



**Public Reporting of Quality Outcomes: What's the Best Path
Forward?
Alliance for Health Reform
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ED HOWARD: Well they're closing the doors, so the select group inside will have to concentrate on the business at hand. My name's Ed Howard. I'm with the Alliance for Health Reform. I want to welcome you to this program on public reporting on health care quality. Welcome you on behalf of Senator Rockefeller, our board of directors, and I'm really very personally excited about this program.

More years ago than I want to admit, I had an economics professor who was on the board of the Consumers Union and he'd go crazy if we'd found out that we had actually bought something without comparing whatever it was not just in price but in value, which of course means quality, the highest quality for the lowest cost.

The trouble with applying that rule to health care is that there has been precious little information about the quality of care delivered in a particular hospital let alone by a particular physician. Just this month, we read in the *Journal of Health Affairs* that one in every three hospital admissions comes complete with an adverse event of some kind and that there are still 40 wrong site surgeries a month in America.

So today we're going to look very closely at the amounts and reliability of information that's available to the

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public about the quality of care that's being delivered by hospitals and other providers.

Now as you're going to hear more from Anne-Marie and the panelists as well, it's been 25 years since what is now CMS began reporting on hospital mortality rates. Now we have the hospital compare website. Just this month, CMS began reporting on what it calls hospital-acquired conditions.

You may be surprised to learn that some of the same questions raised in the mid-80s about the mortality data are being echoed today in the wake up the new safety information that's being published. Do we have enough good information about the quality of care in a specific hospital? How are we actually using those data? Are employers and purchasers and consumers actually looking at those data? Are there any downsides to public reporting?

So we're going to look at these questions today and we're pleased to have in this enterprise, as a partner and a co-sponsor, the Commonwealth Fund, a 100-year old philanthropy based in both New York and here in Washington. Joining me today as co-moderator is Dr. Anne-Marie Audet, the Fund's vice president for health system quality and efficiency.

It's fair to say that today's briefing would not have happened without Anne-Marie's enlightened advocacy. So we're

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very pleased to have her with us today and let me defer to you at this point. Anne-Marie?

ANNE-MARIE AUDET: Well good afternoon and I'm also delighted to be here today. I think there's several reasons why this panel is actually very timely. One of them is, of course, that I think we not deny that we're in the midst of significant transformation in the health care delivery system today in the U.S. in both public and private sector. So now more than ever do we need data and information about the progress we're making and trends over time.

So information is really a key lever to transformation and to high performance. In your packet, you have a lot of materials and in 2008, the Commonwealth Fund Commission on a High Performance Health System looked at eight attributes of a high performance health system and transparency and public reporting, the ability to benchmark, and to compare to trend data over time was one of these attributes.

So again, public reporting transparency is a key lever to high performance health system. There's a lot of evidence that this information can be used for at least two paths. One is the path of accountability, how we push the system to improve by providing information to the system and to providers about how well they're doing, how well they're doing to others, how they compare to others.

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So that's the path of accountability and there's a lot of data to show that indeed by publishing information about performance that really fosters quality improvement.

Of course the other path of great importance is the path of selection, how we drive consumers to better understand the quality of care they get and so that they can better select and be pushed towards higher performance and also work with providers to foster better quality. So that's one of the key reasons why we're here today. The second is, as Ed mentioned, it's the 25th anniversary, the Healthcare Financing Administration in 1986 first really released information about the quality of care of hospitals in the form of mortality.

In your packets, you have a very nice review of how it was received in the public and the press. Of course, a few weeks ago, we had the hospital-acquired conditions and as Ed mentioned, it's really fascinating to see that the response is perhaps very similar and I had some notes that we've made a lot of progress but there's still areas where the first reaction is always to question the validity of the data, the risk adjustment, etc. and you'll hear from our speakers today about some of these key issues that we need to address.

So I just wanted to briefly, before we get to our guest speakers, say that I think in the past 25 years, that's the other reason that the panel today like this today is really

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interesting is that we now have a historical perspective of where we were in 1986 and where we are a quarter of a century later.

That can help us decide where we want to be in another 25 years and in 25 years, who know what we'll be publishing if we have another panel like this but clearly in 25 years, we now have a solid framework by which we understand what quality is and what performance is. We have the Institute of Medicine Quality Chasm Report that has outlined all of the dimensions of quality, effective care, patient-centered timeliness, equity, efficiency, etc.

We also have made significant strides in our methods, how we measure quality so that it's valid and reliable. We have now a national endorsement mechanism with the National Quality Forum who has done really an immense, has provided immense support for quality measurement endorsement and I have to commend them for pushing the envelope in terms of the standards by which measures are endorsed today.

The number of public reporting and transparent sites has also increased. We now have the National Quality and Disparities Report that's published by the Agency for Health Research and Quality. The Commonwealth Fund also has data available so that we can publish our national and state scorecard that profiles the performance of healthcare system

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across the IOM dimensions. Every year, the NCQA publishes the state of health care quality of health plans.

There's a number of regional initiatives. There are 24 chartered value exchange networks, which are charged with publicly reporting performance in their region and to provide information on quality and cost for providers and for consumers. Perhaps two of the more mature exchanges are those in Massachusetts, the Massachusetts Health Quality Partnership, and the Wisconsin Collaborative.

In both of these states, they published data about quality and cost, about patient experience at the level of the practices, so not only hospitals but physician practices. We offer, of course we have CMS hospital compare, nursing home compare, home health compare, and more recently physician compare.

Of course all of this is in the midst of what we're seeing now in the health care transformation. The Affordable Care Act has a number of provisions that are also going to use that lever of transparency to transform the health care system towards high performance. The Secretary will be publishing data on the performance of the health care system annually.

The exchange, the health plans in the exchange will have to also publicly report on their performance on a number of indicators of quality and of course, the recently released

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shared saving proposed rule making has public transparency and public reporting on a very comprehensive set of performance indicators, five domains, 65 quality indicators. So it will be very interesting to hear what some of our panelists will say about this but nonetheless none to say that there is a lot of pressure now and a lot of opportunity to use public reporting and transparency as a true lever to foster high performance in this country.

So the optimum goal is the three-part aim, better care, better health, and lower costs. So with this, I just wanted to say one last thing and that's the role that the Fund is playing in this area, both in our intramural and extramural grant programs. So we do a support evaluation of various measurement systems.

We're evaluating now the impact of the Wisconsin Health Quality Collaborative for instance but more importantly today I just wanted to have your attention on a site that we've been doing since 2008. That's One of the Best that you have information in your package. One of the Best is a benchmarking and quality improvement tool meant mostly for providers but we also have some consumers who use our tool.

It profiles a quality of care of 4,000 hospitals, 500 health systems, and the key attribute of this is the benchmarking. It allows hospitals and health systems to see

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how they're doing against each other. It uses a lot of the CMS hospital compare data but in a much more user friendly way.

It provides trends, graphs, and as I mentioned, benchmark and more importantly, once you have identified gaps, it provides tools for you to address those gaps because it's very well to measure but after measurement, you have to do something about it. So we also provide tools and models to help fill those gaps of quality once you've identified them.

We're always limited by the availability of public information. That's why I'm always very interested in getting more measurement available in the public domain. We're hoping to have more information about physicians once physician compare has more information about quality and we're using some of the British excellence (in reference to "U.K.'s National Institute for Health and Clinical Excellence") data on their physician groups. So I would really recommend that you look at this at this side in terms of benchmarking.

We hear from providers and actually one of the CEOs of a major health system in a major metropolitan area was saying that he always had believed that central line-associated bloodstream infections were a biological phenomenon that once you introduced a foreign body in someone, you're bound to have infections and that's true. So he never really thought that achieving zero was possible.

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They were striving for the lowest rates of infections but zero was perhaps not achievable. It's not until he saw a benchmarking of other organizations that had achieved zero that he totally changed his view of this and in his organizations just went for zero tolerance from any infections. So that's the beauty of benchmarking.

So the panel that we have assembled today is really an exciting panel and it's really delightful that they all agreed to be here today because they really represent colleagues in various different areas of health care that have a wealth of knowledge but also really on the ground experience because they've been here for the past 25 years and they've followed all of this progress and all of this activity around public reporting.

So they bring that real world experience to this topic. So it will be really interesting and important to hear what their vision is of where we've been, more importantly, where we should be in 25 years and what are the challenges and how we can start to address them in this quite opportune moment where we're faced with today.

ED HOWARD: Great. Thanks very much Anne-Marie and let me do a little housekeeping here. You have, as Anne-Marie mentioned, some materials in your kits along with a list of other materials that you can find on our website, which is

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allhealth.org. There'll be a web cast available thanks to the good work at the Kaiser Family Foundation, which provides that as a service for all of our briefings.

That would be at their website, kff.org. There'll be a transcript available on our website in a few days and a pod cast, I guess, through the KFF website as well. You have green question cards you can use during the Q&A portion of the program. There are microphones you can use to ask your questions in your own voice and that's enough overhead. Let's get to the meat of the program. Oh, evaluations. Take note of the blue evaluation form if you would, in your kits, and please fill it out so that we can make these programs even better for you.

As Anne-Marie said, we have a great panel and we're going to start off with a great panelist. That would be Tom Scully. He's senior counsel in the D.C. office at the firm Alston & Bird with the practice centered on health care, regulatory, and legislative issues and health policy and strategies. Now some of you may know before joining Alston & Bird, Tom was administrator of the Centers for Medicare and Medicaid Services where he was in charge from 2001 to 2004.

He has a long history of public service. He was on the White House staff under President George H.W. Bush among other posts and while he was at CMS, Tom initiated the first public

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reporting and disclosure of comparative quality information among hospitals and nursing homes and home health agencies and dialysis centers and God knows who else. They love you for it for every time [Laughter]. Tom thank you for being with us. It's nice to welcome you back.

THOMAS SCULLY: Thanks. I do have some slides that I'll run through quickly but maybe just for a little history, I do spend part of my time, a little less than half at Alston & Bird in Washington but I'm also a partner at Welsh Carson, which is a private equity firm in New York that's the biggest private investor in health care in the U.S.

I mention that because most of my slides are plagiarized voluntarily with this help from, we own a company called Arden Healthcare, which includes the Loveless [Lovelace?] system in Albuquerque and the Hillcrest system in Tulsa, a couple million dollars of acute care hospitals. So a lot of my slides come from what we've done as a company and since Welsh Carson owns them and I'm on the board, I just thought I'd mention that, so I do spend three days a week.

So for those of you who don't see me much anymore, it's because I'm in New York three days a week and you're probably all much happier though but I'm still in Washington a couple days a week. Anyway just for a little history because this was not easy and I don't want Nancy mad at me because she's done a

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great job at [inaudible], but this stuff was not easy to come by. I was a Senate staffer in 1986 so I guess we're all showing our age here, when Bill Romper was the HCFA administrator under President Reagan. He was the guy who first put out the forced hospital mortality data and it was almost ended up in his mortal wounding.

He got clobbered for it and he's still a good friend of many of ours and he could tell you this day probably the number one thing he got pounded for at HCFA back then was putting out un-risk adjusted mortality but I'm a zealot on this stuff for a lot of reasons.

I wish I'd done more in the first White House when I did a little at OMB but I was also the President of the Federation of American Hospitals from 1994 to 2000, which is the for-profit hospitals and believe it or not, the guy who first got me into hospital quality measures, which may even surprise Ed Howard was back then, HEA was run by a guy named Rick Scott, who's now the governor of Florida.

Believe it or not the first person I ever saw actually putting together really detailed hospital quality data was HEA during that time and I encouraged them. They wouldn't give it to anybody else. I said hey you ought to put this out to everybody.

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It was only used internally and I pushed a lot of the federation members to do it. They didn't want to do it. So when I got into HCFA, which I took over in the spring of 2001, I said hey for two bucks an hour, I'm going to have fun and do this. So I started pushing them to put out the hospital quality data because they knew they had it and at the time, the HEA and the federation, most of the hospitals were dead set against it. They pushed back very hard and said we're going to do this voluntarily.

So we had 10 voluntary hospital quality measures that I encouraged the HEA and the federation to do during 2001 and 2002. I see Stu Gutterman out there, was then at CMS, he remembers all this torture. I think they were all doing the best of intentions but they were nervous about it and we had 10 voluntary hospital quality measures.

I think we had 1,000 hospitals doing one. It was kind of a joke. So being Republican, we believe in voluntary stuff. so we stuffed something in the 2003 bill that said this was totally voluntary. You don't have to volunteer but if you don't give us the information, we're going to voluntarily pay you two-tenths of a point less than the market basket [Laughter] and magically it was actually originally .4, then it went to, well just to be accurate, that's ancient history.

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So we voluntarily collected and everybody was angry at first. We just stuffed it in the 2003 bill along with the Medicare drug benefit and a few other things.

People went nuts originally but it really works. Now in between there, we also, Stuart knows because he helped with it, we actually called up Premiere out of the blue and Herb Koon was there at the time, and volunteered Premiere, which I think helped a lot to come in and then Premiere basically started with about 500 hospitals, the beginnings of the hospital quality measures.

They got a lot of flack for it but I think it helped them a lot but Premiere, actually probably with CMS, put out the first set of hospital quality measures in 2002 and to their credit that really broke the ice with both the HEA and the federation but you can understand the hospitals were nervous about it. I don't blame them but I think in hindsight and I'm going to get into this, I think it's worked out very well but it's not easy. Bill Romper almost got killed.

Ed may remember this but the day after I get confirmed as the CMS administrator was a hell of a lot easier to get confirmed back then. I went to some speech the Chamber of Commerce and announced that I was going to really bring in hospital quality measures. I was going to put it in the newspaper. I mean we were

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going to put hospital quality measures in the newspaper and put all these things out.

Of course I hadn't checked with anybody so I didn't tell Secretary Thompson until I made the White House. The next day it's in the front page of *The Washington Post*, it said "U.S. to Measure Hospitals," which almost resulted in me having a one-day tenure as the CMS administrator [Laughter] so since nobody knew about it. So my point is this stuff has never been easy. I'm a zealot about it. I think it's totally the right thing to do. It's been going on for a long time.

It's now ingrained in the culture of hospitals and my own view is that's a very, very good thing but it wasn't without a certain amount of pain. I think the HEA and the CHA and the federation and others have really, really gotten engaged and helped this work the last six, seven years deserve a lot of credit but like any change, it was initially pretty scary and a lot of people were very much against it. Anyway let me run through this, I think I'll go through some of these but the Premiere hospital then was probably started with core quality measures. We also had a little controversy. We started H-caps back then.

When I first started doing hospital, I didn't even know this, Stuart again remembers this but I said hey Medicare's paying all these contractors to collect hospital quality

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measures on how happy you are when you leave a hospital, why don't we put it out in public? I didn't realize that there were about 25 contractors that had to develop these businesses.

So I had the equivalent of World War I with a couple of these groups including, what's the guy's name, he's in Omaha, Press Ganey he was good actually, all these guys that have done this, I didn't realize they all had word, but we put our hospital quality measures and it worked out pretty well. The next year, we started putting full-page ads in every paper in the country rating nursing homes and you can imagine none of these guys liked any of this and they all went a little nuts but it's all worked out pretty well. I think it's extremely popular.

So just to give you a little history about it, it's been going on for a long time and it's been fairly painful but just to drop to my slides here, I'm on the board of Arden Healthcare. We have a pretty good size hospital but this is not something that happened 10 years ago. It's already driving change. Every quarter, we have a meeting. We spend two hours with our medical director going through comparisons and I only put a few slides in here I picked out of our last board meeting where we had 120 slides. I picked out about five but this is really driving change already in health care.

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People are looking at blood infections and looking at rehospitalizations and it drives doctors. It drives patients. It drives from the top to the bottom. It drives big changes in hospitals. I can tell you it does in ours and I'm certain it does in everybody else's. It's clearly the right thing to do and it's not a futuristic thing. This is driving change today.

Again I wouldn't torture you with our whole board book and most of these I stole from SLEE [misspelled?], but there's nothing bad about this. You can argue about accuracy and obviously everybody's always going to be worried about how accurate it is and are we ever going to get it perfect? No. We're never going to get risk guesses perfect either but they're a hell of a lot better than we used to do with managed care plans.

In my view, there's no such thing as a public hospital quality measure or a health outcomes for patient that's a bad thing. It's all good. It's all positive and it's really good results for hospitals. This is one example of Loveless [Lovelace?] and again, there are hundreds of these year over year measuring what Loveless [Lovelace?], which is in Albuquerque, does of one of the core measures and I won't torture you with it but they were about 60 of these bar charts in our last board book on every hospital quality measure around.

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Hospital-acquired conditions, this is a timeline and another one of our big hospitals over time, where you can see the patient in the hospital and every doc sees that and obviously there's some spikes there but the trend line has gone down and that's what you want. When you talk to docs and you talk to patients and you talk to nurses about this, it drives change.

When you show docs and nurses they're making mistakes, when you show them of our seven hospitals in Albuquerque, one's doing a much better job than the other that drives change. When you tell the CEO of the hospital that by the way, your bonus isn't going to be the same thing this year because your infection rates are higher, there's no reason that drives change, all the stuff is good and all results and good things.

Falls and other trauma rates per 1,000 patient days, now is that probably still higher than some people would like? Yes but the trend rate is going down and we watch this. You can see month by month by month over the years, and Steve Langarten is our medical director, beats up everybody in the hospitals we own about this.

It unquestionably drives behavior and it's not the kind of behavior that people had a few years back. Falls and trauma rates per, this is the Albuquerque Women's Hospital and you can again see other spikes there, yes but people didn't sit in

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board meetings five years ago talking about this stuff. They didn't measure it. They didn't have it and they didn't drive decisions and now it does.

I think I got one or two more but readmissions, every hospital in the world's worried about this in the next couple days. These are a couple of big ones, AMI and I won't get into the details on this because I'll take everybody else's time but hospitals weren't measuring this. They're measuring for a variety of reasons, as I was saying, because there are great people trying to do the right thing and they're also worried they're going to get paid less in a couple of years and it doesn't drive it down.

So as I used to say as a regulator, it's not the money. It's the money [Laughter]. When you tell them they're going to get paid less, shockingly, they're a hell of a lot more focused on readmissions but everybody's measuring it and worrying about it and that drives a lot of behavioral changes.

Again, this is H-caps, which is hospital quality measures and I probably shouldn't have put on one of our competitors here but as you can see, when you're going out and talking to everybody in your hospital from 2008 to 2010, one of the patient satisfaction measures, and they're all going up, nobody knew what they were three or four years ago.

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Well that's a big deal. That's nurses respond to your calls, patients, they get out of hospitals. These are basically public polling and they're not quite as quality-based to the quality measures but they're important. When you're running a hospital, you can see the success of our hospitals is directly related to how happy the patients are when they check out. This is all good stuff and none have existed in 2003 or 2002 or certainly not in the 90s. It's driving big changes.

So what is the framework this is creating? I think this may be, I have one more quick one after this, is that we're getting to a framework we're going to have quality measures and what are these going to do? When you measure quality and do it in a way that's satisfactory to the HEA who should be worried about it, you can start paying people based on that.

The real change comes when you start adjusting the money, when you can tell people you're going to get paid differently based on your health outcomes, whether it's the start program for Medicare, advantage plans and we own a big Medicare Advantage plan too, or whether it's nursing homes, or whether it's home health agencies, or whether it's hospitals, it's definitely the right thing to do.

It's definitely driving good change, and there's on, in my argument, position, there's no way around it. So value paid

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purchase is a great thing. Preventing readmissions is great for patients, some hospitals are focused on. ACOs I won't get into but we're moving towards a much bigger bundled world.

I'm in favor of a totally bundled world. I mean I guess my view is we ought to do pre-acute bundling and post-acute bundling and acute bundling and bundle them all together and call it Medicare Advantage and get the government the hell out of the program.

That's my view but that's an ultimate bundled world but we're all going to much more bundled payments and when you get bundled payments, you have to measure quality and you have to measure outcomes and clinical effectiveness research, which gets a lot of people in trouble including my friend, Don Berwick, who's unfortunately gotten in trouble for it.

If you really believe in comparative payment and measuring things and paying people differentially in health care, there's no way in hell you can do it without clinical effective research. In fact, this research, I did it every day at CMS. Everybody does it every day at CMS. It's just the fact of life and all these things are all part of the same discussion. That's as fast as I can go. Thank you.

ED HOWARD: Not bad. Pass that to Gerry. Thanks Tom.

We have another return visitor on the panel that would be Gerry Shea. He's assistant to the President of AFL-CIO where he

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leads the Federation's work on health care and retirement security. He's an official of the National Quality Forum and the Joint Commission.

He's on the board of the Hospital Quality Alliance among other quality initiatives. He's been a member of MedPac and its predecessor and before joining the AFL, Gerry spent 21 years with the Service Employees' union. He knows a little bit about this stuff. So we're very pleased to have you with us again.

GERRY SHEA: Thank you so much Ed and I agree with most of what Tom Scully says including the part about how fast he can talk [Laughter] but I'll do my best to keep up the pace. Public reporting really has been the lynch pin of the kind of improvements that Tom showed in his slides, very substantial improvements, and while many of us carry around the numbers about what we yet need to do, the hundreds of thousands of people every year who get injured or killed in the care process because of preventable errors.

In fact, we've made an enormous amount of progress. It is also the lynch pin, public reporting's also the lynch pin of our hopes to transform the delivery of care and in the process, to make it affordable. We have no other approach to dealing with health costs in this country, in my opinion, other than to

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transform the delivery of care and it does hold very substantial promise.

I'm delighted to be here with a few organizations that have done so much and do so much for health care, the Alliance for Health Reform and the Commonwealth Fund, just tremendous contributions, both of them in many different situations over the years. I'm pleased to be on this panel.

I haven't had a chance to work with Blue Cross Blue Shield or David in person but I know about Blue Cross Michigan work and it's terrific. I have had a chance to work with Tom Scully and Nancy Foster and you got the sense from what Tom said of how much ground he covered and some of the trouble he got in while he was doing that.

He really pioneered this and along with Secretary Thompson who back then took a fair amount of risks himself to move this forward, it really started seriously on the road what got derailed back in the mid-80s, got resumed in the early 2000's in the Bush administration and we are very grateful for it but before Tom took his very non-regulatory approach of withholding people's money [Laughter] if they didn't report, there was a voluntary effort and Nancy Foster is one of the unsung heroes of that because lots of hospitals did report on a voluntary basis.

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I think they actually were even a little bit better off than Tom alludes to even though going to requirement was the proper step. We got a lot of hospitals to report because Nancy called every one of them, as far as I can tell, and talked with them through this process and said well this is just coming. We might as well face up to it. So hats off to her.

So this is my three kind of general categories of what happened based on public reporting. One is it drove major improvements in hospitals as well as other parts of health care and it is very much a function of the light of day but not just because there have been some dark corners of our health care system, there have been and there are today all too many instances of situations that aren't fully explained to the patients who are involved but more so because people really didn't know how bad the situation was in terms of safety and quality until we started to publicly report the measures.

It also led, it was the foundation for purchasers to be, for the first time, to be serious parts of the whole health care equation. Until then, as my corporate colleagues would put it, we paid the same amount in the private sector for every health care procedure whether it was great world class care, pretty good adequate care, marginal care, or downright dangerous care.

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We paid the same amount and we didn't know which was which. That, to a great extent, is what has led to the effort today to base purchasing on measures of qualities but a long time to get from there to here and we're just beginning this but that is a huge step and it, importantly, brought private purchasers as well as Medicare and state Medicaid agencies and state governments into this process in a significant kind of way. So purchasers got a seat at the table for their first time and along with them, us consumer types as well.

Then the third area is consumer engagement, which to a great extent, has been the holy grail of public reporting, the notion early on that if we just explain to people like *Consumer Reports* might do for lots of purchasing that we all do, if we just explain to people what the rating was for health care then we would all be able to make informed decisions. In fact that hash turned out to be a very difficult goal and one that we haven't nearly reached today. I'm going to finish with a couple comments about where I think we need to go.

This is an, illegible on the screen, chart but it's one of my favorites so I get to put my favorite slides in presentations. Some of you have been visited by this before when a group of us may have visited your offices if you're in the Congressional staff while the Affordable Care Act was being debated because a whole bunch of groups that have been involved

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in this quality reporting effort got together under the banner stand for quality and we ran around and knocked on doors saying when you're writing this little piece of legislation, please build in what we believe we've learned over the last 12 years or so about trying to improve quality.

So we just used this timeline and the only thing I really want to point out is that the beginning of this really is the Institute of Medicine report.

There were earlier efforts but the beginning of the consensus that we could really do better in health care, the consensus among the leaders in health care was the Institute of Medicine reports and the reaction was wow, we really can do better. The statistics weren't new.

They'd been around for a while but it was one of those moments where they just came together and the result was and continues to this day to be a remarkable process of collegial cooperation among providers, purchasers, physicians, government, nurses across the board because people all were just simply driven by this. We can do a lot better than this.

There are lots of examples about how we analogize that and so forth but that was kind of the driving point of this and then of course at the end of this timeline, there is the Affordable Care Act, which thanks to your good efforts, many of you, did incorporate a lot of what we believe we learned about

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quality measurement and improvement over those years. This chart, like a few others, is from the Joint Commission.

You'll see the little logo on the bottom. I think it just does a nice job of comparing then and now. It's important to understand that shortly after the IOM report came out, there weren't quality measures basically. There were a few but this is a brand new field I mean relatively speaking. It is complicated, costly, difficult to develop measures that you can really get a consensus on because it's tricky business.

This is health care after all. So we've grown this up but we started virtually from nothing. Now some people would even say, my colleagues at the Joint Commission concluded well maybe we have too many measures or not the right kind of measures. So I think Nancy might talk a little bit about that.

We didn't have uniform data collection. We've gotten to that point. We've gone from little improvement to major improvement, again Tom's slides and the experience, of course, with measures has accumulated to a great extent. Then you have, in the last column, what we next hope to do, which is very ambitious but then this whole enterprise has been since the beginning.

I'm going to use one improvement chart because I like it so much, again thanks to the Joint Commission. The Joint Commission has classified their measures. They currently

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collect about 28 measures of quality. They classified those as being the most, the highest performing measures, the ones that indicate the quality, the best, what they call accountability measures. There are 22 of them.

This shows what public reporting has done. This is, of those 22 measures, the composite of those measures what percentage of hospitals achieve 90-percent on a scale of 100, compliance with those measures. You can see it goes from very low in 2003-2004 to about 90-percent today. Now we need to not have 22 measures but a couple of hundred measures that easily get reported and collected because we're going to automate all this we hope so that we can move on.

These are just sort of break it up by clinical area, I just want to make the point with this, this is about the recent patient safety initiative that the Secretary announced a couple of weeks ago and the point I wanted to make is look at that little goal between 2010 and 2013, our goal is to reduce preventable hospital-acquired conditions by 40-percent.

That's pretty ambitious but the people who came up with these numbers to analyze it at CMS think that's doable. Similarly with preventable readmissions, we think we can get it down by 20-percent and then the bottom here, in case you wondered what the stuff that is a very conservative estimate is that the savings could be \$35 billion a year each year.

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This chart comes from CMS and it is, it just lists the existing CMS programs and the planned CMS programs under the Affordable Care Act that relate quality performance to payments a long way from Tom Scully's bright idea at the Chamber of Commerce one day so that in 2017, if you add up these numbers and there's some pluses and minuses because they phase out some old programs as they bring in new ones, nine-percent of Medicare payments will be varied. They will be at-risk based on hospitals' performance and hospitals will be paid based on how well they do this. So the point here is just this is a lot of money. Thank you.

Then it's not just that hospitals or, in the future, physicians are going to be measured on the quality of care and paid within the Medicare system. The new models of care or the, if not new then the models of care that are heavily promoted in the Affordable Care Act, which really are the most powerful tools, I think that we have, for improving care and lowering costs or controlling costs over time, are based on this quality measurement stuff.

Without it, you can't do these things because you wouldn't know where you were going and yet, we're about to embark on an enormous venture to enroll a lot of people in patient-centered medical homes and accountable care organizations.

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These are basically primary care practices with extra resources sort of blown up to a bigger scale, bigger in primary care, patients out of medical homes, and even bigger yet in accountable care organizations, these are new frontiers but I'll just point out that IBM, which has been experimenting and promoting patient-centered medical homes for years, estimates that they save nine to 10-percent per employee per month for members who are in medical care homes and their studies of people who are in those homes show not only a lower cost but much higher quality, much fewer hospitalizations, lower use, vastly lower use of emergency rooms, and much greater patient satisfaction. This is all based on being able to measure quality.

I was surprised but very impressed to see a note from the IBM folks two weeks ago saying they just sent out their RFPs for all of their health care coverage for 2012 and their position is primary medical homes that's all we want to fund going forward.

If you don't have them yet and you're an insurance company, you want our business, go create them. They're creatable. In primary-centered medical homes, we'll pay primary care physicians grouped in an organization, with certain attributes, more money to be able to deliver and coordinate care.

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So the last point is the consumer engagement one and this has been the elusive goal. I have a lot of experience with this. Unions started with some industries, auto is a good example, in the early 80s to give out report cards and we thought report cards would really drive change in health care.

Since then we've tried many different variations in unions and union funds about how to get people to relate to quality measures that we knew were valid. Basically the response among our members, the people that I talk to in our local leadership, has been this is a nice idea. Why don't you try a little bit harder? They just haven't worked.

We haven't found the right way to do this but there is some important research that was done and one of my colleagues who's here in the audience from the Consumer Purchaser Disclosure Project sent me a note last night about a study I hadn't seen from the California Health Foundation that did extensive consumer interviews about what they wanted in public reporting and interestingly, what people reacted to most was they wanted information about patient safety.

There's enough word out there about this infection problem. We've all had the experience, unfortunately, with family members about infections problems or other hospital-acquired conditions so the people really, they want to see this addressed.

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Secondly, people were interested in patients' experience in going to hospitals, which is, as Tom said, not the most clinical measures but is really important to all of us because we kind of trust the other people who've gone before us in these hospital settings and then third is clinical information, not that clinical information is less important.

It is this old adage that just like with plane safety, when you get on the plane, you don't ask the pilot about the wiring details. You assume that somebody has certified that this plane runs correctly. That's sort of what's going on with clinical care but it also indicates just how much of an education, John, that we've done.

I think, as we move forward with these models here, we have a tremendous opportunity to really get to much better patient engagement and for my money that will require embedding the discussion about quality measures in their patient experience.

Clinicians have to have time and they need to be paid to talk to their patients about how decisions are made in health care or should be made in health care and why quality measures are so important is just an essential part of trying to get to this next level and I hope that we're going to at least seriously try that in the future. Well I guess I didn't do what Tom Scully did.

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ED HOWARD: You need to talk faster. Tom can give you lessons. A couple of quick points before we move on, one is that the California Healthcare Foundation study that Gerry mentioned is listed on your sheet in your materials, the materials list as it were. Second, with respect to ACOs, you should get the early warning that two weeks from Friday on May 13th, we will be doing a program with our friends from the Commonwealth Fund, as a matter of fact, and the famous Stu Gutterman has been referred to several times already, on ACOs.

So put that down on your calendar and respond when you get the notice. I forget what the third one was. Oh as a matter of fact, Nancy's slides and Tom's slides are not in your packets but they will be on our website so you can check back and get them there at allhealth.org.

So as promised, we next turn to Nancy Foster. She's the Vice President for Quality and Patient Safety Policy at the American Hospital Association. She is AHA's point person for the quality alliance, the hospital quality alliance, which is a private/public effort to provide information to consumers on the quality of care in American hospitals.

She's also very active in a host of quality initiatives. She advises hospitals and policy makers on ways to improve quality, patient safety, including regulatory standards, and before coming to AHA, Nancy was the Coordinator

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of Quality Activities at the Agency for Healthcare Research and Quality, AHRQ. So Nancy, thank you very much for joining us today and we look forward to hearing from you.

NANCY FOSTER: Thank you Ed. Thank you very much and like my fellow panelists, I'm truly delighted to be here not only to address this audience, this critically important audience but also to be part of a discussion that is coordinated by the Alliance and the Commonwealth Fund on yet another critical topic. You all have led the way in really helping to address and highlight different points of view about so many critical topics in health care.

So I thank you for all the work that you have done and I thank Gerry for his earlier comments, his kind comments. He has really been one of the premier voices of patients at the table in so many of these important quality discussions and it has been critically important because while some of us who enjoy playing with data a lot would be having debates on whether we can actually accurately count how many angels are dancing on the head of that pin, Gerry would be the voice reminding us to come back to the important stuff of how we're going to advance care for patients. I thank you for that.

So let me get on with my remarks but I have to say while as grateful as I am to Gerry for his comments, I was three weeks into my job at the American Hospital Association

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when my boss turned to me and said we need to get all of the important players together in a room and talk about how we're going to do public reporting better, how we're going to really make a difference about all of this, using all of the data that's being collected?

That could not have happened if it had not been for the leadership of the AHA board and the federation board of trustees and the Association of American Medical College's board of trustees because all three organizations came together to say let's see if we can get people in the room and talk about what we could do together better rather than the independent actions we were all taking. It was that conversation that I think created a foundation for much of the work that went on and the work that later became the hospital compare website.

So when you hear me talk, realize that it is in fact the hospital CEOs in your states that have agreed to essentially show their report cards, that have agreed to do what that guy on the Pizza Hut commercials talks about not being thrilled about doing when his boss says I've asked on every pizza box for people to rate, whatever his name is, chicken.

It's that kind of transparency that we're talking about and it does take some courage to do. It does take some

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willingness to admit that you have flaws but hospitals are fully committed to doing this because it is so extraordinarily helpful to them in their efforts to improve the work that they do.

I'd have to say the mantra that has continued since this work began, the constant refrain that I'm hearing from hospital leaders is really make sure that the data that we are sharing is scientifically sound, it's actionable, it's fair, and it's important. Let me talk a little bit about each of those and as Tom has already alluded in the institution, which he is familiar, the data that are being publicly shared are in hospitals all across this country driving board discussions.

They're driving actions on the leadership teams. We have little evidence yet that the data has actually influenced a lot of consumer decisions but I can tell you it's influenced a lot of discussions, a lot of action within hospitals. That's what's led to the improvements that Gerry referenced in the documents that he was showing in the slides he was showing.

Interestingly enough, a lot of this work has been through collaboratives, that is hospitals coming together to learn from each other more rapidly than they could learn independently. I raise that issue because by tying it to value-based purchasing, which we believe is a good idea, but

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you do create that tension around are we really competitors or are we collaborators?

It would be interesting to see how that plays out over the next few years. Well when we talk about measures being scientifically sound. What we really want is to know is whether these measures are looking at reasonably expected outcomes that is something that you could actually expect me to achieve and/or they're looking at processes that have been clearly linked to better outcomes. Please don't send us after improvement on measures if it's not really going to make a difference in patient lives. That's the tension here. It may be easy to collect but if it's not going to make a difference in the patients I serve, why bother is sort of the attitude.

We'll talk a little bit more about the reliability of data collection and there's some issues around that. That's one of those issues Anne-Marie referenced. It's always been with us, will continue to be with us, and whether or not that we have relevant numerators and denominators. Our preference is strongly that we use all payer data.

So let me just talk a little bit about the soundness of measures and where I think we need some additional work. Good outcome measures would have evidence of preventability. Well Anne-Marie referenced the central line bloodstream infections, the prevention of this terrible thing that can be very deadly

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to patients. It's really an important thing to measure. It's critical to get that right and we're working hard to make sure that happens.

We have a good sound data collection stream. The data are not yet publicly available on hospital compare but the data have already started to flow in to the CDC's national health care safety network. So we're going to have really good solid, credible, reliable information on this particular adverse event.

We also now have and you can click and get it on the CMS website, data on basically the same thing, vascular catheter-associated infections collected through claims data. What I would tell you is it's not as reliable. It's not as clinically found. There are a whole list of reasons for that. we could talk about it but the tension for hospitals is couldn't we wait just a few more months and get the really reliable data that we want to use, that we are using already internally to drive improvement versus publishing data that's Medicare patient only, not all patients, and not as reliable? That's sort of the tension you feel in the room.

We can come back to talking about whether the numerators and denominators are sound or not but essentially the way the HAC rate, the hospital-acquired condition rate is constructed here, the hospitals that rise to the top are those

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that have very small numbers of Medicare patients or that have high numbers of patients who actually have a central line, who have a disproportionate number of their patients that are exposed to this particular risk because those hospitals that have few patients, relatively few patients with central lines, don't have as many chances to create a central line infection.

Actual, for us, means you really got to have good science that will show us what we can do to change the outcomes or at least give us some basis for how we will move forward. The science doesn't have to show us how to get to zero but it's got to show us how to get from here we are to someplace better than that because otherwise you'll just cause a lot of churning and a lot of frustration and that the changes within the influence of the organization.

One of our hospitals in Ohio is sharing with me a great example that they went back, in an effort to try and reduce their surgical site infections, and one of the common denominators that they found is for the majority of patients that ended up with a surgical site infection in their hospital, they came into the hospital with blood glucose levels, sugar levels out of control right?

If you get the patient with the sugar level out of control, they were finding very little they can do to effectively prevent that infection and yet for elective

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surgeries that is within the control of the primary care provider or the surgeon before he or she admits the patient rather than the hospital when you got the patient in there. So lots of things need to be thought about as you're thinking about what measures are appropriate and how do we use this information. There are regulatory factors we should deal with as well.

In terms of fairness in measurement, we want to make sure that we adjust for all of the differences in the patient that will affect their outcome or whether or not they should get that process measure within the context of that measurement.

A lot of the measures that are on hospital compare do a very good job of that but there are questions being raised now about whether there are other factors that should be taken into account. For instance, in the mortality measures we're currently using, they look at mortality for heart attack, heart failure, and pneumonia from the time the patient is admitted to 30 days post-admission.

That's a good thing to be looking at but they don't take into account right now whether the patient may be in the last stages of life and decide that they don't want more aggressive treatment or the family members make that decision on behalf of the patient.

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So if you've got a large number of patients who have that personal option and make that choice that they don't want aggressive treatment, your mortality rates may look abnormally high. I put up genetic information here on this slide because lots of things are changing in the science.

We have to remember that you all are investing a lot of money in NIH and hopefully that will result in major changes in the available science to help clinicians deliver better care but as you do that and as we invest in and learn about things coming out of the genome project, I expect that different patients with different genetic make-ups will be getting different kinds of drugs.

So if we're measuring right now did this patient get the right antibiotic, our definition of the right antibiotic may be changing enormously over the next couple of years. All of that is a challenge for our measurement going forward.

We have to think about how this all changes as we move to these accountable care organizations, medical homes, and other organizations that try to stretch more broadly across the care delivery system. What is it we should be expecting of those?

Are the risk adjustments that we've used for these measures for so long the right ones when you're talking about a bigger piece of the action or not because within that bigger

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piece of the action, you may have different expectations about what could be managed and what could be expected of the patients coming in the door.

Well 30-day readmissions would be a good example here of another issue around fairness. What we've found is in doing some deep analysis at the AHA is that when you look at the data, some of the hospitals that float to the top that have high readmission rates are those that you and I would call the safety net hospitals that operate in communities that lack effective health care resources abundantly for the patient population.

It shouldn't be a surprise to us that if they can't get their medications following discharge from the hospital that they can't get into the right physician office or rehab treatment or whatever else they need. Those patients are going to come back to us in larger numbers than in communities where they have adequate access to all those kinds of resources but does that mean that kind of hospital should get penalized? That's a public policy discussion we need to have because right now these measures are not adjusted for those socioeconomic factors.

We also see hospitals that have a disproportionate share of the low mortality rates having high readmission rates. I won't, because I'm out of time, I won't trouble you with

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going through all of this but if you look at this, this is the heart attack and heart failure, those who are shown to be at the outside, high levels of readmissions but low levels of mortality and the red arrows point to those that are on both lists, unexpectedly high readmissions, unexpectedly low mortality or unpredicted low mortality. Hopefully it's expected but that kind of dichotomy makes us wonder are we measuring the right things? Are we going to cause some unintended consequences?

Again an important public debate to have none of which should be taken to mean that we should stop doing this measurement but we should get smart about it and Mark Chasen and his colleagues at the Joint Commission have laid out an incredibly important paper for us to use in thinking about what measures should be driving our performance and how do we review those. I would commend that paper to you and thank you very much.

ED HOWARD: Great, thanks very much Nancy. Finally we're going to hear from David Share. David is the vice president for value partnerships at Blue Cross Blue Shield of Michigan. He's a physician and for 30 years, he was the medical director of the Corner Health Center in Ipsilanti, community-based health center for teenagers and their children where he still practices.

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Today, he's agreed to share with us the view of a health care purchaser of the importance of health quality reporting for hospitals and also share some cautions about the possible unintended consequences of public reporting. David thank you for being with us.

DAVID SHARE: Thank you very much Ed. So I notice they ran out of time. I'm not going to do that. So I'm going to go quickly and hope that if there are question, we'll be able to address them with the time that will be left. I'm going to divide my comments into some comments about the issue of public reporting from the consumer perspective and from the provider perspective.

We have touched on both of those but I'm going to separate them a little bit more. In my mind, the consumers are the most important and the fundamental goal is to empower them, empower them to do what? Not just to seek or find the best care because ultimately we want all of the hospitals and all of the doctors' practices that our consumers and our communities have access to, to be of high quality.

What we want them to do is to be activated, to be empowered in terms of their personal behaviors, in terms of their health care-seeking behavior, and in terms of their role as an active participant in the health care when they're actually encountering a need and seeking care from providers.

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Currently there's pretty much, in my view, no evidence that consumers use the existing information as publicly reported to seek health care. There are few people, very few, small single digit percentages, who look at websites and find out who does well on a particular service that's technically complex and high-risk that they may need in the not too distant future and they may make a choice based on that but that's quite unusual.

Also the available data, when we talk about the kinds of aspects of care that are reported on tend, in my view, if you just step back and look at it, just shine very narrow spotlights on selected aspects of care where we know the relationship between process and outcome or where we can measure an outcome with some degree of reliability, the caveats that Nancy just offered notwithstanding. The vast majority of health care that patients need is much more complex than that. Those areas are still pretty much left in darkness.

Also fundamentally, I don't think, from my experience as a physician from everything I read when people study it that patients or consumers have much interest at all in the kinds of clinical measures that we report on hospital and doctor performance. It just doesn't inspire or motivate them. It's too technical. It doesn't speak to their life experience and the health issues that they face.

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From the provider perspective, there's no question it's demonstrated today that provider behavior has been changed substantially in response to publicly reported performance data. There's evidence of a tight link there that behavior change is catalyzed by publicly reporting data not just sort of a vague general effect.

However, again think of this image of health care on the stage, narrow spotlights highlighting very selected aspects of care. There are no floodlights out there in terms of the kinds of data that we report publicly casting broad light on large swaths of health care. So if we only rely on public reporting, I think we're pretty limited. I think we're hamstringing ourselves even if you look at the 65 measures that CMS is proposing for the new ACO demonstrations. They're nice but they still are these tiny little finely focused spotlights.

So I'll just mention very briefly a couple of other models. The AHA Get with the Guidelines Program and the American College of Cardiology GAP, Guidelines Applied in Practice Programs, are very good examples of how hospitals and doctors can come together to identify aspects of care where the process is known to be linked to a good outcome and to standardize practice to provide more reliable care in terms of the provision of those particular services, and we know that

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that leads to better outcomes. That's all without public reporting.

Another example, which I'm particularly excited about and there's an article referenced in the booklet or rather the packet that you have today in your list of references. It came out in *Health Affairs* this month from a group that I work with in Michigan and basically it's taking the workings of comparative effectiveness research with comprehensive clinical databases on complex areas of care, general surgery, vascular surgery, cardiac surgery, coronary angioplasty, breast cancer care, collecting data on all patients across the vast majority of hospital providing the care in a region, getting the doctors and the hospitals' experts together to examine their performance collectively in a cross-setting and learn from one another what works.

So basically harnessing comparative effective research in the real world with real patients to catalyze hospitals and doctors to be continuously self-optimizing. Dramatic reductions in mortality and morbidity, dramatic savings as a result, again all without public reporting. So there are other models.

I want to speak briefly to unintended consequences of public reporting. Nancy' spoken to some of the challenges of reporting. When we think about diabetes performance

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measurement, we tend to talk about the reduction or glucose control below a certain level, seven is a common number.

If your number's under seven, you're likely to have better outcomes but it turns out you get a lot more bang for the buck in terms of health care improvement and outcome improvement, if you move from nine to 8.5 then if you move from say 7.5 to under seven but that doesn't tend to be the focus of public reporting. So sometimes the way we measure actually forces providers to focus on cohorts of patients who aren't going to get the most benefit but they'll focus there because they are concerned that they won't look good if they don't.

So this is a little challenging to understand. I'm going to run through it quickly but this is a report of some work that we did and it was reported on in one of the journals of the American College of Cardiology in 2005. Basically we compared using comprehensive identically risk-adjusted data registries from New York State and Michigan, public reporting in New York, no public reporting in Michigan.

It turns out that unadjusted mortality rates in New York were almost twice or rather half as high as in Michigan. So boy Michigan's bad. Don't go to Michigan for your cardiac care but when risk-adjusted, it turns out that the mortality rates actually were identical.

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The differences in the patients that drove the differences in the raw mortality rates were that in Michigan almost twice as many patients who had heart attacks were getting angioplasty and in Michigan, several times more patients, almost six times, who had heart failure got coronary angioplasty than in New York.

I might have misstated it but anyway, so the patients in Michigan were sicker than in New York but those patients, it turns out, have better outcomes if they get the service than if they don't. So they were more often not getting it in New York than in Michigan. They weren't just disappearing. Their hearts were more damaged. They had less good functional status.

They might've died on the medical service of a heart attack out on the interventional cardiology service but it looked good in public reporting. When we talked to leaders of catheterization labs in New York or just rank and file cardiologists in New York, they say we avoid the sicker patients intentionally because of public reporting. So there are definite negative consequences associated with it.

I want to speak briefly about the frame of reference of public reporting. We didn't talk much about doctors. We talked more about hospitals so far today but there's very much interest in focusing on physician performances as well.

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When we talk about individual doctors or even doctors in small practices and their practice performance, a small number of problems lead to accuracy problems. Also so my practice is with poor teenagers and their children, so a very high-risk population, Medicaid and uninsured. When my reports come out, they tend to have about oh 40 to 50-percent of them in the 30 to 70-year-old age range. I see teenagers.

So the opportunity to or the ability to measure accurately at the individual physician level is limited but also if you start doing public reporting at that level, they're going to want to avoid those high-risk patients. They're going to want to avoid the Medicaid patients because they can guarantee their reports won't look as good.

So it's much better to think about public reporting and provider behavior at a population level, A, because it's more accurate and B, because the problem isn't with individual provider performance. The problem is the systems in which they work are not structured to yield reliably high quality care. So let's reframe it and focus on system performance instead. I may not actually finish on time.

So I'm going to suggest that reporting should be thought of as separately for reporting on providers and reporting to consumers. I've actually already mentioned the idea that we should be reframing to focus on systems of care

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but we want them to not only get information about their performance, we want to hold them accountable.

The accountable care organizations are wildly talked about now. I'm not sure anybody will sign up for them the way they're structured but people are now getting the idea that population management and systems to assure good quality and good results at a population level, quality results in cost performance. All of that matters. So let's begin focusing our performance reporting at that level as well.

Then I want to finish by making some comments about what we should be reporting to consumers or groups of patients or potential patients. So again getting back to this notion that we want to empower them, what do we want to do? We want to foster and active engage patient community to be closely connected to a medical home and to be focused not on procedure-based care but on relationship-based care.

So instead of telling them about the 65 measures that CMS is going to require for ACOs and for the doctors or doctor practices in their community, information they won't look at, why not focus on telling them about the patient-centered medical home-based practices in their community that already have demonstrated the willingness to implement sophisticated capabilities to partner with patients and manage their care

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effectively and to integrate care across the continuum of care in service of those patients.

Also instead of focusing on clinical quality measures like we do with providers, let's focus folks on patient engagement and patient satisfaction. So are the medical homes that patients might seek or the systems of care from which they might seek care, are they doing a good job satisfying patients and engaging them? That's probably a lot more meaningful to patients and will be more useful in guiding their decisions.

So then lastly, let's not think of public reporting as a strong lever or catalyst on its own. Let's think of it in a context, a situation in which we were trying to reframe the incentives that exist not just for providers to scurry around and fix care in the areas with the narrow spotlights that we happen to be focusing on but let's reframe incentives so that providers come together in communities of care givers with collective responsibility for population level performance where they receive more resources if they do a good job at a population level in cost and quality outcomes and in satisfying patients and meeting their needs from patients' perspective.

Let's also decrease the member liability, the out-of-pocket costs for individuals when they go to a medical home-based practice.

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So then the information you give them about where a medical home is helps to lead them to a source of care at which it's going to be less costly for them because they know they're going to get better value. Let's decrease the cost of care from a specialist when they're referred by the medical home for a chronic illness. That will help sort of harness the knowledge that we can offer them in public reporting to information that will lead to new relationships, more effective relationships, and more effective patient behavior. Thank you very much.

ED HOWARD: Thank you very much David. Green cards are the order of the day. If you want to fill out a question and hold it up, someone will pluck it from your hands and bring it forward. There are microphones at the far left and the far right. I won't tell you which is which so that you can ask the questions directly if you would like. Let me just reiterate that my co-moderator, Dr. Audet, should feel free to jump in with questions of your own. In fact, we want to start with that, that's a good idea.

ANNE-MARIE AUDET: Thank you. Yes, while we're waiting for your questions, David, I just wanted to continue on the wave of your discussion because I think you have a really important point about the population-based approach to this.

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The big challenge I hear though is that for that, we're segregated and we're siloed in how we measure providers, hospitals, physicians, specialists, etc. but we're also siloed because the source of our data is often from payers. So a few of you have mentioned all-payer data. How do we get there because a lot of groups, a lot of communities are really trying and some of them more or less successful but it's still a big challenge so how can we get on that route so that we really get to population-based measurement?

DAVID SHARE: So I know that in Wisconsin and I'm sure there are other states that have done this but only a few that they have a comprehensive community-wide all-payer, all-patient registry and we are working on it in Michigan.

Also it's important not just to have this common source of data from which you can generate more robust and more complete analyses that speak to the totality of care that people get in the community not just in silos by provider type or by region or wherever but also it's important, as a foundational challenge, to get natural communities of care givers, primary care doctors, the specialists with whom they collaborate, and the facilities that they use to self-identify so that you can begin to define the population on which you're reporting based on the patients seeing by the primary care

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practices because that should be the foundation, the basis of the population of interest.

ED HOWARD: Yes, Gerry?

GERRY SHEA: Just a follow-on. We've been severely hampered in all those enterprise by basically only being able to develop those measures and somebody came forward and said we'll pay to develop them. It's like a quarter million dollars to do one of these measures and to test it out to make sure it is right and it is not going to lead to the unintended consequences and even then, you have to refine it all the time because the science changes.

So we had a huge accomplishment early this year, which is that the first national quality report was issued in the nation, which should drive all of the federal agency work on quality and should be the basis on which we identify well where do we need the measures and so forth and then not to ask for money in a no-money time, somebody's got to put up the money for these things.

So is there just like a basic practical matter here about, and we can debate which is the best way to do it and so forth but basically we've developed those measures that somebody came forward, whether it's a foundation or it's CMS or it's a Joint Commission. Somebody's come forward and said well we'll pay for this.

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ED HOWARD: Okay. Yes, start over here. I ask that you identify yourself and keep your questions as brief as you can. Thank you. Mike?

MIKE MILLER: Thanks Ed. It's Mike Miller. I'm a physician health policy consultant of too many years. Gerry and Tom did a great job just discussing the history of quality reporting but I just want to make sure people understand the context back in the 80s when this all started. It took what, two years before you had any information about the hospitals. So you're looking retrospectively back two years ago.

So now my impression is people can get data that looks back maybe three months about how health systems or physicians are operating. That's really important if you're going to change behavior and a lot of that's been driven by the health information technology and I know people were talking about the Accountable Care Act but a lot of the incentives and funding that came for that came from the economic stabilization acts back in '08 and '09.

It's funded through ONC and also the Medicare/Medicaid incentives. I just wondered if people could talk a little bit about that health IT infrastructure and how critical it is and what steps need to be taken to keep moving that forward to enable the kind of quality reporting, quality assessment, public reporting that's needed. Thank you.

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ED HOWARD: Nancy?

NANCY FOSTER: Sure. Let me take the first stab at it. In all honesty, most of the measures that we have up on hospital compare right now are data that are at its most recent, a year and a quarter old because that's the cycle for collection and scrubbing the data, doing all of that other stuff. We would love to get to the point where you can push a button and generate quality information both at the local hospital level or for a broader array of providers who come together in a health information exchange.

There is, as you know, an enormous amount of work to be done. It starts at the very ground level of making sure we all have agreement on what a common data element looks like so that as nonsensical as it seems, the health IT vendors can all know how we want to describe what the data of admission looks like because if you don't have that in the common way, you can't build off of that to embed it in all of your measurement.

So there's that ground level data but then there's the fact that most of our measures that are at least in the hospital role, most of our measures are collected not from claims data but by individual extraction from medical records. That requires that we go back and respecify those measures so they could be collected in electronic format. Lots of

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fundamental work needs to be done and no ready source of support for that level of work that has yet emerged.

ED HOWARD: Yes go ahead.

TOM SCULLY: You got to keep a balance here and I'm a big fan of obviously reporting. As Nancy mentioned, you got to make sure you don't torture the providers and you're getting stuff you really need, which is a balance because it's expensive. Somebody gave you a grant to go do the study and that's great but you got to look at what's happening to the hospital CEO and the nurses and the time and the effort and you only want to make sure that you're getting the right stuff.

This is ancient history but in 2002, is something called Oasis, which is for home health. Some of you may remember this but we were doing a collection of Oasis data, which is the home health measurement and we got into redoing it and we had 64 measures and it turned out there were 30-some.

I still remember they weren't being used and I said how the hell did that happen? What's going on there? Well the guys doing this years ago in Colorado thought they were neat to collect. We weren't doing it with them. Every home health agency in the country had to collect them.

We had a big fight and can't get rid of them but the point is every home health agency in the country was collecting

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32 measures, if I remember, that were completely useless and it was a huge waste of time. They weren't used by anybody.

So keeping the balance between, no matter who gives you the grant, between looking at it from the consumer's point of view and the hospital's point of view and the doctor's point of view, what's the right thing to collect? It's not always necessarily with all due respect what a grantee wants to collect. It's what's useful you get out there for the world to use. It's not a waste of time for the providers and incredibly expensive in the system to collect.

ANNE-MARIE AUDET: Just a few other comments or ideas here, I think as many of our speakers have said, there's a lot of limitations to claims data that are really designed for payment and with the development of the information technology infrastructure, the goal or the vision would be that the data that's collected is as a result of the delivery system.

It's not something that's done after the case. So in the case of eprescribing, for instance, I mean as soon as you do it, it's automatically, the transaction is information that can be used. So it's not something you collect retrospectively. So it's just in time. Now to get from where we are today to there, it's going to take a long time because if actually if you go to NQF and their website, I mean they're doing a lot of work in translating all the measure

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specifications into electronic format. It's just amazing and it's very complicated but that's where the movement should be going towards.

DAVID SHARE: So I understand the theoretical potential of health information technology but I have to say that either in the literature or in the real world where I practice and the people with whom I practice, I'm not seeing it realizing that the tools are actually quite weak. They're actually mostly made for capturing data and billing also not for managing populations.

So to tie meaningful use to anything like ACOs or pretty much anything else is premature and I think it's a little misleading. We've been working on catalyzing the development of medical home-based practices in Michigan and have several thousand practices involved in this adventure since 2005. We have 5,000 that have a critical mass of medical home capabilities and good results on cost and quality at a population level.

They're very far advanced and their experience and our experience in examining them in a pretty nuanced way is that it's not those that have sophisticated or current state-of-the-art HIT in place that are doing the best. It's those that are committed to population management, committed to engaging with their patients actively, have a clinical registry, a

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comprehensive patient registry so they know who the patients are and what they need. They do eprescribing and they have a care coordination and care management system in place. It's pretty much relationship-based not technology-based. Those are the ones that are performing the best so far.

ED HOWARD: Interesting. Yes, go right ahead.

WARREN GREENBERG: Yes. My name is Warren Greenburg from George Washington University. I know the title of the seminar is public reporting but I wanted to ask this question. How do we create incentives for the private sector, Blue Cross, United, Aetna, and the rest, the health insurers to provide quality information and to help out in this quality effort?

For example, what incentives do we need to have Blue Cross come out and say if you join our plan and you have a cardiac problem, we'll send you immediately to the Cleveland Clinic or the Mayo Clinic? I don't see any health insurers saying this. I think I know some of the reasons but I'd be interested to hear the panel's reasons why we don't have more private sector involvement in this.

ED HOWARD: Sounds like a question for David and Tom.

DAVID SHARE: Okay. So when I get the kind of question, the image that comes to mind is the cartoon with the VW bug and the clowns and it works in that context getting 80-percent of the population with needs for cardiac surgery into

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institutions that have the capacity of five-percent of the national capacity just doesn't work. So we're taking a radically different approach. We're saying we need to raise the bar of quality across the entire state at all institutions.

We bring them together to collaborate using that registry-based approach that I mentioned and that is reported on this month's issue of *Health Affairs* and we've been pretty effective at achieving dramatic improvement.

Say nothing of the fact that when you look at and actually this was examined in New York, when you look at mortality reporting or other outcome reporting on cardiac surgery, we'll stick with that example, in year one and then follow that over two more years, the hospitals that were in the highest tercile tend to be in the middle or lowest by the end of three years. Those that were in the middle or lowest tend to have jumped up to the first and the reason isn't because some got worst and some got better.

It's because they're all kind of clustered pretty closely in performance and there's natural variation over time sort of regression to and from the mean. So our ability to actually say which are the truly best and consistently best especially when the data are a year-and-a-half old by the time they're getting out into the public's eye, I don't think that we have that ability.

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TOM SCULLY: My answer will be much more unpleasant and more, I know of a few people in the health care world that still believes that capitalism exists. So my own view is last time I checked, we're spending too much in health care not too little. We want to expand coverage to another 40 million people, which I happen to be a fan of, through exchanges and other things.

So sending everyone to the Mayo Clinic as great as that may be is not the answer. The answer is how do you allocate health care resources the best and we can't send everybody off for Mercedes, BMW coverage. We have to give people effective rational coverage and consuming less is no, the per capita, is what we have to do, not more.

So my view is I don't think insurance companies are evil. I don't think auto companies are evil. I don't think any capitalist is evil if they're well regulated. A well regulated insurance company's probably going to have a four, five-percent margin. My own view is I would much rather send my patient or my taxpayer dollars just as I do for every Senator and Congressman, to Blue Cross of Michigan or Aetna, United with a four or five-percent margin, regulate them.

They do collect a lot of data. They're going to find because their money's at risk not the trust funds, and they don't fix prices and they don't pay every doc in every hospital

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the same thing. If you pay a well regulated capitalist \$12,000 a year like we do with Medicare, they're going get better outcomes.

If they think the best way to save money is to send the person to the Mayo Clinic, they'll do it but they're not going to do 15 MRIs a week on you. They're not going to churn the fee-for-service system. They're not going to pay every doc in every hospital the same thing.

So if you're looking for long-term health care outcomes, spending more money and sending everybody in the country to the Mayo Clinic is exactly the wrong way to go, the right way to go, in my opinion, is to find honest, well regulated capitalists and put their cash at risk like we do for every other sector in this economy instead of the trust funds. That's a much more global problem.

GERRY SHEA: Just a different dimension to this. In the wake of CMS' announcement of the beginning the patient safety initiative, there was a tremendous response among private purchasers, among corporate, among union funds, among employer, I mean the enthusiasm level is just through the roof because this is the first opportunity that private purchasers have been asked to participate with the big 800-pound payer, which is Medicare.

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Once you get Medicare in the game then it's a matter of getting the private purchasers to follow Medicare's lead, which is exactly what a number of us are spending our time trying to organize.

Whether it's the value-based purchasing, the nine-percent of the Medicare money that's in play, or it's ACOs and patient-centered medical homes, we have the opportunity here to do something we've never done before because the structure has finally been set up for the private purchasers to play on real ground.

By the way, not a minor point here is the market power involved in current negotiations between purchasers and providers is enormously tilted towards providers not every provider but if you are an insurance company, like a big insurance company or a large employer and you go to some systems in the country, actually many places in the country and you say we want you to meet these standards and we want to pay this price or we want to negotiate it, their basic answer is go jump. They say oh I guess your people don't want our doctors because they know they hold the cards, which is people do want those doctors and they want those facilities.

This story has been repeated time and time again across the country. So we have to get purchasing power. It may come as a surprise if you're not familiar, it's like the big

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insurance companies don't have enough purchasing power. So we finally got the structure set up where we can actually make this thing work we believe and we're going to try to do it.

ED HOWARD: Nancy, you had some comments?

NANCY FOSTSER: Just one other thing and that is Gerry, I'm going to speak on behalf of the patients here. They have a say in this too and not everybody wants to go to the Cleveland Clinic, as wonderful a place as it is or to the Mayo Clinic, as wonderful a place as it is, they may want their care more locally. I'm with David.

I think our job is to make sure that we raise the bar so that every place in the country that's offering cardiac care is doing it as reliably and as error-free as possible because if we can't do that then we're actually asking people to have disjointed health care, go halfway across the country to get your hospitalization then come back to us for the follow-up care.

That doesn't square right with our notions, our current notions of how you get the best long-term outcomes. So I think we have some thoughts to work through here before we start shipping people around the country but having the purchasers involved as Gerry has mentioned, will be enormously helpful in bringing more to light.

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ED HOWARD: We have a number of folks standing at the microphones. We have a limited amount of time. If you have filled out one of these cards and you desperately want to get that question answered, I suggest you line up behind these folks and we'll get as many of them asked as possible. So the pressure is on.

JOYCE FRIEDEN: Hi, Joyce Frieden, MedPage Today. This question is for Gerry Shea. You mentioned that you think doctors should be paid and have the time to talk to patients about how decisions are made and why quality measurement is important. I wanted to hear more about that because I think doctors already feel they don't have enough time with patients and I'm trying to envision a CPT code for quality.

GERRY SHEA: I didn't mean the physician, herself or himself, needs to do it but it needs to be embedded in the clinical experience. It needs to be in the practice. I'm talking about just we need a new paradigm for engaging consumers because what we've done so far simply has not worked. Now one thing is to give information, as David made the point, give consumers the information that they say they want.

That would be a good start. So the California study's very useful in that and they're not the first to point that out but I think that beyond that, we need to get this part of the clinical experience.

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When you go to see your primary care physician and part of the process, whether it's the physician, herself or himself, or it's the nurse or it's an assistant, ought to sit down with you and say by the way, you may some day need to go to a hospital, many people to do. So we want to tell you the information we look at when we make recommendations and it ought to be quality information.

Just sort of explain to them and say you might want to sort of check out some of these sources but more than an idea, we have an opportunity to build that into these patient-centered medical homes and accountable care organizations. These regulations are going to be written in the next six months. They ought to be in there as part of the process. That's the only way, it's Tom's experience. You've got to get them into the federal regulations to get Medicare to do them and then the other people will follow the lead.

ED HOWARD: Anne-Marie?

ANNE-MARIE AUDET: Yes. We recently head from the Cambridge Health Alliance who has implemented the medical home model and it was really interesting because we heard from the physicians and they work in clinical teams so every patient has a primary care physician, nurse manager, pharmacist, social worker, so it's a true clinical team, and over the past year, they've been able to reduce their, they had a number of

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different types of visits, long visits for complicated patients, short visits, etc.

Well they now have only two types of visits and they've been able to improve their productivity because when a physician sees a patient with a lot of complex conditions, they've already been seen by all of the other members of the care team. They know all about the patient. The patient's already prepped with some questions and so it's really improving the efficiency with which the physician is able to deal with very complicated patients.

So again it's really redesigning how you deliver care and going to this medical home functionalities, clinical care teams, and then you have multiple points in the patient visit to be able to talk to the patient and to address many of their questions and it's not only one person who does that.

DAVID SHARE: So that's a great description of a model that can be used, clinical model to actually provide relationship-based care and if we want to move away from volume-driven and procedure-based care towards cognitive relationship-based care then payers have to pay for that. CMS needs to change its reimbursement structure so that EMM fees go up and procedure-based fees go down and other insurers need to follow suit.

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I mention our physician organization incentive where we have 500 medical homes in place. We are actually paying them not across the board more money but more money for cognitive services in the office setting relationship-based care and reward money for building medical home capabilities for achieving good results at a population level and cost and quality. When you add all that together, all these various incentives, many of these medical home practices are able to get 30 to 40-percent increased reimbursement from us, these primary care practices and that's what's allowing them to then sustain this new model that Anne-Marie described.

ED HOWARD: Tom, you have a quick comment or not?

TOM SCULLY: Well I just say that the way the docs save money, it's just a fact of life and it's not driven by Medicare, when you look at medical homes and you look at any special doc practice and this is the problem again with ACOs going forward, is they save money by keeping patients out of hospitals because they love hospitals, those are the cost centers. It's just flat out one plus two equals three.

So when you get to ACOs, I mean the issue is you're going to capitate docs, put them at risk, give them some involvement, make the medical home. They do two things. They knock out name brand drugs and they push out generics and they lower hospital days. I can give you a million examples but

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that's simple math. Those are the choices. So I'm a big fan of medical home. I'm a big fan of doing all this stuff but the reality is this is all about dollars and costs. We're dreaming if we think it's not.

DAVID SHARE: Could I just respond to that please? So I agree and so before ACOs were talked about, this medical home model that we have in our state, we've been thinking of as an evolutionary step towards what we call organized systems of care. Facilities are in those organized systems not as competitors but as partners and we're now in the process, although it's a slower process to get them engaged, of holding them accountable for population level performances well. So there's a glide path towards sustainability for facilities.

They're able to reframe and restructure so that they're providing the right amount of service and the right amount of capacity to a community based on the need not just on again a desire to churn volume. So there is a way to do what Tom just said, which is to save the money through avoiding high cost, facility-based services but also to not just simply cut the legs out from under the hospitals at the knees as a result. It doesn't have to be a conflict.

ED HOWARD: Yes, go ahead.

AMANDA BROADNAX: Hi, my name is Amanda Broadnax from Congressman Rangel's office. My question deals with the fact

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that it was addressed that the data currently is not used to help consumers base their decisions and if that's going to be something that's going to be implemented going forward, how will you address the fact that some people that are low-income or receive Medicaid or Medicare don't have access to the Internet?

ED HOWARD: Right and I would throw in one of the card questions that asked about shared decision making, which sort of fits into that same framework. Gerry?

GERRY SHEA: Yes. I'm really glad you asked that question because there is this model in some policy discussions that you build a website and they will come and then they'll use this information. I think it highlights the importance of focusing on purchasers as well as representatives of consumers as well as consumers themselves and you see good examples in low-income communities, community hospitals, I don't remember the exact name of them, in North Carolina, the Medicaid system, they've done phenomenal jobs at this.

So it's not enough to simply rely on individuals. I think we've proven that doesn't work. The question is how can you help people get into this? I think we need a culture change with individuals but it starts with getting the purchasers playing a significantly different kind of role.

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DAVID SHARE: I just want to add that so my practice is in a low-income community and mostly poorer and at-risk teens. We're certainly not relying on the purchaser or the payer to do anything to help us out with that. Really if the frame of reference, if we keep our focus on the frame of reference being the doctor/patient medical home team, patient relationship and relationship to the community.

It's not just the people who stumble in the door with an acute problem; it's the community of people for whom you are responsible to provide care. Safety net providers, federally qualified health centers, and other types of safety net providers do a good job of that.

They're not relying on the Internet, although starting to, although 144 characters with Twitter's maybe not enough but they're reaching out through community partners, community agency partners, school and faith-based organizations and so forth to make these connections to get the community whom they serve has some ownership of the service or the organization that serves them.

ED HOWARD: Nancy, do you have a 144-character comment?

NANCY FOSTER: Yes I do. One of the important things that's happened as a result of the publication, the data in hospital compare is that newspapers and other media across the

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country have picked up on that and are publishing it many times in their own way.

That is helping to reach a broader audience and engage people in conversations. It may not be the decision making that people had envisioned yet but at least is engaging a really broad community in asking the questions of their hospitals, so how are you doing on preventing infections or other errors in care? That is a start.

TOM SCULLY: I have just one thing to add. From the beginning I never thought and I think we need to get as much information to low-income folks who don't have the access to the Internet as you can, but from the beginning, my view and this was just to drive providers.

Nobody wants to be in the lowest quartile if you're a doc or a hospital but almost every hospital and doc and every other provider I know is trying to do the right thing and there, of course, nobody wants to be, my seventh graders want to be in the lowest quartile of their class in school either but I'll tell you when somebody sees the grade, she changes her behavior and this drives immediate changes by putting it out there.

Everybody's worried about how they're going to look and oh my God, my hospital, my doc practice might be the worst in town but the fact is they change the behavior immediately as

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soon as they see it and just getting it out there as long as it's credible and useful changes behavior whether the consumers see it or not.

I think, to me, the biggest goal here is to drive physicians to take care of patients not hospitals, all due respect, their high-tech office buildings filled with docs. When people see this information, they change their behavior overnight. It's just getting out there even if nobody sees it is extremely helpful.

NANCY FOSTER: And nurses, and nurses [Laughter].

ED HOWARD: While we turn to my right for the last question, I would ask you to fill out the evaluation forms while you listen and it's a lot of pressure to come up with a great question to end this discussion.

TANYA ULTRAS: Hi, this is Tanya Ultras at the Consumer Purchaser Disclosure Project at the National Partnership for Women and Families. My question is for David. On your last slide where you talked about some of the different ways of thinking about public reporting for consumers, all which I thought were really progressive and much needed; one thing that's missing is ratings of individual providers.

That's, right now, one of the things that's really missing out there for the average consumer who is looking for anything from a primary care doctor to a specialist is how do

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they go online and find comparative information on the quality of the providers who are in their community. Right now people go to their coworkers or their family members but there's no place to go for standardized information on variability and quality and cost. It's a whole different forum. So just wondering was there a reason why that wasn't part of your list and if you wanted to address that.

DAVID SHARE: Yes. So I'm known for lapses but that wasn't unintentional. I did leave that off the list on purpose because I'm not a fan or a proponent of reporting at the individual practitioner level. I mentioned briefly that when you try and measure individual physician performance, there's some really serious limitations. One, I'll give you an example. Diabetes is a very common chronic illness.

In our Blue Cross population, there are many diabetics, 20-some thousand doctors have some contact with those diabetics in the state in a given year but if you want to get enough data to reliably measure quality performance on an individual doctor basis, we actually can only study it reliably about 1,200 doctors and then if you add three quality measures in the mix and you say so you can't just say a doctor is good, treat a good practitioner for patients with diabetes.

If you have one quality measure, let's say three are needed, it turns out that we can only reliably identify about

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100 or 115 doctors in the state of Michigan who do a really good, demonstrably good job with patients with diabetes so that there's a small numbers problem.

The other problem is the doctor who, well patients cluster, nonrandomly. They seek doctors with some patient-driven factors and so patients who go to a doctor tend to have some similar characteristics and if those characteristics involve lower socioeconomic status or complexity of care, comorbidities, psychiatric concerns, pain syndromes, that doctor's performance is going to look a lot worse even though that might be the very best doctor for that group of patients. So I think it's not safe. It's not good. It's not in the patient's interest to measure at that level and report at that level. More importantly, that's why I keep coming back to this medical home notion.

Patients need to know where are the practitioners in team-based clinics or practice, units we call them, where they are using comprehensive care management approaches. They're relying on a proactive approach to take care of people not just when they're in the office but over time and where they have been demonstrated as a group of practitioners to reliably offer good care and with good results.

Then lastly, no doctor takes care of a group of patients only and in isolation. It's always in partnership

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with others even if it's a virtual partnership, another reason to think of what's the community of care givers? What's the team performance for a group of patients? It's more reliable as a way of measuring and it's more meaningful as a way of reporting to consumers.

ED HOWARD: Not a bad place to call a necessary halt to this discussion. Thank you for filling out your evaluation forms as you leave. Thanks to the Commonwealth Fund and to Dr. Anne-Marie Audet for helping us shape what I think has been an exciting and really an enlightening discussion.

Thank you for your active participation in that discussion and ask you to thank the panel with me for making sure that we got the best out of this subject [Applause]. We'll see you for ACOs two weeks from Friday.

[END RECORDING]

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