Briefing:
Checking Up: What are your Hospital's Vital Stats?
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ED HOWARD: Welcome I'm Ed Howard with the Alliance for Health Reform, on behalf of J. Rockefeller, Bill Frist our Vice Chairman, the rest of our board including John Sweeney the head of the AFL CIO, welcome you to this briefing on how consumers can check on what hospitals do better on several important measures of the quality of care they deliver. Our partner in today's program is the Hospital Quality Alliance which is a partnership that includes government and hospitals, consumer groups, those who do their own ratings of hospitals and the jumping off point for our discussion will be the Website newly launched by the Centers for Medicare and Medicaid Services called Hospital Compare. First off we'd like to hear from one of the prime movers of that Hospital Quality Alliance, Chip Kahn, who is also President of the Federation of American Hospitals. Chip.

CHIP KAHN: Thank you Ed and I want to thank the fellow panelists many of whom who participate, who have participated with us in the formation of the Hospital Quality Alliance. Let me just say that that the hospitals I work for and the hospital community generally is committed to better informed consumers and understands the opportunity that more information about the hospital care that's actually provided, particularly when it's comparable between hospitals will help providers, doctors and hospitals do a better job of serving those patients as well as

informing those patients about the services they provided. The hospitals organizations, The American Hospital Association, The AAMC, and the Federation got together at a time in which a few years ago there was a great deal of work going on, the National Quality Forum, CMS itself at the JCHO, a great of deal work in terms of preparations for approval of measures and talking hospitals into making information public along the line, collecting information on the measures and making it public. Our response in a sense was dual, one we wanted to cooperate, we wanted to join with the government, with consumer groups, with the accrediting agencies, with others and develop a program that would at once serve the consumer, serve the providers who were providing the care but also one of our concerns was we wanted to make sure it was rationale and that the information that was collected was the information that could be collected rapidly and be most useful to the consumer and providers. And also we were worried about the possible because there were many, many measures being discussed by various different groups, there were many demands placed on hospitals and least in this pre-electronic medical record age the collection of information, the extracting of information from medical records is not a simple thing. So we were very happy when the other groups joined with us and over time led the product you're going to see today, the reporting of the 17 measures. We look forward to two things happening in the

future; one to an expansion of the number of measures that will ultimately be available to the public that we'll collect and make available and also on the consumer expectation side, I look for a great deal of cooperation by my members and other hospitals in also providing that information. So the information will not just be clinical but also will be in terms of the consumer experience.

Let me conclude by saying that in the days leading up to the first reporting it was a tremendous commitment by the hospital community about that same time, the MMA was passed and you'll remember t hat the framers of the MMA said, "Well gee, this reporting program sounds great. Why don't we just give hospitals a little extra payment towards their market basket if they cooperate?" And since then at least with this stage of the reporting, these first measures, you're getting almost complete compliance with hospitals. I still believe that these programs ought to be voluntary but I'm not naïve and I think as we proceed into the future there's going to be a blending of the pay for performance initiatives, is a likely blending of the pay for performance initiatives with the information the quality alliance will produce and I think that's all to the good because at the end of the day the Quality Alliance is just trying to get it right and has the right approach to bringing everyone together and making sure that the right decisions are

made about what ought to be reported and Ed hand the baton back to you.

ED HOWARD: It's been what, more than five years now since the Institute of Medicine concluded that the quality of health care left a lot to be desired and they used as exhibit A where the IOM concluded that tens of thousands of preventable deaths occurred every year. Now a lot of initiatives, have been launched since then. The experts we've heard from and the ones the I suspect we're going to hear from today as well say that there has been a lot of progress that's been made, Chip alluded to some of it and they also there's a lot more that's needed to be done and I suspect we'll hear both parts of that sentence talked about this afternoon.

Let me just do a couple of logistical housekeeping items if I can. There's a lot of background information in your packets as well, there were a couple of handouts on a separate table that you may have missed, you may want to pick up. There'll be speaker biographies in there that are more extensive than I'll have time to give them or that they deserve. As usual there will be a web cast of this event available by the close of business today on Kaisernetwork.org. If you wait a couple of days you'll also be able to get a transcript both on that one and on allhealth.org, which is our website. And those of you may not know, ought to be aware, that even the day before as we get the materials that are in

your packets in electronic form we post them on our website so you can go back and check them or you can read them in advance if you want to do that to get yourself up to speed for the debate. I would be remiss if I didn't ask you in advance also to fill out, at the appropriate time the evaluation form, the blue form that's way in the back on the right hand side of your packets and there's a green question card that you can use at the appropriate time when we're finished with the presentations. Now let me just make one final note before we get going, you can tell by the numerous groups who's work is represented by the materials that you received that a lot of people know and care about this subject of quality in hospitals. A panel that included everybody who knew a lot about that and could make a real contribution would stretch both ends of this dais to it's breaking point and I want to thank those people here, or not on the dais rather, for their indulgence. I want you to take advantage of the Q&A session to get into this and make sure the audiences knows what your views are and I also should note, I guess, that we plan at the Alliance to focus a fair amount of attention over the next couple of months on the subject of quality including a session on pay for performance that we have scheduled for I think the latter part of May.

Now the speakers who are on the dais, I have to say, are an outstanding group so let me get started so that we can

hear them. We're going to start that list with Michael McMullen. She's the Deputy Director of the Center for Beneficiary Services, CBS I guess within CMS, as the name implies CBS' mission is to try to meet the needs of Medicare and Medicaid beneficiaries. That is scores of millions of Americans and their families, she's held a number of different positions within HHS, she's been cited for outstanding achievements in almost all of them, and I'm pleased to say she's a veteran of Alliance programs in years past. Michael thank you for being with us.

MICHAEL McMULLAN: As I was saying Chip did a very good job of setting up the collaboration that's gone into Hospital Compare. This is a continuation of efforts that CMS has made over the years to look at the quality of care in different settings. There are also Compare tools available for nursing home care, home health care, and hemodialysis care and all of this is an effort to give information both to the consumer and to the providers so that people can understand quality and understand that quality does differ and people need to take action to choose the care that's best for them and also to incent providers to improve the care that they're providing to all Americans. The Hospital Compare website includes information on three diseases that are commonly occurring in the adult population? Heart attack, heart failure, and pneumonia care and this is the beginning as Chip mentioned of

what we hope to be an ever growing array of information. The Hospital Compare deals with the care of all adult patients and it can be found on www.hospitalcompare.hhs.gov and it's also available through medicare.gov. We wanted to make sure that it was on the department website because it does indeed apply to all adult patients. We went to a lot of trouble to make sure that the website was designed in a way that was easy to navigate both by patients as well as by providers and professionals. So as we go through the website I'll show you different features that are available to each of those two audiences. The design of the website is the result of a lot of consumer testing and we understand that it's a work in progress. We look forward to more feedback on the Website and encourage people who use it to tell us what we can to do to make it a better tool for the two purposes that I cited.

So with that introduction, let's start. We start with the search feature and you can search by a number variables; state, county, city, and zip code. We'll pick state.

ED HOWARD: Michael can I just clarify for people that this the actual Website that you're looking at. So you won't find any slides of this because this is real time on the Internet.

MICHAEL McMULLAN: And then we'll pick the state of Washington and then you hit next steps and then you get the hospitals that are in the state. Now the hospitals are grouped

by acute care hospitals and critical access hospitals. In order to understand the difference you click and you see here you have the definition of what a critical access hospital is and these are hospitals that are in remote locations, have relatively short stays to prepare, often patients go to other hospitals. So we group them differently, the data arrayed by separately by the critical access hospitals and the acute care hospitals. We then go back and you can also get information about how hospitals participate in this activity and this gives you an overview of the rules and what happens actually when hospitals are participating in the Hospital Compare Website. So you can get a lot of information about what it means for hospitals to participate.

We then go to selecting a hospital as you can select at any number of hospitals that you choose. You have to do it in groupings because you don't want to do all in one state at one time. You need to select either from the acute care list or the critical access hospital list but you can go back and do the other at another time. You can select one or all of the conditions to look at the measures. And then you look at the measures and you can select 1 to 17 measures. There's 17 measures in the measure set, 10 that are part of the MMA reporting and 7 that are not. You can select all or any of those. And then you go to the graph that is by the hospitals. The graph includes an average for the United State, an average

for the hospitals in the state picked, and then the performance of the hospitals that we chose. And you'll see that one hospital is reported on this first graph, they had an 80% success rate with ACE inhibitors. And then the caution signs are there because there were insufficient data to include the report on the site and if you click on that hospital it will tell you that they had 4 cases. And in the 4 cases they provided the care that was specified, but that is not statistically significant. If you go back to the graph, then on the far right side, that bar is what the top 10% of hospitals were able to achieve. So in this case, the top 10% of hospitals were able achieve a 100% rate. And if you go further down on this page, since we selected all of the measures you will see bars where all of the hospitals that we selected actually had reporting. And you can continue to go down until you see this set of reporting. In this case this is percent of heart failure patients given assessment of left ventricular function. And so all of them reported, the top 10% is 98% and you see in each of these cases in each of the hospitals selected.

Then if you go back to the top of the page there is other information that's available and we can look at the other information that's available on the bars across the top of the page. There's a tab at the bottom of quality measure tables so you can actually see the data that was reported not just in a

bar chart but in the actual number that were reported. And then on the experience with the number of patients reported. So if you look you see the top line says that care was provided to 80% of 25 patients, so you get more detailed information by looking at the tables.

If we then go to the about tab, this gives the basic information about the Hospital Compare and you'll see here there's a list of all of the collaborators in this activity, in the hospital quality alliance, and this is really a very successful alliance helping to understand the different perspective of the people who care about improving the care in hospitals and it is an active dialogue and as a result of that there's a lot of positive forward movement in this area. And then we can click on data details and then we'll click on professionals and you'll see here that you can get significant levels of technical information for people who have more interest in the background. You can look at the confidence intervals in the information that was provided as an example. So there's all level of information for most people who have background in measurement as well as quality improvement so they can delve more deeply into the information, this is not likely to be something that a consumer, unless they were someone who had that background would look into. But there are users of this data and one of the things that we're very interested in having it used for is to do improvement and

people need to understand this level of detail to actually foster improvement.

And then finally if we go to the resources slide we get information which is something that would be helpful to a consumer if they wanted more information about how to get heart care or others, you have information about other people, other organizations that can help patients and understanding their care and what the most appropriate care is.

And finally I want to look at the frequently asked questions. Here you have a set of questions they're ranked in the order of numbers that we received so that you see what other people are interested in knowing about this tool and it includes the information and then we have a full set of Qs and As there. Again just to reinforce what Chip said, the purpose for this tool is to get people to think more concretely about quality, they take that into account when they're thinking about the care that they received. To understand that quality does differ and that we are all interested in making sure that quality is improved across the board and to have information that they can use in talking to their physicians and others. This is not the only information that people should consider, but it's a very important piece of information to go into that dialogue.

Now I also want to talk about what it isn't. This is not mean to be the top 100 hospitals. It's not meant to rank

and rate hospitals, it’s meant to give information so that people can understand one aspect of what goes on and very importantly for quality improvement and it is a work in progress we hope to make it better as time goes on and to understand more fully how to make it as meaningful as possible to both the consumer and the professional audience.

ED HOWARD: Thank you very much Michael. I should say that a non-live version of Michael’s presentation we will get onto our website by the time you get back to your office or shortly thereafter so you can get a guide to recreating what she has just described.

Next we have Elliot Sussman for the last 12 years he’s been the CEO of the Lehigh Valley Hospital and Health Network in Pennsylvania. He’s a physician, he’s trained in internal medicine, he’s served in a lot of responsible positions in groups like the American Association of Medical Colleges. His hospital has run recognition for quality throughout his leadership and I guess I should mention he didn’t neglect his formal education, either. He holds undergraduate degree from Yale, his MD from Harvard, and an MBA from the Warden School [misspelled?] thrown for good measure. So we will look forward to a well rounded presentation, Dr. Sussman.

ELLIOT SUSSMAN: Happy to be here, thanks for that kind introduction. I’m going to talk from the point of view of hospitals and many of my examples this afternoon will be drawn

from Lehigh Valley Hospital up in the Lehigh Valley about 60 miles or so north of Philly, 80 miles or so do west of Manhattan. I'd begin by saying they're fine people in health care and when you think about nurses, therapists, doctors, social workers, technical partners, administrators, I think they want to do the right thing and often do do the right thing. I believe they believe deeply in the notion of quality being important and improving quality being a challenge and an important one to address. I do agree with Ed's three points that he made earlier, one much has been accomplished. Michael's overview of the new website Hospital Compare I think is just one example of that and an important one. So secondly we are making progress. And thirdly there's lots more to do and we have lots of challenges to see that that happens. Hospital Compare focuses on what I would call process measures. Process measures, the 17 that are voluntarily submitted, I agree with Chip, I do believe in volunteerism. Voluntarily submitted by the hospitals for three very common conditions, heart attacks, heart failure, and pneumonia. Things that affect a wide number of patients who are admitted to hospitals. Hospital Compare is, what I'd a starting point, to collect and share quality data from the point of view of most importantly our patients and there families, our communities overall, and our organizations. For us at Lehigh Valley Hospital this is another occasion, to frankly, look at our own results in

absolute terms. Look at our results in comparison to others and ask the question, how do we do better? When we see other hospitals that do better we call and ask them what they're doing. I mean I'm a great believer in stealing ideas shamelessly and I think this a wonderful opportunity for hospitals throughout the country to do that.

Patients get better informed, that is a very, very good thing. Just simply knowing, "Gosh after I have attack I should have been told to take aspirin." Simple thing, makes a difference. Asking about, "Where are my discharge instructions?" Making sure you have them before you leave the hospital. Also one of the things that I think is important, kind of a benefit of this and a number of the other websites that I'll just briefly mention later is the numbers. If you think about it numbers are important. If you will, the repetition of something makes a difference, so I'm a tennis player unfortunately I haven't played in a couple of weeks I'll get out on the courts, my game will be a little rusty. If I was playing every day, look at me, I could easily beat Navritalova or anybody else right? But in fact if I play sporadically I can't. Well if you think about it the same is true in healthcare particularly where it's a team sport. It's not an individual sport, it's a team sport, it's about system. So I would say that there's some important information and Michael talked about the confidence levels about saying, gosh

it is more likely that a place that treats 100 heart attacks may be able to do a better job just because they have a whole lot more practice at.

Hospital Compare is one important tool in improving safety and quality of care. There are many other websites this is an important because of it’s nature, because of the large public, private group of partners that Chip and Ed alluded to. Those other websites also important, Leapfrog, Jayco, some of the for profit sites like Health Grades. I recently read that only 1 out of every 5 patients, prior to admission to hospital actually check out this kind of information. The good news on the other hand is that that number doubled from 1 out of 10 18 months earlier so we’re making progress. Because the end result of more informed and empowered consumers who become patients will be more information, raises standards, and by the way it will intensify among these hospital organizations.

If you stop back for a second it’s extraordinary how we do make decisions in health care. You know probably over this past weekend a number of you went out to restaurants. It may have been a place that you went to before, or a neighbor said try it and you tried it. And by the way at the end of it, you would know whether it was good meal or a bad meal. How about cars? How many bought cars in the last couple of years? Well actually 1 out of 5 people before they go into a hospital check it out, actually Ford just reported that 4 out 5 people check

out what car they're going to buy before they even get into the show room. I hope that doesn't mean that our cars, what we drive is a whole lot more important than our health, I worry sometimes about that.

And then what about the hospital? How do we make that decision? Well all too often, the doctor, Dr. Sussman says to Michael, "Well you'll go into Smith Hospital." And she salutes and says, "Yes doctor." That's not good. I don't think Michael would to that by the way, the look she just gave me [laughter]. But it's not an informed way to make decisions in hospital care, Hospital Compare improves that. The 17 important measures are an important start.

There have been many state efforts, I again live in Pennsylvania. Our Pennsylvania Health Care Cost Containment Council has been reporting data like this for over 10 years. Also reporting outcomes which is important. Chip said we'll develop this website more and I think moving to outcomes is an important step. Outcomes like survival for heart surgery, that's an outcome. It's not just about the process measures, at the end of the day it's did you live or die? Is your heart maximally performing? So important to think about that, it's obviously easy for me to say coming from the hospital that had for two years in a row the best cardiac outcomes in the state of Pennsylvania, but enough of commercials.

I do think it’s important to not that our hospitals in America are dedicated to continually improving the care for patients. Hospitals are extraordinarily complex organizations, do this is very, very difficult. We need to learn how errors occur, of omission and commission and prevent them from happening. High-tech ways to do this, we’ve read about computer assisted physician order entry. Really important to do it, we’ve done it at our hospital, it’s been a three year process, it works. We’ve decreased the medication error rate from 30 per 10,000 beforehand down to about 1.5 per 10,0000 now. We’ve gone to medication barcoding at the time of administration with further decrease in errors. Recently in our emergency room we introduced computer assisted physician order entry and a new information system there, one of the ways we don’t fare well in Hospital Compare is the time to get antibiotics into a patient with pneumonia and we believe this may be a way, a systematic way to further do this. There are low tech ways as well. There are thoughtful ways to restructure care, the tasks that nurses, physicians, other perform that in fact get a lot more of this expensive resource directly involved with patients and not involved with the kinds of administrative and bureaucratic stuff that unfortunately all too often our systems encourage.

So a conclusion is improving patient care is difficult, we need to focus on systems, this is not about individual

people. And also the data that we present needs to be actionable, when we sit with this data with a doctor, with a nurse, they always ask, “What does this mean for me and what can I do about it?” And those are the kinds of questions we need to be able to answer for them.

Finally to bolster quality care we must involve patients and their families as full partners in decisions about care and treatment. Better communication is a key and Hospital Compare is one important example of how to get there through public reporting. There are other things to do for patients, obviously important in terms of sharing information when they come into the hospital. I’m also a big fan of hospitals being out and about in their communities with whether it’s patient safety videos about what to think about if you need to be in an hospital, whether that’s hand washing, whether that’s identifying surgical sites for infection, to have people thinking about this before they’re under all the anxiety and stress of being a patient or being the family member of a patient and having the associated anxiety. We really can’t have this website in the ambulance when somebody with symptoms of chest pain being rushed to a hospital, I guess just not today, by the way let’s kind of look and who gets the best score for heart attack care and that’s way I want to go. Better to have those decisions made beforehand. And that emphasizes opportunities for improvement for how patients

process information as well as how we in our organizations do what we need to do.

So briefly to sum up I'd say we've done a lot to in fact enhance and improve quality and patient safety. We're making progress Hospital Compare is an important step and still we do have many challenges along the way, but I believe that creative organizations despite what maybe great challenges as we're in the midst of a revolution in a medicine and a revolution in biology, creative organizations can in fact put extraordinary quality results up on these type measures that show that they're able to provide for their patients and communities excellent care and keep up with that revolution in medicine. Thank you.

ED HOWARD: Thank you Elliot. I'm going to move to my left now here. Gerry Shea is next. Gerry is the Assistant For Governmental Affairs to the President of the AFL CIO John Sweeney. As I mentioned John is a member of the alliance board. Gerry has been active in health care quality as a concern of his for a number of years, for example he's a founding member of the board of the Foundation for Accountability which was a consumer oriented movement that produced a lot of good results. He served on the Social Security Advisory board, he's also graced a number of Alliance programs over the years and we're glad to have you back.

GERALD SHEA: Thanks Ed and the kind introduction aside and thanks to the Alliance for sponsoring this briefing as you've sponsored so many useful briefings for congressional staff and members of the press over the years. I'll only add to Ed's introduction that while I may be to his left Chip Kahn is also to my left so this we're going to continue the bipartisan nature [laughter]. This is really a watershed event, that is the debut of the Hospital Compare website. The introduction of an independent website with a comparative information sponsored by the federal government in this case the CMS is a really a big step forward from the consumer point of view. And I want to sort of take my hat off to the people who made this happen, you won't know all of their names but some of them are in the audience but many, many more of them have worked whether it's at AHRQ or CMS or AHA or the Federation or the AAMC or any number of other groups on our side, the consumer side, AARP, AFL CIO and some of others had a sort of minor role and a supporting role. But the real heavy lifting here happened from the federal government and from the provider side and I just want to salute them at the beginning because this is a big step forward. And I make that point not just to sort offer due congratulations but because this is really an example of the kind of collaboration that we need to address health care problems, that is people getting together and really solving some of the tough, technical issues that are

undoubtedly on the way to being able to transform this system as some people have put it. And I think this is a big step forward. It is not the only, by a long shot the only example of that if you look at the work of the National Quality Forum of the joint commission, of all the different stages that we've gone through in terms of quality improvement over the last few years, you see a continuum of people focusing on quality improvement and systemic change as a way to change the healthcare system overall and this is just in some ways a culmination or at least the beginning of the beginning for some of that stuff. That's the first point I wanted to make.

Secondly, I would just say other people have said it's just a start, this is a modest set of measures and consumers need a lot more information than even these measures make available. Many, many times this. And I will give you as an example what we need explicitly need to get done fast is the consumer or the patient experience of care measures that is now almost, almost done after many years of work in the CMS process. And hopefully we will be collecting information on that at the end of the year. Consumers have said and the research has shown, you see the Judy Hibbert [misspelled?] article in your packet there people want comparative data on their own experience. This is not the only measure of what's a good facility to go to, but it's a very important measure and it adds to the clinical measures whether they're processed as

process measures or even outcome measures here and we need to get that finished up and in the stream.

And then the last thing, the last point I wanted to make is no one should have the illusion that as important as this or even more sophisticated reporting mechanisms are that will actually do the job in terms of addressing the basic problems we have in health care. From our point of view you can't load the problems of health care on to the individual consumer. Consumers should have this information because they deserve it. We shouldn't be going to unsafe facilities. We shouldn't be going, from a purchaser's point of view whether it's union funds or employers, we shouldn't be paying for poor or even either mediocre health care. We should only be paying for high quality health care. So this information is basic and we need to get it out for people. It's not going to solve, however, all the problems in our health care system. You just can't expect that of it. Now I could make the point that it's not just consumers who benefit from websites like this, it's providers as Elliot and others have said physicians don't have this information. You've all struggled with these issues over the last couple of years whether it's in the context of information on comparative effectiveness of drugs within a drug class. We came close, you came close, your bosses came close, to passing a little piece of legislation some of us have been working on for about 7 or 8 years which is Patient Safety

Legislation. We actually passed it, or you did in both houses of congress, if only we could overcome this little problem about the senate and the house talking together we could have gotten it done because they president would have signed it. We need to get that done. It's just another building block in the whole process but these are just part of a constellation of things. And we need a lot of these pieces to come into place before we can actually make the big change in health care. And let me just finish with this comment which comes from my day job which is representing or working with unions who bargain health benefits. Mostly what we do is the economic side of health care however more and more we've come into, because you can't avoid the quality discussions as well. But the relation between the two is critical from our point of view. We're not going to lower health costs by improving quality but if we can slow the trajectory of health care inflation by squeezing out poor quality care and there's undoubtedly an enormous amount of it, then we could make a dent in the overall healthcare cost problem. And at the moment that's essential. Making that dent is essential to maintaining the health coverage that we now have and frankly avoiding from our point of view a total melt down of the employment health system. So in sum, we're happy to be here, we're strong supporters of this. We play a role of urging everybody to sort of move it forward and get it going a

little bit faster, but we think this is a real achievement and that's all.

ED HOWARD: Thanks very much Gerry. We have a final voice for you to hear from and then we want to open it up for your comments and questions. Peggy O'Kane is our final speaker, her day job is as President of the National Committee for Quality Assurance, NCQA, a post that she's held since 1990 or so. Most of you know that NCQA is the voice for quality information about health plans if you will thanks to the work of Peggy and her staff. And obviously NCQA's primary focus is not hospitals, it's on health plans but in fact that is why she is on this panel today, she is knowledgeable about health care quality in all it's permutations, she's thoughtful and she can give a perspective on Hospital Compare that those directly involved in it might not have. So we're particularly grateful to you for joining us.

MARGARET O'KANE: I'm very pleased to be here. I again want to applaud the Alliance for the wonderful work that you do and I'm pleased to be on this panel. And it feels like a historic moment to me to have people in the hospital industry and I think it's very welcome.

I just wanted to make a couple of comments to begin with about my personal experience. In 1990 when NCQA first opened our doors a health plan called me and said our immunization rate is 80% is that good or bad? And I think a

light went on and we really started going down this road to measurement. Another anecdote is that in 1992 my daughter had open heart surgery and I went with my yellow pad and interviewed one of the local hospitals here and said, “How are your outcomes for open heart surgery for kids?” And the doctor said to me, “Our outcomes are better than Children’s Hospital in Boston.” And I said well Children’s Hospital gets all these kids flown in from all over the world with single chambered hearts and all kinds of very unique cases and you know therein lies the tale. How you do this and what kind of comparisons you make and whether they’re fair is very important. So I think everybody is really very determined to do this in a way that makes the comparisons fair. The final point and I think this goes to the complexity of trying to get information or good performance out of a complex organization. A friend of mine was in the hospital and she was very, very, sick. She had had a stroke with complications, and her husband said to me, “You know there are 5 different doctors taking care of my wife. Which one of them is in charge?” And it turned out he wound up being the hub and kind of the quarterback for a lot of the care. So I think that’s one of the challenges for people that are running hospitals. I am a former respiratory therapist, I totally agree with the comments that have made that people go into healthcare because they want to do good. And I think what we’re about, I think those of us that work in quality is

creating the environment that enables people to feel really good about they're doing and to make patients well as far as that's possible. You've heard a couple of comments of NCQA, we do accredit health plans. We did launch the first national system of performance reporting in 1993. Talk about some general comments about what we want from health care, what lessons we've learned from our experience, and then just some talk about where we go from here.

We're a 501C3 non-profit. We measure and report on health care quality, we've always put diverse groups around the table. Early on when I started working in quality it occurred to me that people see quality very differently depending on where they sit so getting the different stake holders together for a common vision is absolutely crucial to moving forward. Our mission is a very simple mission to improve the quality of health care and our vision is to transform health care through measurement transparency and accountability and we do sit in a very unique position because I think health plans are in a position to really leverage what providers do as they are improving quality. We are the keepers of HEDIS [misspelled?], you may have heard of HEDIS, the Health Plan Employer Data and Information Step. This is kind of again the first national system of measures used to assess performance on key measures of clinical effectiveness. We also are users of, not the developers of, CAPPS [misspelled?]. This is the first national

survey of the patient’s experience and it was called the Consumer Assessment of Health Plan Survey, it’s now gone generic like Kleenex or something so you’re not supposed to spell it out anymore. But we’ve been integrating both HEDIS and CAPS into our accreditation and currently about 30% of a plan’s score on the accreditation is driven by how well they do in comparison with their peers.

Just to step back a minute, what do we want from health care? And I think this goes to some of what Gerry was talking about. Clearly what we want is we want more health for the health care dollar. This picture comes our of a book by George Halverson [misspelled?] and George Eisham [misspelled?] called *Epidemic of Care* and what it represents is the population, any population at any given moment falls into one of these categories and we call them bubbles. Most of the time most of the people are down in that left bubble, they’re healthy and they’re low risk and if they have good health behaviors and nothing comes in from the outside to make them sick, they stay there pretty well. And then inevitably they age or maybe they have, they eat too much or they smoke, they move up into “at risk.” They may move up into high risk, early symptoms and active disease and the goal of health care is to exert some pressure down towards the healthy end of the spectrum. So if you identify somebody that’s at risk and you get them to quit smoking for example they can move back down to that healthy end

of the spectrum. Now the other interesting thing to point out is that most of the costs are up at the active disease end of the system and a lot of that would be appropriate because people that are sick need more health care. But really a lot we know of bad things happen up at the complex end of the spectrum as well because there is lack of coordination, there's all kinds of things that happen when people are sick. The hospital turns out to be kind of a high risk situation and people moving in and out of the hospital or changing any kind of location are also at very big risk of quality falling apart. So I think the role that health plans have played in the system is really kind of an integrative role and also beginning to be a steerage to higher value providers. Health plans are very much looking forward to having good information on hospitals so that they can encourage their members to go to high performing hospitals.

Let me comment a little bit on the health plan's experience. I think we have very good news to report. You know we've been reporting on this since 1993, we've been in business for 15 years but HEDIS has only been since 1993. But we're always looking back a year so the latest data have right now out in the public domain is the 2003 the plans are actually collecting their 2004 data right now as we speak because you need a whole year to be complete before you have the data. So looking back we had 33 clinical measures, 30 out of the 33

showed improvement. There were strong gains on cardiac measures so there's a certain complementarity here. The gains on the cardiac measures the plans are reporting on will actually help keep people out of the hospital or take better care of people after they come out of the hospital having had a heart attack or some cardiac procedure. The average improvement though, and this is something I think I really want to say very encouragingly is 50% since 1996, so on these measures that we've been publicly reporting there's been a 50% improvement in that time span. So I think you can look for a very remarkable improvement in the hospital sector as well. Now the little fly in the ointment here is that 1 in 4 Americans is a plan that's reporting HEDIS and we're working on getting that to change and I actually feel pretty hopeful about that. Again this stuff really works.

I just wanted to show you a few of the areas that we've been measuring. Beta-blocker treatment there was a study in 1990 on beta-blocker use in New Jersey and the fee for service Medicare program that showed about 20% use of beta blockers in the eligible population. And that's when we started getting interested in this. We first publicly reported this in 1996, the average of plans then was 60%, it's now 95% and if you look at the green bar and the red bar up there what that's showing is how the mean performance of all plans has improved over time and how there's a narrowing in the variation. One of the

things you learn when you learn about quality and process engineering is that when a process is working well you have less and less variations. So really I think patients today have a very good chance of getting their beta blockers appropriately, and that's really what you want, you don't want to be in the ambulance with your Palm Pilot.

Measurement improves quality and consistency, this is controlling high blood pressure. Another enormously important, this is on the ambulatory side. You know that high blood pressure is rarely very well controlled, these plans have made some real gains here from the first time that we reported on it in 2000, 45% up to close to 60% now, controlling high blood pressure is crucial for preventing heart attacks, preventing strokes, preventing renal failure, there's all kinds of suffering and expense and these two tend to go together in the system has a result of uncontrolled high blood pressure. So the fact that this number is moving up and it's very, very difficult to move this up is very good news for the system.

This is a measure where lower is better, this is a measure of glucose control for diabetics another disease that really causes a lot of real problems for people, lot's of complications. In 2000 the poor hemoglobin A1c control was higher than 30% it's now in the 20s. Again, remarkable systems have been put in place to really work on getting those

diabetics to control their blood sugar better and again tremendous progress?

So what do we need to do next? We need to expand the accountability model and I think the hospitals have really stepped up to the plate, I think there's a lot of real interest in physicians as well kind of joining in on this movement. There's work going on in nursing homes, one of the very important things that needs to happen is we all need to get on the same page. One of the greatest things that happened with HEDIS was a lot of people said, "Okay we can go along with this measurement system. Maybe my favorite measure isn't in there but these are important things for all of us." So getting this kind of standardization sends a very consistent message out and it gives people their priorities in the system. So hospitals today I think are facing a very challenging environment where there are all kinds of different things being measured and it's very difficult then to figure out, "What do I work on first?" What's really most important here? So for the public, for you, it's very important to get this kind of alignment.

We need to look at our payment systems. The DRG system for example has embedded in it, a lot of adjustments for complications. Now we used to think that the complications were something that were kind of embedded in the patient, we know now that complications are often cause by the system. So we know that DRGs pay extra for infections, there are 100 DRGs,

I heard this from somebody at PHC4 actually, there are 100 DRGs where if there is a urinary tract infection accompanying the admission you get paid double. That's not a good incentive and when people are getting less money for doing the right thing that's a not a good scene. We need to incentivize the use of health information technology. This is not a panacea it is however the, it's kind of like a central nervous system. We need to have a good central nervous system and then we need to be creating the processes that are the bones and the muscle that create really a functional organism of health care. So those are my comments. I look forward to hearing your questions. I think it is again a very exciting time and a time in which hospitals really are stepping up to the plate. Thank you.

ED HOWARD: Thank you Peggy. Now you get a chance to ask questions, there are microphones in the front and in the back. There are green cards which you can fill out and hold up and someone will bring them forward and let me also remind you about the blue evaluation forms that are embedded in your packets. And before we take the first question, and I encourage you to use the microphones, let me just ask a very factual question that came in on a card. Actually two parts similarly framed. What is the time period for the data gathered for Hospital Compare and how often will it be updated? Michael do you want to tell us that?

GERALD SHEA: I can jump in on this.

ED HOWARD: Gerry?

GERALD SHEA: The data is a rolling four quarters so it's updated every quarter and when it gets fully operationalized which will be early next year I guess it will be a full year's data but it will be updated every quarter.

ED HOWARD: We have an additional resource, reinforcements from CMS. Do you want to add anything to that and identify yourself?

LISA LANG: My name is Lisa Lang with the Clinical Standards in Quality for the 10 measures that are part of the payment incentive arrangement established by the Medicare Modernization Act we've got two quarters worth of data, first and second quarter 2004 and then there are an additional set of 7 measures to bring the total to 17 and for those measures it's a single quarter, it's just the second quarter of 2004.

ED HOWARD: Yes go ahead Bob.

BOB GRIST: Bob Grist [misspelled?] with the Opportunity Agenda. Since we know that these quality measures differ by race and ethnicity what will it take to get hospitals to report these process quality measures by race, ethnicity, and even the primary language of the patients in order to more effectively reduce health care disparities.

ED HOWARD: I might point out that the AHRQ Quality Report is in tandem with the Report on Disparities because they

understand and want to do something about the link between those two.

MICHAEL McMULLAN: The need to look at the data that way is something that needs to be part of the dialogue with the people who are developing the measures and how do we best do that so that needs to be developed the same way that the underlying measures are developed. How do you best do that? You don't want to just assume that by simply breaking the data by the race of the patient coming in that that's right way of doing it. So we need to have more dialogue and that's something that needs to go into the mix of how do we improve these measures over time.

GERALD SHEA: Just to add to that that in the process that the National Quality Forum recently or is about to complete to certify or review the development of the patient experience of care standard, it's now in the sort of the final balloting stage which the NQF uses there as a of debate about how to specify the experience that patients have in terms of the characteristics of the individuals reporting and there were some restrictions in there that OMB visits upon us as they do in so many areas. But I think that even with that we're going to have good data that breaks this out by race and ethnicity. So hopefully we'll be getting to that question although again I would just say we're really at sort of the beginning stages of this and your question is extremely important in terms of

making this usable and useful data for people and we've just got a lot more to do.

ED HOWARD: Elliot Sussman?

ELLIOT SUSSMAN: I would also second what Gerry said about the import of the question and this being a significant issue for the entire system and as we're thinking about as both Michael and Gerry said, the right measures to in fact report overall that doesn't mean that in fact there aren't lots of opportunities to go out there and improve care so we shouldn't be sitting back and I don't believe hospitals are. A simple example from our place, 40% of our where our inner city hospital is located 40% of the people are Latino and speak Spanish. Well we looked at who was serving them and in fact 18% of the people employed were bilingual. So in 4 months time we've made major changes where up to 58% of the staff being bilingual. If you can't communicate you obviously can't get really high quality care so there were many steps along the way and I'd come back to, in part, as a partial answer the reservoir of people in health care wanting to do the right thing and we should try to use that. At the same time it's very important to also get these measures that you've referred to out.

ED HOWARD: Yes Joyce go ahead.

JOYCE FRIEDAN: Joyce Friedan [misspelled?] from *Internal Medicine News* I think you Dr. Sussman talked about the

patients tending to go to the hospital that their doctor's tell them to go, so I'm wondering now having this information how willing people think patients will be to question their doctor or say, "No I don't want to go where you want to send me." And how willing providers are to hear that or whether they'll push them to go where they have privileges.

ELLIOT SUSSMAN: I think we're beginning frankly a change in how at times these doctor patient relationships are established and how paternalistic, if you will, those relationships have been and I think we'll see some major changes in the future where they become less that way. So I think that we know we have a very mobile society in America. I think that often times when people come into a community their going to look at measures like this and say, "Which are the kinds of places I'd want to be cared for." And then, "Who are the doctors on staff at those places?" So it's going to in a variety of ways change this whole process and may in fact change patients, we've seen experience where people in fact change their doctor relationship because it may be that one learns that, "I really like Dr. Jones, he's a good doctor but he's not on the staff of what seems to be the best hospital. And either he does that or I'm going to find myself a new physician."

JOYCE FRIEDAN: You've seen that already?

ELLIOT SUSSMAN: We have seen some of that, yeah.

MARGARET O'KANE: I agree with Elliot. I think you know remember physicians have been working in an information vacuum as well at that includes both the physicians that are involved with the particular procedures in the hospital and also the primary care physicians that are referring to specialists. I think we can't underestimate the impact that transparency has on changing everything. I feel very optimistic that this will lead to a lot of positive changes.

GERALD SHEA: Peggy's point is excellent in terms of the impact of this information because we often look at in terms of consumers but in fact clinicians don't have this information either.

The point that I wanted to make here was that the research is clear that what consumers generally are looking for is a partnership with physicians and in order to have a conversation that creates a decision making partnership you have to have independent information so that's why this is so important on the consumer side. It's not going to change the nature of the relationship it's going to enable change to happen. And then let me just add a caveat sort of similar to what I said in my remarks which is, don't expect this do everything because I think you can make an argument that there are very serious limits to how much consumers can drive change in the health decision making process. And in fact a equally fruitful strategy would be in trying to change the preparation

and education of clinicians so that they come to this suggesting that a partnership would be a good idea. This is implicit in what Elliot and Peggy said but I want to make it explicit because in terms of the policy discussion that the congressional staff is sort of involved in, you just, you can't expect too much out of the consumer strategy and in fact there's a whole lot of activity going on by say the Boards Of Internal Medicine, some of you may know, in terms of sort of the culture of physician decision making and the approach that they take to relationships with patient which is at least as important as what's going on with consumers.

CHIP KAHN: I'd like to endorse that and say that at the end of the day the kind of information we're talking about here as it grows, so we have 17 measures now, 33 measures within a certain amount of time and you get more and more of this information, I think it will be more and more difficult, actually for the average consumer unless they just have a real ability to sort of work through the numbers. To figure things out other than this is either an okay place or a dreadful place and you obviously want to stay away from dreadful places. I think at the end of the day the question is how do we achieve the goal that Gerry sort of alluded to, which is to make sure that everyone in a community who is providing care, all the hospitals and all the doctors you know rise up to a level that is at least acceptable and hopefully is exceptional. You can't

do that without being able to make comparisons and study what you do and be accountable. So I think this is really more about accountability and using that accountability to improve care than it is about consumers on average making more decisions.

ED HOWARD: Quick comment?

MARGARET O'KANE: I am confident that the market is going to provide infomediaries that will aggregate the information and weight it, so even though I agree that it's very patients to process the measure that we have more difficult it will be. But the other point that I think is interesting is not hospitals that are excellent at everything but we see a lot of hospitals that are excellent at one thing and not so great at others. I think as process engineering becomes more core to the hospitals though you will see hospitals that will break out and that will be excellent across the board compared to the norms today.

ED HOWARD: We've got two questions here that are related. One is sort of the general form and the other a specific application. More generally, what efforts are being made, you will recall that as Chip pointed out these data are being reported voluntarily, what efforts are being made to assure the accuracy and completeness of these data? And I supposed these two folks might have been sitting next to each other. The *L.A. Times* this person writes just won a Pulitzer

Prize for its series of articles exposing the problems at Martin Luther King Jr. Drew Medical Center in Los Angeles. Given those many errors, how do you explain the mostly favorable ratings of that institution on CMS Hospital Compare? And they sent along a print out in case you wanted to verify those numbers.

MICHAEL McMULLAN: I'll start and then Lisa can go into the detail. In setting up the reporting structure we went to a lot of effort to make sure that hospitals could have mechanisms provided to them to make sure that the data we got was uniform and consistent, et cetera. And there are additional data abstraction validity assets that we've provided to them. The underlying issue of auditing the data is one that is still open and needs to be discussed within this alliance we have. I can't address the specific instance but I would just go back to what Dr. Sussman has said more than once, we believe that most people are there to the right thing and they want to do this and want to report in a way that will help them and others advance the quality of care. The underlying issue of data validity is a real one and it's one that the community will work on together to make that.

ED HOWARD: Peggy you had something of the same issue arise with health plans, didn't you?

MARGARET O'KANE: All our data that are reported, the data are reported by the health plans and they are audited by

independent external auditors and we have kind of a stable of external auditors that we audit. So we have an audit the auditor strategy which I recommend and we'd be happy to work with the hospitals.

ED HOWARD: Yes Tom.

TOM MILLAGE: Tom Millage [misspelled?] Joint Economic Committee. We tend to measure what we can measure because that's what we can measure and that's better than not having any measurements so taking that into account. . . Looking at kind of one of the pieces in the packets from Kaiser and Harvard Survey it seems like patients want to know objective things that really matter kind of on the bottom line. How often did you do the procedures at the hospitals? Who died of complications? As opposed to a little further down the little is actually this standard of the number of patients who did not get this standard recommended treatment. Not that that's not important. Where are we on being able to move to knock this kind of binary measure which says, did they get the right care? And how do we get them to get the right care as opposed to more of tiered concept which says, who does a better job than someone else? One measure of that that's been talked about in the employer community is evaluation of the longitudinal costs, the value of the care for a particular episode of care. And to look at this in more at the position level than in more at the big brick building level. Do we have barriers to getting that

information, I know it’s going to be hard to get, what are some opportunities? Where are we on that timeline so we deliver something that is truly relevant to what people are trying are to do find value for money as well as the best care?

MARGARET O’KANE: I’m afraid a boring answer for you which is there are technical problems with small numbers for many procedures in hospitals. So while we all want to have the outcomes of this information I think what’s important is to measure the processes that are associated with good outcomes. So for example if you’re counting infections you may not have a small numbers problem there, you may have more of a reporting problem, but if you actually look at how many people got the appropriate antibiotic prior to hear surgery for example, there you’re talking about something that’s really a fair measure and there’s enough numbers that you can do a fair comparison. So we all want to know these numbers but I think there are some real technical barriers to fair comparisons.

CHIP KAHN: I think that Peggy’s right on and the problem is, until we have that wonderful electronical medical record for all of us in the sky the collection of information is going to be extremely difficult. But I just know from one example of some hospitals that even though on errors of giving drugs which is something that you would assume you would have good data on many hospitals don’t because it isn’t always even reported internally, once you put bar coding in, which this

particular group of hospitals did and others are adopting it, they knew how many times the bells went off so at least they new how many errors in the current system there were as compared, and they could work on those. I think we are until we get our data systems to that equivalent of the bar coding example I'm using, I think we're going to have a lot of trouble responding effectively to your question. And at the end of the day, so much is going to be hospital oriented because in a sense that's where the capital and the ducks are in terms of being able to develop systems because when I go into my physician's office and it's a practice with four physicians and there are rows and rows of medical records. None of which he has the capacity in his practice to have anybody analog. And I don't see that changing any time soon frankly.

ELLIOT SUSSMAN: I'd agree with everything that's said. I think what we'll see well before we're able to do those careful models across the system is hopefully some detailed case studies but we will get to outcome measurement a lot sooner, no question about it. I mean we will with appropriate adjustment so we'll be able to really do those apple to apple and orange to orange comparisons, be able to figure out the front door back door rule. You know if you're a patient and you come into the hospital via the front door, you don't need to be an economist to figure this one out, it is very bad to leave via the back door. That's just a reality. We can and in

fact a number of states regularly do measure that. I do think that people are smart and increasingly as we have access to more of this information and people being curious, health care being a big deal, people will see it often times before they get in the ambulances. I think what's going to happen actually, we're going to have hospitals differentiating themselves, much, much more. And we will see intensified competition in the good sense of things, principally not entirely because competition has it's downside as well and we will see differentiation based on some of these outcomes between haves and have nots and a large part of it may well be getting back for example to what Peggy said. If you have the volume you can get really get something, it's a lot bigger problem if you're doing 20 hips a year versus if you're doing 250 if you're serious about it gets stellar results.

ED HOWARD: Gerry?

GERALD SHEA: I really appreciate your raising the point about physician's performance because until we get to that point we're not going to be even within the ballpark of a reasonable set of measures and there is fortunately a lot of work that's going on in the CMS pilots around this and in some other activity but that's clearly a next big challenge and it's not without some difficulty because of the extreme anxiety within the physician community that you know we're going to need to address or overcome. Secondly just on the point about

outcomes, this is generally it's one of the watch words of this discussion when you get outcomes and so forth. I just think the experience over the past few years is we've got to take this a step at a time and I would again point out the importance of getting a zone in which we can get reporting for medical errors. The Patient Safety Legislation that I referred to earlier. Unless we can protect the reporting and analysis of medical errors you're not going to begin to get at the real outlier problems, not small, 100,000 preventable deaths a year according to the institute of medicine. And that's the importance of this. I think that's the next big step that we need take in terms of outcome before we jump all the way to sort of comparative. How does this hospital do against that hospital? I just think we have to really address a very, very, difficult problem on the edge and I appreciate Dr. Sussman's comments even before he referred to the front door back door problem but I guess this is in that category, so.

ED HOWARD: If I can just follow up on that somewhere in our materials there's reference and actually I think Dr. Sussman mentioned its application in Pennsylvania there are a bunch of states that do require some outcomes measures, including the number of infection that get developed in hospitals. How's that working? Do we know anything about compliance? Anything about the use of the information?

ELLIOT SUSSMAN: Well specifically about infections that's being developed, it's not publicly reported yet. There's some concerns about compliance the Pennsylvania HC4 recently noted that one hospital has reported a total of 2 infections. I don't think so, so back the issues of auditing and the like that can be frankly a very, very real issue. That said there have been a couple of studies and concerns raised and this often cited that when some of the early outcomes data came very few patients actually looked at it and there was the law of unintended consequences where some doctors may have started turning down high risk patients because they didn't want to have bad outcomes. I think that as the adjustment issues get better in terms of severity and as we see more and more patients regularly and their families use this data and in fact it becomes standard operating procedure, I believe that that problem is going to become a much, much smaller concern and we'll begin talking about outcomes much more openly than we do now.

ED HOWARD: And how about the Hospital Quality Alliance is there some sense of when you'll be able to do some of these things? Some of the outcome measures or is that not the next step?

CHIP KAHN: I think in terms of the next step on the quality alliance will be, at least within the next 18 months or so, will be more measures and hopefully going to some kind of

consumer expectation kind of survey, so that we get the consumer side of the hospital experience. I think that the quality alliance in some ways is going to keep its radar out and with the work that NQF does or JCHO or others do, as they move effectively into those areas when they develop their measures, you know we'll go to the measures that become acceptable. But I think at least in the near term we probably are caught in being able to do the possible which Jerri's been talking about which is those measures that people can have confidence in. I think that in terms of consumers making decisions though that the consumers, it's not really consumer satisfaction but whether or not institution meets consumer expectations is going to be critically important and that's something people will have no trouble understanding when they see the data.

ED HOWARD: Peggy?

MARGARET O'KANE: I just want to point out that a number of health plans are talking, many health plans and with a lot of urging by payers are talking about tiering their networks to make it more financially advantageous for people to go to what they see as high performing hospitals. I think that people that have been trying to solve these problems for years are not willing to put all their eggs in this consumer information basket and people are thinking about other ways to

move market share to organizations that really embrace high performance agenda.

CHIP KAHN: If I could just add I think with due respect to many who have great expectations for individual consumers, at the end of the day whether it's the debate over Social Security or pensions, people choose to have mutual funds as their alternatives not to buy individual stocks and if you think that's a problem then making decisions about your health care is not much different. So at the end of the day I believe that we're only going to be really successful here as consumers if we can figure out who are going to be the best proxy buyers for us and whether it's health plans or whether it's some of set of physicians that we can feel real comfortable then I think we're kidding ourselves if we think the average a person is going to be able to go to website even if the market of the websites, even if the market takes the quality alliance data and does something with it at the end of the day we really do need people acting for us here and giving us information in a way we can understand.

ED HOWARD: I got a question that's formally addressed to Gerry and Chip although others should feel free to chime in. Nursing Home Compare which is the website having to do with nursing homes about which you'll find some information in your packets contains some information on nurse staffing. To what

extent do you believe Hospital Care is complete without such information.

GERALD SHEA: Well coming from a union of health care workers originally I guess this is kind of softball for me. One of the simplest experience that any of us who've been in institutions have had or go to a doctor's physicians office is the availability and accessibility and expertise of support staff and I think it's stating the obvious that this is critical measure that needs to be incorporated. You only need to look at the analyses of the medical errors or seminal events on the joint commission in the joint commission database which is the largest database of medical errors in the country and see the joint commissions analysis that in a vast majority of cases an underlying cause of medical error are either staff levels or communication among staff to see how central this issue is. And so I would say that we need to get to that point and I think too, that this question raises the issue about you know how do you asses what we have here? And again just to be a little bit repetitive I think we need to be appropriately modest about where we've gotten even as we celebrate what a good beginning this is because we need to get to these kind of measures and this kind of information before we think we even have a very serious beginning. But having said that, I just want to say again, this is a tremendous step forward and this is, in my opinion and in my experience in Washington a terrific

example of public service leadership. This is the federal government starting with Secretary Thompson and now Secretary Leavitt, the directors of CMS Tom Scully and now Dr. McClellan in all the hospitals and a bunch of consumer groups nobody was perfectly happy about how this thing went forward. But we got it done and we showed that it can happen and now the challenge is can we fast forward this experience and get a lot of stuff like staffing information out that will be even more relevant to people. But I just can't underestimate or understate from our point of view the importance of the leadership that went in to getting us to the point we are today.

ED HOWARD: Elliot.

ELLIOT SUSSMAN: If I could just make a quick comment, I think it's impossible to overstate the importance that nurses have in the achievement of these process measures and excellent results in hospitals. That said I do think that hospital environment differ greatly and as we employee technologies differently, for example computer assisted physician order entry medication bar coding and the like the important issue is not the structural measure just of how many nurses there are, but it is what they're doing, what their training is and it comes right back to the outcomes question that we said. So for a process measure for example when we literally blew up the system of care in our hospital and went to real patient centered care like every other hospital in America we looked

before that for every 100 hours of nursing care we purchased we got about 20 hours at the bedside. Now we're up to about 55 hours at the bedside. What do you think has happened to patient satisfaction? Through the roof. What do you think has happened to nosocomial infections? Way down. What has happened to bed sores? Way down. And to say that those are correlations is true but I believe there is a pretty strong correlation and probably a linkage. So I think with all these measures we just need to be careful including some of the staffing ratio issues.

MARGARET O'KANE: I think that's a great point if you think about the nurse anybody who's had a relative in the hospital, the nurse is the person where the buck stops. And when there is a hospital that is not really quite well managed the nurse is running around looking for a wheelchair, looking for equipment, trying to find the patient who went down to x-ray and so forth. When you have a hospital that reengineers its processes the role of the nurse is completely different and it's actually an attractive career so I think that's very important.

ELLIOT SUSSMAN: Peggy if I could just jump in our hospital happens to be a magnet hospital for nurses so we're down to no agency nurses and a 4% vacancy rate. So it makes it an attractive place in which people can come to work.

ED HOWARD: Chip?

CHIP KAHN: I just think this, I think we should put an exclamation point on this discussion though because one you have to have nurses. Two, we know the role they play. But three if you don't have the good management and the systems then it probably doesn't matter what your nurse ratio is, so there really is a problem I think with the jump in some areas, California for example to regulate in this area where you tend to get sort of stultified kind of governmental response that is not going to necessarily solve problems. Although I can say and one advertisement, it's a lobbying effort today since that's what I do part of the time. I was down in Puerto Rico week before last and I can tell you I went to a couple of hospitals, if you don't have enough money you will not have enough nurses and Medicare needs to pay better in Puerto Rico. Because I can tell you it was scary in one particular hospital we went to when on two different floors I did not see it and literally if you do not have a family member go with you to the hospital when you're being hospitalized you are not likely to emerge. So money does matter here as well as management and systems.

GERALD SHEA: So I would take that as a ringing endorsement of stultified government regulation in our healthcare [laughter].

ED HOWARD: That's something you don't get very often on these programs. Let me just ask a follow up question and

maybe it’s the last one. Implicit in the way some of you have just responded is that hospitals will reengineer themselves and move to computer physician order entry and other examples of IT and the questioner asks what’s the best way to incentivize the use of IT by physicians and hospitals? Pay them?

MICHAEL MCMULLAN: I think we can have incentives for IT maybe for a brief period but ultimately we need to incentivize good performance that’s enabled them. So I think if only for a very limited amount of time that you’d want to pay, I mean dropping an IT system into a hospital or into a physicians office will not create the kind of change that Elliots place has brought about.

ED HOWARD: Yes Elliot how did you get incentivized as they say?

ELLIOT SUSSMAN: Carefully and I would agree that incentives have a role but it’s usually a component of many aspects of the change process. And it’s really important to see just as we talked about Hospital Compare as tool to have a better informed consumer, I think it’s really important to see these information systems as a tool and only tool to better enable and enhance the processes of care that result in better outcome. So for example, our computer assisted physician order entry process is a three year effort that by this December this will become archaic at our place and it just will not be allowed any more. There may be a few diehards and we’re going

to tell them to go across town or to the next county because in terms of really good patient care that's necessary. And respectful of ones colleagues by the way because once other nurses and docs can't read those notes, how disrespectful that for a physician to be and when you put it in those terms, people don't want to do that. But one needs to recognize the realities that when you put in these new systems, actually work performance for a short period of time will deteriorate. It often times is a larger burden on doctors and nurses and how do we compensate for that in some ways. So this is very, very difficult management issue but one that is by no means insurmountable.

CHIP KAHN: I think that the point that Leonard Shaffer [misspelled?] about trying to get physicians to do outpatient computerized prescription ordering where they were ready to give away the PDAs that sometimes free is not cheap enough. And at the end of the day here I think it goes back to the issue we were just talking about which is all technology is not good but most technology can be helpful and can improve situation but it can only be adopted in a hospital situation where we have mostly voluntary hospitals meaning voluntary medical staffs, it can only be applied with great effort. I mean here is one of the best institutions in the country and we're talking about a three year process. And looking across the country it is going to take awhile even though the JAMA

article debates it, but I think reasonable people would find it difficult to argue against CPOE although I guess that article did.

ED HOWARD: It must have been written by someone who's unreasonable [laughters].

CHIP KAHN: That's not for me to judge.

ED HOWARD: We've come to the end of our time. I want to thank you for providing a lot of grist for some very interesting conversation in this last 45 minutes. I obviously want to thank the Federation, American Hospital Association, the members of the Hospital Quality Alliance for cosponsoring and helping this event take place and ask you to join me in thanking the speakers for helping us explore this very important but somewhat nascent new development in health care quality [applause]. And please fill out those blue evaluation forms.

[END RECORDING]