getting this message. That this accountability agenda is causing a movement forward that really is unprecedented, that we've never seen anything like this. And we're particularly impressed this year. There's a 4-point gain and that really translates into a lot of lives saved and a lot of misery prevented.

This is beta-blockers. I remember when we first adopting the beta-blocker measure. Beta-blockers after a heart attack are a huge lifesaver. They have about a 40% impact in terms of prevention of the next heart attack. And they were tremendously underused. In the early 1990's there was a study done by the Medicare, on Medicare patients in New Jersey and 21% of the eligible patients were getting the beta-blockers. We first reported this in 1996 and it was 62.6% at that point. Look at the performance this year, 94.3% of the population in these plans got their beta-blockers appropriately. That is just remarkable.

I'm going to gloss over these. These are new measures, colorectal cancer screening, hugely important. It accounts for 56,000 deaths annually. The screening has a tremendous efficacy of 40-50% reduction in mortality and this is the baseline rate and we're looking forward to the important progress that we're going to see on this measure.

Osteoporosis management, huge burden for older women and basically this is looking at women who have had a fracture

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and are they getting screened for osteoporosis and treated?

There is absolutely effective treatment, reduces the incidence of subsequent fractures by half.

Another new area is appropriate use of antibiotics. We have had a big problem in this country with inappropriately treating sore throats, colds, earaches, and so forth. Two new measures on children. I'm a mother. I know my friends used to tell me I demand my antibiotics and I used to give my friends all these lectures about how it's not going to do your child any good and it really causes a problem. And part of the reason we have so many drug resistant bacteria in the system is because we're overusing these. So these are really a step forward in terms of public health, as well as saving money from wasted use of antibiotics.

So the report covers 563 health plans and 69 million Americans, and it includes commercial, Medicare, Medicaid, and its HMO and the associated point of service plans which go with HMOs. So it is a segment of the system, so that's a very important point. And the good news is that we have data on 23 million Americans, which is that blue quarter of the system that you see there. The bad news is that we don't have data on the rest of the system. So we have 45 million Americans with no insurance and we've documented how terrible the quality of care is when you have no insurance. But then we also have plenty of people that are in other kinds of plans where we don't really

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know what's going on, but if you look at the overall numbers obviously the focus on improvement is just not there yet. And I think we have some foreshadowing of the movement of this agenda that I'm very excited about.

Quality gaps. We came up with this construct, basically the 90th percentile among the plans that are reporting to us, that is achievable quality. It is the top 10% of plans nationwide. We think that is by definition an achievable goal. The average performance of the system is about half and that's been documented by many other experts, but so what we have here is a gap between the top 10% of accountable plans and the average performance of the system. So what does that gap mean? Let me just talk about it.

I'm not going to go through these but we're giving you these handouts so that you can see them, but for everything we measure you see that there is this huge differential between the best performing plans and the rest of the system. This translates, and now we've modified our way of estimating death. Last year we reported 57,000. what we're doing now is reporting a range because we've gone into the research a little more. We've also added some new measures here. So our estimates and we feel pretty confident, 42,000 is the conservative end of the spectrum. 79,000 is we think not unrealistic but not as conservative. So in that range is how many deaths could be avoided if the rest of the system performed at the level of the

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top 10% of plans. So I want to make sure you got that, that we're talking about the top 10% of plans who are continuously improving and the rest of the system,, which is just not accountable yet and where we have to broaden this agenda.

It also translates into costs. We tend to have this mindset that if it costs more it must be better. And when we think about cars and so on it may be true, but it's certainly not true in health care. Very often there is a toll of human suffering that is associated with higher costs. So 1.8 billion dollars. And remember, we're talking about the conditions we're measuring in HEDIS. We're not talking about the overall picture in health care. Sick days, productivity. 66.5 million avoidable sick days or presenteeism, that is people who are sick at work who really aren't producing at their optimal level because they're not feeling well. 66.5 million sick days. Think about that. That's almost 300,000 full time equivalent workers or another way to think about it, the employed population of Ford and General Motors. That is a giant toll.

So what can we take from this? What is this roadmap? Well we think it's really pretty simple or straightforward what we need to do. Now the details are not simple, but we need to measure the performance of plans. We don't care which part of the alphabet soup you are, we want to know how you're doing and we want all buyers to say, I don't care what you're called, tell me how you're doing. We want to know information on

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hospitals and physicians. This is a new part of the agenda, steering to better performing hospitals and physicians. We need the information to be able to do that effectively and fairly. We need to learn how to engage patients better. We have important net technology coming out with the web. It's wonderful and we need to really move the agenda. We need to encourage the use of information systems in care management. The government's playing a great role in making their bully pulpit and their payer position an important driver of that. And we need to reform the payment system. So we need to stop punishing quality. And so I think that's the agenda and I'm looking forward to hearing the other comments. And I know we're going over a little bit, but I'm sure it was worthwhile to hear Mark McClellan. Senator Durenberger.

SEN. DAVID DURENBERGER: Thank you. Let me begin with congratulates to Peggy O'Kane who has been the pioneer in this field and needs always to be recognized for that, to the NCQA and all of the staff members and to accountable health plans and providers across this country. The Medicare program serves the health care access needs of 43 million elderly and disabled Americans just like me. Despite nearly 300 billion dollars spent this year on my behalf, Medicare does not meet our needs for care quality or safety. In fact, Medicare pays more money for failures to meet professional standards of care than for success. Since I'm a Twins' fan, it's like paying class C

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baseball players the same amount you pay Johann Santana or the major leaguers. And public moneys saved by major league doctors, clinical systems, hospitals and health plans in part of this country like New England, the Upper Midwest, is wasted on poorer quality care for a majority of the people who happen to live in many other parts of this country.

The Medicare Payment Advisory Commission, which I've been honored to serve for the last 3 years has been advising Congress to change this system by paying for performance. Beginning with recommendations on endstage renal disease and kidney dialysis, recommendations on Medicare Advantage and this year, on home health, skilled nursing facilities, hospitals and doctors, we have proposed that we will encourage and we will educate members of Congress to the importance of this policy. You've already heard from the Administrator, CMS has launched demonstration initiatives in a wide variety of very important areas. The Medicare Modernization Act has authorized even more under various sections of that Act.

Medicare regionalization holds the potential as well of capturing the benefits of natural regional communities of caregivers and plans as this report so well points out. As this report also recognizes however, Medicare Modernization Act presents a threat to its own potential to help improve care quality for elderly and disabled Americans. And I quote, moving away from the tighter networks of HMO toward the broader access

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of PPO and the web powered promise of "consumer directed health plans and HSAs" presents a danger that some of the quality gains of the past decade are a result of a focus on plan initiated care management and preventive care will be lost. Therefore, it is critical that all health care purchasers, especially health plans, large employers both public and private, and state Medicaid plans move quickly to change their purchase orders. As those who follow me will demonstrate better than I buying and paying for performance measurement, care coordination, public transparency and accountability is a mandate in this health care system. Examples abound across America as the NCQA report points out. The examples must be encouraged as quickly as possible. Thank you.

MARGARET E. O'KANE: Thank you Senator Durenberger. Our next speaker is Peter Lee, the President of the Pacific Business Group on Health and a real leader in the purchaser community and we're very pleased to have him today. Thank you.

PETER V. LEE, JD: Good morning. This report underscores a value disconnect in health care. Costs are up double digits for the last 4 years. That pain is being felt by employers, government and consumers, at the same time quality of care especially outside of organized health plans is uncertain at best. This report shows that organized systems of care often means better care. It also shows that the key to closing the quality gap is our ability to measure quality and to make sure

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that information is available to consumers as well as to providers and to payers so we can change how payment is done.

In California, the Pacific Business Group on Health is thrilled to be involved with the Integrated Health Care Association's pay for performance initiative. This initiative has 7 health plans working with 200 medical groups and this year they'll be paying in the neighborhood of 50 million dollars in performance based bonuses to medical groups in California based on common clinical performance measures anchored in the HEDIS measures that NCQA has developed, but also patient experience and information technology systems. This information though isn't just being given to those medical groups, it's also going to be given to consumers. Consumers will have new tools in California to make better choices. Taken together, these payments and this public information is encouraging medical groups to focus on quality improvement as they never have before and we've already seen the results in California.

Many employers recognize that the solution to the staggering cost increases that they're facing and the all too uncertain quality will not be found in blind cost shifting. Rather, the path to solving health care's value disconnect is both to work with health plans that demonstrate real improvements while demanding accountability for quality of all health plans. As Peggy noted, the alphabet soup of health plans

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can't be the thing that defines whether or not you get good quality care. We have to have common expectations whether our employees are in an HMO, a PPO, a CDHP, or fee for service. Increasingly PBGH's members, like Calpers, Wells Fargo, Intel, Stanford University, are providing tools to their employees to make informed choices between health plans so they can understand the health plan difference, the quality of differences between those plans, and the financial exposure that those employees have. We have to go beyond the health plan differences to make those differences transparent at the hospitals level, at the medical group level, at the physician level and NCQA is taking a real lead in doing just that.

We have to demand that health plans provide employees with tools to make choices at each of those levels, medical group, hospital health plan, and treatment. We will not transform health care as Dr. McClellan noted until we actually change how we pay for care, give providers the information to understand how their quality is different, give consumers the information to make better choices. The information in this report charts part of the course to bridge the quality gap that we know is all too large. Thank you.

MARGARET E. O'KANE: Thank you Peter. Our next speaker is Ellen Stovall, President and CEO of the National Coalition for Cancer Survivorship and a passionate advocate for patients and I look forward to her [Inaudible].

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ELLEN L. STOVALL: Thank you Peggy. It's a real honor for me to appear on this panel today. I'm especially honored to share a panel with Senator Durenberger and Peggy and Peter who I served with on the board of the NCQA. It's a dynamic group of people, very diverse, and one of the very distinctive places in the community where consumers, purchasers, plans, large employers, people like Senator Durenberger come together to really solve some of the, I think, some of the more thorny and very, very confounding issues for consumers in health care.

I'm here also as a 32-year survivor with 2 bouts of cancer. I'm one of the lucky people in this country who at the age of 24 - I'll do the math for you, I'm 57 - was treated with the very best care that people with cancer could expect to have had in 1971. but I'm also here to say that in the last 32 years while treatments may have been improved for cancer, people's access to quality cancer care is still very, very much at risk.

The facts associated with cancer in the United States are sobering. It's the diagnosis as the Gallop and Harris polls have told us over many years is the disease diagnosis that people in this country fear the most. 1 in 2 men, 1 in 3 women will get cancer during their lifetime. 1.3 million people in this country will be diagnosed with cancer this year. 500,000 of them will die, many, many of them suffering needlessly in pain or with other distresses that we know how to deal with, we know how to take care of. It just doesn't get to them. 2/3 of

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all cancers in people are over the age of 65 with at least 1 more chronic health condition as part of their medical history, very likely during that period. There are 10 million cancer survivors in this country in addition to me, 10 million and 1 who are alive today and are largely lost to follow up. This excludes children diagnosed with cancer. And not only are they lost to follow up, but they're lost to secondary prevention issues, screening, for other diseases at which they are very much at high risk in addition to cancer.

We all want to believe, I think each one of us in this room wants to believe that if we were diagnosed or someone we love were diagnosed with cancer today that they would have access to the very best care that could be provided for them, and the fact is, the only really study we have on this issue was done at the Institute of Medicine through its National Cancer Policy board in 1999 and it basically gave us some very, very disquieting facts. And that is that there is no system of cancer care in this country that is reliable, responsible or accountable to those 1.3 million people who are going to be diagnosed every single year.

The report also tells us that too many patients are getting the wrong care. They're getting too little care or they're getting too much care in the form of unnecessary procedures. This is especially true for two of the leading cancers for which we have a lot of advocacy and funding around

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research, prostate cancer and breast cancer. And with all these improvements like I said, 50% of people diagnosed with cancer will die within 5 years of their diagnosis and they will die in pain.

People diagnosed with cancer or at high risk have very few direct or surrogate indicators of quality to help them choose doctors, hospitals and health care plans. We do know key components of quality are as strong, and a strong scientific base and accountability are critical to our health care system, but they're very, very critical to cancer care, which largely falls outside the bounds of accountability in this country. The way people in this country get their information about where to go for cancer care is usually on the cover of U.S. News and World Report, which gives them a listing of the top 10 cancer hospitals, but 89% of people treated in this country never get to a comprehensive cancer center. They are treated in the communities where they live, where we'd like them to be treated frankly, and there is no scrutiny, no accountability, no transparency, and no predictability for how the decisions are made to support their treatment choices.

In addition to measures associated with the rates of breast cancer and cervical cancer screening in this report, this year's report on health care quality includes rates for colorectal cancer screening, one of the few cancers that may be prevented through screening for this deadly cancer that can

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remove early, precancerous polyps before they become deadly.

While NCQA's report released today sends a very encouraging message to consumers generally, huge gaps in quality persist. This is no time for complacency. In fact, this is the time for all of us to seize any opportunity to become advocates for transparency and accountability in our health care system. We all must be advocates for ourselves and those people we love. NCCS applauds NCQA stewardship as a reliable and honest broker of quality information for and reporting for these measures and we look forward to working with them in partnership to improve cancer care for all Americans. Thank you.

MARGARET E. O'KANE: Thank you Ellen. As one of my friends said, they said it couldn't be done which is measuring the quality beyond HMOs and we are just thrilled to have Allen Schaffer here today, Dr. Allen Schaffer who is the Chief Clinical Officer of CIGNA Health Plans, one of the largest national insurers in the country. And he has some momentous news for us today, so welcome.

W. ALLEN SCHAFFER, MD: Thank you, Peggy. Good morning. You've already heard others discuss the impressive gains that health plans have achieved in quality performance this year and I'm proud to say that this is true for CIGNA plans as well. Beyond the simple statistics, the numbers represent a very real impact on the lives of individuals. Real progress is being

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made. We are improving the quality of life, preventing illness, and helping those with chronic illness manage their condition according to evidence based standards.

You have also heard that troubling gaps in quality and patient safety remain within the nation's health care system. I would like to comment on what CIGNA is doing to address these gaps. Important areas, which I feel, hold great promise for additional improvements in quality. For many years, CIGNA has been a significant contributor to NCQA's efforts to establish a credible, independent, external source for measuring and for reporting on quality of performance of health plans. In fact, we were among the first to embrace the original HEDIS metrics many years ago. At CIGNA we do not create proprietary measurements to measure health plan performance, instead we have chosen to give our customers and our members information on performance using standards established by one of the recognized best brands in health care performance, namely the NCQA.

It is in this tradition of leadership that I am here today to announce our latest initiative to extend our HEDIS activities, including public reporting to millions of members in our PPO plans. This initiative answers the call to action from the State of Health Care Quality report. It is also part of our larger initiative focusing on patient safety. It is the significant next step for us and for the industry and it places

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us in complete alignment with the priority areas for quality improvement identified by the Institute of Medicine. We are the first national company to make such a commitment. It is one we undertake voluntarily because we are committed to providing value to our customers, committed to helping our members get quality health care each time they use the health care system, and committed to accountability, the public reporting of our results. Make no mistake, our goal is not only to lead the industry in voluntary reporting and inspection, but to lead in results and to achieve the same kinds of advances and quality for our PPO members as we have demonstrated through our many years of participation in HEDIS for our HMO members. We look forward to our collaboration with NCQA as we build this new initiative.

I also want to emphasize our strongly held belief that the pursuit of quality in health care cannot succeed without information and that accountability for health care quality must be a shared responsibility among all in the health care industry. At CIGNA we have invested heavily in support of efforts to develop and to provide consumers with objective, accurate, independent information about physician and hospital performance. Information about their treatment options and information on what scientific evidence proves to be the effective treatment. We are making this information available through the Internet, through services of personal nurse

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coaches, through disease management and case management programs and through new product and benefit designs, which give consumers and providers incentives for quality of care. These efforts support consumers making good decisions about their health care based on objective data and recognize the efforts of health care professionals who deliver quality health care.

I close by saying that today's report demonstrates that measured quality at evidence-based standards is within reach for millions of people. Thank you.

MARGARET E. O'KANE: And our last speaker, I think, has a special distinction, which is that Charlie Baker is the CEO of Harvard Pilgrim Health Care, which has the unprecedented honor of having the highest HEDIS and the highest patient satisfaction results in the country. And I just want to say a little bit about Charlie because his personal commitment to excellence is incredibly impressive. I was at a meeting with him a couple months ago and he was telling people at the table that he's on the road a lot going out and meeting with his customers, and while he's in the car he's listening in on the customer satisfaction on the member services line and he's also calling people who are not happy with Harvard Pilgrim. So I mean this is very unusual behavior I think for a CEO and I say this as a CEO. And I think it reflects this kind of unrelenting passion for excellence, which is part of the Harvard Pilgrim

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tradition, but which I think he's a tremendous example of, so I really want to congratulate you Charlie on this really tremendous accomplishment.

CHARLES D. BAKER: I'm not sure what that means about CEO's generally. It is true that when I drive around from meeting to meeting I periodically call our member account and provider service lines just to see how long it takes for somebody to answer the phone and since I am a member, I have all kinds of questions that I like to get answered when I call.

What I thought I might try and do today is to speak very simply about how we think about some of these issues. And I'm going to try not to use any acronyms, no words of art, no jargon, because I think one of the problems the health care community has generally when it comes to talking about simplicity and transparency is we speak a language that's hard for most people who don't spend everyday in it to follow.

We work on a pretty simple proposition at Harvard Pilgrim, which is that what we ultimately want to deliver at the end of the day is a reliable, predictable experience for our members. And when we talk about that, a lot of people say, well, that's not very aspirational. It doesn't have a big wow to it, reliability, predictability, dependability, and all the other abilities, but fundamentally if you do that for people and you really think hard about what that means it becomes in some ways a way to make sure that people not only feel

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appropriately served, but that they also get the service that they need. And I think that's a big piece of why our members tend to feel pretty good about us sort of day in and day out.

And there are kind of 4 points in time when we like to focus on this. There's the point of enrollment, what we call sort of the point of interest, which is somebody shows up as a diabetic based on the monthly review of our claims data, or somebody shows up as having 4 or 5 comorbidities, but and 5 trips to the E.R., but no doctor's office visits. Or somebody shows up on the data we run and it turns out that it's pretty obvious that there's a kid with asthma in that house. And at that point, or they have a birthday. I constantly get e-mails and phone calls from friends of mine saying stuff like, thank you so much for reminding me that I just turned 50 and now I need a colorectal screening. You really made my day with that one.

But I think part of that is about recognizing the fact that the only experience we have with people is at that point of enrollment and then never again, we've sort of missed a big opportunity, because we do transact data all day long on behalf of our constituents, and if we're not trying to use that information to come up with proactive ways to help them get a more reliable and predictable experience out of the health care delivery system then we've missed an opportunity. And some of this is not very expensive. We send wallet cards, just

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laminated wallet cards with key questions you should be asking your provider to people who fall into a variety of disease categories. And the reason we do that is we did some focus groups and it was pretty clear to us that most people when they go to the doctor go in there in their own minds with a whole bunch of things they want to ask and then they freeze and they forget and they don't ask. Or they get in there and they start down that path but then they forget and they leave, or they get told a whole bunch of things and then they leave and they can't remember what it was they asked or they talked about. And those wallet cards have turned out to be incredibly useful tools to people to simply sort of take out and say, could you just answer these for me? And they track needless to say the NCQA standards with regard to what most people consider to be best practice there and then we send on a monthly basis to the doctors on our network how they're doing based on our claims data and reporting against all of those criteria. And then if they do really well over the course of the year on behalf of all those members, they get a bonus. And it's sort of one way of taking our data, giving it to our members to arm them to go in and ask good questions, sending it to the doc's office as sort of a reminder or indicator about how they're doing against that stuff, and then rewarding them at the end of the year if they hit certain benchmarks.

And then the final one is sort of at the point of

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payment. And I'm one of these people who thinks that health care ought to recognize the fact that it's a heavy transaction business and that it's okay to spend time talking and thinking about how we're doing in managing the administrative fees of our relationship with our constituents, because if you don't do a really good job with that one you never get to part two. You never get to talk about managing data and information and providing decision support and that type of thing. And we, it's sort of a multichannel strategy. We have approaches that are driven by phone contact. Approaches that are driven by mail contact, by fax contact and a lot of doc's still think the fax or at least their administrators think the fax is the best tool to communicate, and we have a lot of online tools as well. And work on the assumption that whichever channel you like to use as a Harvard Pilgrim constituent we're going to do what we can to make sure that channel works to manage your administrative relationship with us so that when we do interact with you, it's going to be based on the stuff we'd all rather be talking about which is how can we make sure we deliver a more reliable and predictable experience for our members.

And one thing I would say in closing is I have three kids. They're 13, 10 and 7, and Peggy, you'll be pleased to know that when my 13 year old was a toddler he lived all winter on amoxicillin, which is probably a bad thing. My 10 year old when he was a toddler got it almost as often, but not quite as

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much, and my poor 7-year-old daughter when she was a toddler, they wouldn't give her amoxicillin if we begged for it. She just had to tough it out and I used to have these great conversations with my wife about this, who would stomp her feet and sound a lot like some of you, no, no, it's really a good thing that we're not giving her the amoxicillin. I think in some respects that one has clearly penetrated at least the pediatric community, even if the moms and dads still have a ways to go. Thanks.

MARGARET E. O'KANE: Thank you very much. We're ready for questions and answers. Yes. Could you please say who you are?

TONY FONG: Tony Fong with Modern Health Care. You talked a little bit about pay for performance. Can someone talk about how the reaction from the provider community has been when health plans have tried to do that? Because it's been my understanding that when they've tried to do pay for performance with doctors they have not reacted well and they sort of take insult to.

MARGARET E. O'KANE: Well, actually, I think it depends on which doctors you're talking about and do you want to start?

TONY FONG: Can you also talk about hospital reaction, the tiering the initiative to try to tier hospitals in California?

MALE SPEAKER: On the pay for performance initiative,

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in California many of the medical groups originally were nervous, were saying, is this just a way that you're going to move money around or is this going to be new money? And the health plans said, some of this is new money. Some of it is changing what we used to pay based on utilization and other things based on true clinical quality. So that medical groups have welcomed this, think this is a great thing. They just want to see more of it. What they want to see is instead of in the neighborhood of 3-5% of their compensation in bonus, they want to see more. They'd like to get up to 10% and so in the medical group world in California it's been embraced and it actually is making a difference in terms of medical groups making new investments in IT, in systems in care they weren't making before because they're seeing actual rewards for it. Let me come back to your hospital question after other people address the pay for performance.

MARGARET E. O'KANE: Anyone else want to make a comment?

W. ALLEN SCHAFFER, MD: The response I think of the physicians depends on whether there are proprietary measurements, which a health plan has created as a marketing differential, or whether they're truly nationally standardized performance metrics, which indeed used by everyone. Our approach has been to use the NCQA defined quality measurements and we've had a very good response to that. I think those who create their own and create more work for positions have had a

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less favorable response.

MARGARET E. O'KANE: Charlie?

CHARLES D BAKER: I would reiterate Allen's point about using standards that most people consider to be sort of community standards and the NCQA ones are good ones. We have a lot of pay for performance programs in place and I guess I would say they operate under kind of a 3-point rubric. The first is measure me on something I can control. One of the things you hear constantly and with good reason from physicians is they don't want to be measured on things that they really don't think they ultimately have the ability to do much about. So point number one is pick things that people believe they actually have some ability to influence. The second is, if you're going to measure me the data you give me on an ongoing basis better be pretty good. And that means your operations better be pretty good. It's one thing to talk about sending people data, but if the data you send them is 50% right based on their own data and their own records, so by definition you're not in a position when you can actually have a legitimate conversation about what truth is. And then the third is, think about it as an incremental and not a revolutionary approach. Our pay for performance is absolutely on the margin in the context of how you think about it, but if you make marginal improvements with marginal financial incentives over a 3, 4 or 5 year period you end up with a major improvement that

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sort of gets baked into the way people practice and what they think about in terms of expectations over that time.

MARGARET E. O'KANE: Part of the point is that the current payment system punishes quality, so if you have a diabetic that needs a lot of coaching and that needs to be brought back in more often because they're out of control. It takes extra effort to do that and if you ultimately get them stabilized and so on you're actually going to make less money than if they were out of control and they went into the hospital. Those are kind of cold, hard financial facts. So the point is to reward the extra effort and the care coordination and so on and that's why we've been very actively involved in promoting the concept. You know, I think leaving aside the sort of politics and there's kind of, I think there are political statements that are being made about this, but when you actually talk to like our practicing physician advisory council which we have representatives from all the major specialty societies, we had a conversation about this, many of them said to us, you know, it really doesn't pay to try to deliver value health care. It's very difficult. And so I think there's a differential between the sort of public political statements and what doctors actually say when you talk to them more quietly. Other? Yes. Somebody on the phone has a question.

SHAWN KENNEDY: Hello, my name is Shawn Kennedy from the American Journal of Nursing. Yeah, thank you. Several studies

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over the last few years have shown the value of advanced practice nurses assessing nurse practitioners in improving outcomes. Martha Hill's work on improving blood pressure control in inner city Blacks and there's been numerous ones last year and just a few months ago Mary Mailer at the University of Pennsylvania showed that older adults with heart failure who are managed by a nurse practitioner had fewer rehospitalizations and lived longer. Saving I think about \$5,000 per patient and I'd like to ask the group where they see the role of nurse practitioners in your quality improvement efforts?

MARGARET E. O'KANE: Well, just let me comment from NCQA's point of view, we are very aware of the important role that advance practice nurses and even other nurses play in the delivery of health care and I personally use a nurse practitioner for some of my care and I always was very pleased with the nurse practitioner in my pediatrician's office. So I think we usually talk about practitioners. Our pay for performance and recognition programs that we're involved in usually focus on the physician just because of the structure of the financing of health care, which tends to be physician centric. And you know that much better than I do. But many times nurses are playing a very critical role here either as a part of a team or sometimes as independent practitioners. And we're very aware of the tremendous value that they deliver.

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Anybody else have a comment on that?

W. ALLEN SCHAFFER, MD: We think that nursing across the range of credentialed and level nursing is an essential ingredient to improving quality and one of the reasons for our successes over the years on HEDIS scores is the use of nurses at all levels in case management and specialty case management as coaches. And in fact one of our most popular programs this year is the health advocate program where a company retains the full time services of a nurse to advise their employees using our HEDIS measurements for improvement as well as answer questions and move beyond that. I don't think that we can close the quality gap without bringing nurses into direct contact with patients on issues which patients have identified as important and which the data identifies as important.

SHAWN KENNEDY: I'd especially like to hear a response from Mark McClellan.

MARGARET E. O'KANE: Oh, Mark has left. I'm sorry. He had to leave.

SHAWN KENNEDY: All right. Thank you.

MARGARET E. O'KANE: All right. Thank you. Yes?

PEGGY EASTMAN: I'm Peggy Eastman with Oncology Times and Emergency Medicine News and I'd like to ask Ellen despite the inclusion of the colorectal cancer screening data, it doesn't sound like much has improved since that 1999 Institute of Medicine report, which is a bit discouraging. And I wonder

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if you could maybe address some things that would help improve the picture for cancer patients?

ELLEN L. STOVALL: Yes, thank you Peggy for that question. I agree, not much has happened. There have been some studies done independently and in the public sector both by the National Cancer Institute and by the American Society of Clinical Oncology, two very large studies to get more data, frankly, because the database of information on which these decisions and this evidence needs to be brought forward is just not very good for cancer. And so we've been relegated to some of these screening measures that will help maybe detect cancer earlier, but with the exception of colorectal screening or cervical cancer screening. there's a grey zone of uncertainty about mammography screening in terms of ultimate outcome. There's not a whole lot of good data there so that's one issue. So getting the data is the problem. I really think that there should be as much emphasis on process measures as there have been on outcome measures over the years for cancer because with cancer you either die or you don't die, but the fact is the process by which you make your very important decision about your initial treatment is very, very important and there's no transparency or predictability with how that might happen or uniformity. And there's great disparity in where you get treated for cancer. A lot of Jack Winberg's work over the years has demonstrated that if you get a mastectomy in Florida versus

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one in Michigan the morbidity and the adjuvant therapy issues associated with procedures in those two parts of the country are drastically different. So eliminating some of this disparity and taking a big snapshot of some of these process measures, I think, could go a long way toward improving care.

MARGARET E. O'KANE: I'm just going to comment from NCQA's perspective because we've been struggling with the issue of cancer treatment for a number of years and it is highly complex, but I think that there are some really good models out there. I don't remember the name, the Children's Cancer Network?

ELLEN L. STOVALL: Yeah, the Children's Oncology Group. I mean the way we treat children for cancer in this country is wonderfully demonstrative of how adults in my opinion should be treated. They should always be offered a clinical trial if possible rather than as a last resort. Where children are treated on protocol we learn a lot more. But their tumor types are a lot more predictable as well and a lot less diverse than.

MARGARET E. O'KANE: Yeah, but I mean if you think about the progress that's been made on children's cancers, it's just remarkable and I think that kind of collaboration and public accountability is really the model. And for us it's been quite complex but we're really relentlessly pursuing it. Peter asked me to ask him again about hospital tiering. There's been some very interesting I think experiences with that in California.

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PETER V. LEE, JD: The question earlier was what have been the responses of hospitals to tiering in California? And I think part of the response is first to remind everyone that currently there is tiering of hospitals throughout America, but it's invisible to consumers. If you're in a PPO what hospital is or is not in your network is in fact, tiering. And there are huge financial differences of being able to go in or out of network. What's happening increasingly, employers are saying, we're seeing huge cost differentials of hospital A versus hospital B and huge quality differentials and those are not the basis upon which consumers are being encouraged to go to different hospitals. And we've seen in California some of the early steps and it's happening in other parts of the country as well of making it visible to consumers the information about quality and cost and having that play out in tiering, whether in copayment differentials, et cetera. The response of the hospital community has not been to welcome this with open arms. It's been concern and some of the concerns come to what we've heard earlier today of the need for standardized measurement. We currently have in the hospital world not enough standard measures to be able to say validly across the board this is a better quality hospital, nor do we have standard measures today to say on an efficiency basis this hospital does a better job caring for a cardiac patient. This hospital does a better job from an orthopedic surgical episode. So some of the work we're

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doing and NCQA is doing a lot of work along this, just driving to get tools so health plans can make sure they're differentiating hospitals and physicians is to say, let's make valid comparisons. So there's been pushback from hospitals. I think some of that pushback has been valid because we don't have what we have in the HMO world, which is standard ways to make comparisons between hospitals and we're looking forward to push that agenda so consumers can make better choices.

MARGARET E. O'KANE: Charlie, did you want to comment?
Interesting hospital market.

CHARLES D. BAKER: Yeah, I'd just say a couple things. One is that the employer community for the last 10 years or so and they're not monolithic, but generally speaking have preferred to see plans work pretty hard to keep their networks as open and as broad as possible. And as a result that has created some of the differential with regard to price that might not have existed 5 or 10 years ago. If at the end of the day every hospital that negotiates with a plan knows the plan needs to say yes, the ones that have the most leverage tend to do quite well. And I think actually one of the real problems we have on transparency around quality is everybody currently reports on a procedure specific basis to their Departments of Public Health or whatever their hospital regulatory entity is complication rate data, infection rate data, mortality rate data. All of this information which we don't' turn into

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publicly available information. I don't get it frankly. I'm quite, in Massachusetts we've been supportive of making all of the data that's currently collected by public entities like that on a procedure and facility specific basis publicly available. So that people can see it because we think as part of the transparency discussion that's a critical component. And then also talking about what additional information we ought to be collecting and making available. And frankly, I think at some point Medicare and Medicaid and probably the private plans through some mechanism ought to be putting what they pay for all this stuff into some public domain so that if you're out there as a consumer it would be pretty easy for you to figure out what various hospitals and various provider organizations are getting paid for providing various services and how good a job they do relative to others. I think part of the problem we have is that a lot of people that know the answer to this question, but they all work for the organizations inside the health care delivery system and it's not out there in the public domain.

MARGARET E. O'KANE: Other questions? No more questions on the phone? All right. Well I think then we're ready to wrap this up. And I want to thank our distinguished panel. I appreciated all of their comments. I think we've given you a lot of food for thought. I just want to make sure though that we're really clear about what the message is today. The message

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today is that we have remarkable progress from accountable health plans. We have continuing quality gaps with the rest of the system and that there is really a roadmap here for accountability for the future. Now NCQA, we are in the process of changing our accreditation program to reflect some of this stuff. With customers like CIGNA stepping up to the plate that makes our job enormously easier though not so simple. But I want to make sure that your stories reflect the fact that these plans have labored long and hard and used every possible type of innovative strategy to get the tremendous results that they got and make sure that the stories reflect that. So thank you so much. Does anybody have any other questions? I know you've got a lot of information today. Thank you so much and thank you for coming.

[END RECORDING]