How Good is the Quality of Care in Medicare?
May 6, 2005

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ED HOWARD: Good afternoon. I'm Ed Howard with the Alliance for Health Reform. I want to welcome you on behalf of our Chairman, Senator Jay Rockefeller, our Vice-Chairman, Senator Bill Frist, and the other members of our board to a briefing that we have put together to look at the quality of care delivered to more than forty million older people and persons with disabilities through the Medicare program.

Our partner in today's program is the Commonwealth Fund, a New York City based philanthropy that, over the years among its other broad interests, has been most active in promoting higher quality in our healthcare system. I want to thank Karen Davis, the President of the Fund, who's joined us today, and her staff, Steve Shonebaum [misspelled?] and Kathy Shane and others who've been very helpful in shaping this program and supporting the kind of information, exchange and dialogue that we're going to have today.

A lot of us are fond of saying that America has the highest quality healthcare in the world. The evidence unfortunately keeps piling up that that's not always true. Today we're going to hear what Paul Harvey likes to call "the rest of the story" from some of the most knowledgeable experts in America.

Let me just do a couple of logistical items before we get into the substance of this program. Most of you know this

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drill. In your packets, you're going to find a lot of good background information, including the speaker's slides. Many of them consolidated into a single packet that you ought to use to follow along, since the lights are making the screen a little less legible than you might otherwise find it. You'll also see in that packet for the first time in Alliance history, a CD-ROM that contains the entire contents of the chart book on Medicare quality that is the jumping off point for today's discussion. You'll hear more about that as you go along.

By the end of the end of the day, you'll be able to see a webcast of this briefing on kaisernetwork.org. It's being broadcast live on C-SPAN right now and probably will be repeated throughout the weekend in case you want to see it again and again. You'll also find that both the Kaiser Network website and the Alliance website at allhealth.org and I suspect that the Commonwealth website as well, cmwf.org, copies of the materials that you find in the packets so that you can make sure that somebody out of town gets what you have without a whole lot of difficulty.

I should say that those of you who are watching on C-SPAN can find those materials if you're somewhere within ailing distance of a computer, you can follow along with the slides by going to one of those websites that I mentioned and looking at the materials that are associated with this briefing. And for those of you here in the room, I just want to say you have

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green question cards – some of you have filled them out in advance, others are waiting to key on what the presentations give you, and at the appropriate time, you can either fill out a card or go to one of the microphones that are in the audience that you can ask the question directly.

I just want to formally acknowledge Karen Davis' presence. We're very pleasantly surprised that she's able to join us today after having a conflict in her schedule earlier when we were planning this event. We've asked her to join us not just because she's President of the Commonwealth Fund, but because when we get into the Q&A session, she's also one of the foremost experts in the country on Medicare and we hope to entice her to be part of the panel as we respond to your questions and the presentations.

We also have with us from the Commonwealth Fund, Dr. Anne-Marie Audet, the Fund's Assistant Vice-President for Quality Improvement. Real stall work in helping to bridge the gap, I guess you could call it a chasm, between what we know about delivering quality healthcare to Medicare beneficiaries and what we do in delivering that care.

Anne-Marie, could you explain to us a little bit why quality of care for Medicare beneficiaries is an important issue and what the Commonwealth Fund's interest in it is?

ANNE-MARIE AUDET, MD: Good afternoon and again, from the Commonwealth Fund, I welcome you to this event today and I

will also like to take the opportunity to thank our speakers and our panelists who have graciously agreed to participate and contribute from their own perspective in an area of expertise to the debate today, which is really about what we know about quality of care.

The timing of this even is also quite interesting. Today is Friday; it's the end of "Cover the Uninsured Week" and it's so relevant because, as we try to address the challenges we have in the increasing number of uninsured, the rising healthcare cost, it's essential that we bring to the table actual knowledge: data, fact and information about the value we're getting from our healthcare system.

And today, what you'll hear from the chart book on Medicare that has been authored and the work of Sheila Leatherman and Doug McCarthy, I think you will realize that that's exactly what they set out to do is look at what we know today about quality of care in Medicare, provide a synthesis of this and bring that knowledge to the table to inform decisions and policymaking.

This is actually the third of a series of chart books, and it's been a wonderful collaboration with Leatherman and McCarthy over the past three years. The first chart book was developed by our two colleagues here – it was published in 2002 – and really was about the quality of healthcare in the US. The second chart book focused on children and the quality of

healthcare of children in this country. And this third chart book I think was probably the most challenging one, but I think will have great value because of the challenge and the wealth of expertise that these two colleagues brought to their work doing this chart book, specifically on the Medicare program.

And because we know that information and things change on an ongoing basis – although this is the final of our three series of chart books – Sheila and Doug will be continuing this work on what we call the ongoing snapshot initiative that will provide more timely information about quality of care issues that are timely as things are brought up in the policy domain in this country, so this is work we can watch for in the ongoing months and years.

The goal of this initiative was really to provide a contour map of quality in this country and to bring in a way that would be credible, comprehensive, in a very condensed and synthesized report, what we know today about quality. And I think that Sheila and Doug have really set their goals and have achieved them in a remarkable way. When you hear what they say about they and you hear it from the speakers and when you have a chance to look at the chart book when you go back to your work and home environment, I think you will agree that for the first time, I think we have in our hands now a very high quality report that went through an extensive review of hundreds of reviews of papers, set about a series of sixty

charts. So it's very readable, very accessible, it also synthesizes why these areas of quality are important, what the data means – so it's a synthetic approach to quality.

And from this report today, we can really have a very good story and map about the quality of care we are getting out the Medicare program. So that's what Sheila and Doug McCarthy have achieved. So that's what I wanted to say about it and now you will hear about all this wonderful work.

ED HOWARD: Thanks very much Anne-Marie. I should say, it's Anne-Marie Audet's diligence and insight that has assembled this all-star cast of experts for us today. We're really pleased to have them. I can't imagine a better group to help us understand how good the care is that we deliver to Medicare beneficiaries and maybe some notions about what we do about improving it.

Sheila Leatherman co-authored the chart book that gives us the occasion for this briefing. We'll hear from her co-author, Doug McCarthy, later in the program. Sheila leads a bicoastal professional life, which isn't unusual in this town, except that both her coasts are on the Atlantic Ocean. She's a research professor at the UNC Chapel Hill School of Public Health and a distinguished associate of Darwin College at the University of Cambridge in England.

And the chart book we'll be talking about today is just one, as Anne-Marie noted, of a series of chart books that

Sheila has authored on different aspects of healthcare quality with support from Commonwealth over the years. She's run an HMO in her previous life. She's been a senior executive in the biggest managed care company in the United States as well. And we're extremely pleased that she's with us this afternoon. Sheila?

SHEILA LEATHERMAN: Thank you. And thank you for joining us today to talk about this topic. I just want to acknowledge from the outset, my colleague, Doug McCarthy. I'm giving the presentation, but he's done a Herculean amount of work to produce this book.

Starting with what's at stake here – we know from many studies and research that quality of healthcare across the US is deficient and uneven. But we felt, for this third book, that it was particularly important to concentrate our attention on the thirty-five million elderly that are living in the community because they have distinct healthcare needs.

Also obviously, this is a big cost issues, with more than 250 billion dollars in cost annually in the Medicare program. It's important to note too that we know from experience that very significant improvements in quality of care can take place if using proven methods. And also that the Medicare program, when it improves performance, is likely to have a broader salutary effect on US healthcare across the country.

So the chart book is basically a distillation of over four hundred studies and datasets. And the way that we have defined "quality" is to look at it in five different dimensions. First of all, looking at the effectiveness or the appropriateness of healthcare. Secondly, access issues. Thirdly, patient safety. Fourth, to make sure that the healthcare system broadly, as well as the Medicare program is responsive to individual patient needs and family needs. And finally to look at issues of equity and disparities.

We have also added a section called, "Capacity to Improve" which simply highlights eight exemplary programs across the country showing that improvement, and sometimes very dramatic improvements, are indeed possible.

So what is the bottom line here? And that is that it's a mixed picture. There are many improvements in care occurring, but many more that are needed. And this slide just gives some examples of the positives.

First of all, in terms of appropriate effective care. In the past decade, the screening rates for breast cancer have tripled – 90% of elderly diabetics are getting proper hemoglobin A1C testing and blood lipid profiles. There's been a reduction in use very significant of about 37% of those drugs that are contraindicated or considered unsafe for the elderly.

In terms of the access to needed care, also a number of positives. When seniors are asked, "Do you have a usual source

of care?" which is an indicator of quality, they answer that that's the case many more times than other Americans. And we can see when Medicare coverage improves in terms of adding benefits, then there's increased uptake. For example, preventive services.

And in terms of the healthcare system and Medicare program being responsive to individual patients, we can see there too that the Medicare elderly rate their insurance coverage higher and also their experience with healthcare better than other Americans; but there are many quality deficiencies and of several different types.

The first is that we will be showing you that there's very large variation occurring across states in the US and that this variation is without justification. Secondly, that there's a lack of adherence to evidence based standards for care. And this is true in complex care as well as burden variety, common conditions. Thirdly, that disparities exist based on rates, ethnic and other variables, and that's true in preventive and chronic care. And finally, that there's plateaus in performance. So even in those areas that we see that there's been improvement, the performance appears to plateau at a much suboptimal level.

And I'm going to demonstrate these in the next four slides. Hopefully, you're following along in your paper. On this one, we're looking at immunization of elderly adults. And

basically if you keep your eyes to the left hand side of this slide and just look at the line graphs. We're looking at two immunizations of importance. The first is whether a flu vaccine occurred in the past year and that is the blue line, and the black line is whether a pneumococcal vaccine ever was received. The importance of this is that between flu and pneumonia, those two account for about the fifth leading cause of death for the elderly in the US.

And what you see there is that the rates for flu vaccine have about doubled over this period of approximately fourteen years that we're tracking, and the rates for pneumococcal vaccine have tripled. But if you look closer, you will also see that in the past five years, the rates are plateauing; they're not moving up dramatically. And so for example, just for the flu vaccine, it means that we are plateauing at about just two-thirds of the elderly in this country.

If you look then on the right hand side at the map of the US and just keep your attention to the top one, that is showing you state performance by quartile, from highest to lowest, of vaccinations in 2003 for flu vaccine. And what you see is that the best performing state is Minnesota, and that has about four-fifths of the elderly vaccinated. And the worst performer is Nevada, which is only at 60%.

Now if you look at this next slide, this is looking at

acute care because I'm just trying to give you a feeling across the board of the problems. This is looking at hospital treatment for pneumonia – about six hundred thousand cases occur yearly of elderly hospitalized for pneumonia. It is a big risk for them, including death. And so along the left hand side, the bars show you that there are three standards of care that should be adhered to: Blood cultures collected before the antibiotic given; the antibiotic given with four hours of arrival at the hospital; and the antibiotic consistent with guidelines.

If you look at the bottom bar there, what it shows you is that in less than one-third of cases across the US did the patient get the full care that would have been adherent to evidence based standards. And if you look at the map on this page, you see again by quartile ranking, the large disparities across the US. Again, let me underline this as unjustified variation. The top performer being South Dakota that had about three-quarters of its patients that met these standards of care, compared to less than 50% in the state of Delaware.

Now moving on to mental illness – it's very difficult to get nationally representative data for mental illness. But this is looking at a study published in 2003 of patients who were treated in eighteen primary care clinics across the US, eighteen hundred patients, all with a diagnosis of major depression. And what you see in those three bars is the

judgment of experts of whether they had received effective treatment for major depression. And the numbers show you that just about slightly over one-quarter to less than one-third of our elderly were receiving effective treatment.

The last then is to make the point that even in common variety care – very common conditions – we still have big deficiencies. This is looking at blood pressure control. On the left hand side, the two vertical bars simply show you that when patients or asked, or the public was asked, whether they had their blood pressure monitored in the last two years and whether they knew whether it was high or normal, over 90% were able to say, “Yes.” So that was good.

On the right hand side of the slide is much more troubling data. You’re looking at two time periods, because we’re trying to see whether progress is occurring. The first is the light blue-grey, 1988-94, and the darker, 99-2000. Two age groups. The middle aged adults, ages 45-64 and then on the right hand side, ages 65 up, so Medicare. And what you see here is very disappointing performance that for middle aged adults, they’re doing better, but at the best, 40% have blood pressure considered to be under control by objective measurement. And for the Medicare elderly, just one-quarter and no progress in a decade.

Moving on to access – we know that it matters what kind of insurance that you have; we know that across the population,

and what we can see in Medicare is that it really does seem to improve the general predictability of access. This is very good news. The converse of that though is that where there isn't coverage, we can see adverse effects and you'll see data later regarding drug adherence affected by cost barriers.

But the third point is that even though benefit coverage may be a necessary condition, it's not sufficient to assure quality. We can see for example that in colorectal cancer screening, only 50% of elderly are getting that as recommended, even though it's a covered benefit. And only 50% of women say that they have discussed osteoporosis with their physicians. And further, we can see that even though the benefit coverage is equal, there are still disparities by race and ethnicity.

So looking first then at this slide, this simply shows you, again, two populations. The light is ages 45-64; the dark, the Medicare population. They're asked two questions: "Did you not get medical care in the past year because you could not afford it?" And the second question is, "Did you delay seeking medical care because of worries about cost?" And what you see is about less than half the rate of Medicare beneficiaries say that than those who are middle aged, before Medicare eligibility.

However, again the point is that even with equitable coverage, we still see disparities in medically necessary care.

And what I'm going to show you is data for preventive services. At the bottom of the page, it's six different types of recommended services for preventive health and health promotion. The bars are four different racial ethnic groupings: White, Black, Asian and Hispanic.

Let me just draw your attention to the left hand side – the two vaccinations that I earlier described as being important – and you can see there significant variations between Whites at the highest rates, and then lower for all others. However, on the right hand side, to present a balanced picture, cholesterol and blood pressure checks – this is a much more equitable picture and there are a number of explanations that are simply not just the fault of the healthcare system, there may be other issues, such as patient-seeking behavior.

In terms of a really critical question – is the healthcare system responsive to patients and families? Again, what we'll be showing you is a very mixed picture. There is good news in terms of satisfaction and high ratings of coverage, but concerns about vital human needs that will be described later.

This next slide shows you experiences with insurance and care and has, again, a mixed picture. If you look at just the left hand side, when asked to rate health insurance as good or excellent, or whether satisfied with care, Medicare beneficiaries rate both higher. On the right hand side, where

it's better if the bar is lower, there are two issues – they're asked, "Have you ever had coverage problems with current insurance or gone without medical care because of cost?" Medicare performs better. But again, let me hasten to say that 40% show that they did have some coverage problems with current insurance, and one out of five said that they went without medical care in the past year because of costs.

Before summarizing, I just want to address this problem and issue of building the capacity to improve. What do we mean by that? We are talking about building a predictable systemic-wide capacity to continuously improve performance. This sounds ambitious, but it is possible. And what we mean by this is to increase effective care in the country while being responsive to patient and family needs and preferences, and in some cases – not all cases – even being able to save money at the same time.

And I will illustrate this with one example. This is looking at a program – an innovative program – of Kaiser Permanente, which offered expanded palliative care options at the end of life for patients with life threatening chronic illness. In the dark bar is the Kaiser palliative care program; the light bar, the contrast is usual, Medicare, homecare. And looking just at the left hand side of the slide now, you'll see that what happened is that Kaiser intensified homecare, three times as many home visits as the usual Medicare

home benefit.

But at the same time was dramatically reducing higher cost medical visits to physicians, ER, hospital days that were reduced by about two-thirds and skilled nursing care by even more than that rate. At the same time 90% of the patients were satisfied with the services. And the last bar on the right, you can see that one-third more of the individuals in this palliative care program died at home, as was their expressed desire.

Finally, to summarize and to give a preview of action needed. First of all, I think it's very important to say that what we want to do is build on the very considerable strength and assets of the Medicare program in the US. Several of those assets are public good will and support for the program, the current efforts of CMS and Health and Human Services, which is focusing now on quality and does have infrastructure for quality, including quality improvement organizations in all fifty states.

And most importantly, it is the 800-pound gorilla. It has huge financial clout as a program in this country and can garner attention. So what are we suggesting? We are not suggesting a change in the course, but rather an intensification and focus of effort.

First of all, we believe that because there are so many areas that are deficient, it's really critical to identify

national priorities and focus in those areas. And we also suggest a somewhat controversial action and that is to identify explicit numerical targets. So expectations and accountabilities are clear for what kind of performance we're asking for.

Secondly, to continue to look an see whether the design of the Medicare program does compromise quality, for example, in the past in terms of the lack of drug benefit. And thirdly, we suggest that we need to concentrate very clearly now on low performing and unjustified variation that's occurring across the US. This is a national social insurance program and therefore should be able to guarantee some satisfactory level of performance no matter where you live in this country.

And finally, to make the point that improvements in the Medicare program are not only important for Medicare beneficiaries, but there is very likely a beneficial spillover effect that improvements in Medicare will also improve the performance of the US healthcare system more broadly. Thank you.

ED HOWARD: Thank you very much, Sheila – a great beginning to this discussion. And I should point out that the rest of the slides from other presentations continue in that same packet of paper that you've been following along to Sheila Leatherman's presentation for.

Now we're going to hear from Christine Cassel, who is

the President and CEO of the American Board of Internal Medicine in Philadelphia and its affiliated foundation. She's a geriatrician, former chair of a prestigious geriatrics department and in fact has been Dean of the Medical School of Oregon Health and Science University. She's a very active member of the Institute of Medicine, including service on IOM committees that issued a very influential report on quality of care and medical errors. So she's uniquely qualified to help us understand more of this issue about the quality of Medicare services. Chris, thanks for being here.

CHRISTINE CASSEL, MD, PhD: First, let me just again the importance, as Anne-Marie said, of actually having data to talk about this important national program and congratulate the Commonwealth Fund on supporting this work and Sheila and Doug on the tremendous work that they did and how quickly it was pulled together, I might say, given the volumes of information that were reviewed.

I want to spend just a few minutes with you talking about Medicare from the perspective of a physician, a specialist in geriatric medicine, who has spent my entire career taking care of Medicare patients and, in that sense, working with the Medicare program from the perspective of the provider.

The first way to think about this is to point out something that is often not recognized as we think about

Medicare. The science of geriatric medicine has advanced enormously in the forty years of the Medicare program's existence. Compared to 1965, we now have an extraordinary amount of information about what is necessary to take good care of older patients.

There is always the need for more research, but if you look at the advance in knowledge, I think you can really safely say that there is a model from the perspective both of medicine, but nursing and other health professions as well, of what the standards of care for Medicare patients ought to be.

The first area in which the advances have occurred, is actually in biomedical science, much of it's supported by NIH, important understandings of the basic scientific phenomenon of aging and how that interacts with illness. And related to that complex disease physiology, when I first started doing geriatric medicine, people said to elderly patients, "Well we can't help you, it's just old age." We now understand that aging brings with it higher risk of certain kinds of illnesses, but that there very often are things that modern medicine can do and should do to help either prevent or ameliorate those illnesses.

The fact that the disease physiology is complex, comes both from the disease itself and also from the fact that older people are extremely likely to have more than one condition. So as we think about how specialized medicine is, you realize

that an elderly person is likely to have six, ten, many, many more chronic conditions that they're taking medications for, getting procedures for, seeing specialists for, and that adds to the complexity of what they need.

Because of that, the geriatricians, the specialists in geriatric medicine, works with multiple disciplines; it has to have a broad understanding of those disciplines, but also has to understand the system of care and how to coordinate the care for that patient so that there isn't redundancy, so that there isn't medication errors that occur because they're getting too much medication, but also so that there aren't gaps in their care.

Another important feature of geriatric medicine that is important as you look at these charts and the chart book is that the geriatricians work with the patients and their families with the goal of improving function. It's not just about treating this disease, getting that blood pressure correct or getting that malignancy to reduce its size in the x-ray, it's about what really matters to that patient in the whole spectrum of how their illness affects their life. And in order to do that, that requires someone who understands the broad spectrum of specialties, but also, importantly, for the Medicare program is able and willing to spend the time talking with the patient and their family to understand those functional goals.

And then finally, the ability to coordinate care, and by this I mean the infrastructure that we might need with an electronic medical record, but also the ability to share data among all of the different providers who are taking care of patients. So that's a big task for the healthcare system and it's particularly a big task, as Glenn and other know, for the current way that Medicare is structured, especially traditional Medicare.

The Medicare benefits are not enough. There need to be financing approaches and other kinds of approaches. I would argue also, more expertise about this complex area that we call geriatric medicine. You probably can't see this very well from where you sit. But this is a study drawn from the Rand Corporation that was put together by the Alliance for Aging Research. This red line is the number of projected number of geriatricians the nation needs just to be able to teach all of the other physicians graduating from medical schools and all the other specialties enough about aging that they can take good care of older people and to act as systems consultants to large healthcare groups, et cetera.

This is the current number that we have – it's less than a fifth of the number that is the minimum number projected. One of the reasons that so few people go into geriatrics, and these are now board certified geriatricians – there is an identified specialty of geriatric medicine – there

aren't a lot of incentives for young physicians to go into this field because there isn't a lot of support within the Medicare program financially or with the infrastructure to support it, so one of the things that might support that, particularly since Medicare also helps to pay for training physicians.

I want to then move to look at some of these specific quality areas with that framework in mind, the framework of expertise, knowledge and how the deliver system and the Medicare program either help or don't help support those things.

I too want to emphasize this phenomenon of geographic variation across the country and without justification based on differences in the kinds of patients that live in these different states. This graph shows you two things – this is an overall score of provision of effective care to Medicare beneficiaries in the Medicare fee-for-service program and a quartile rank from first to fourth. And again you see a tremendous variation in different dates overall scores.

Now we were talking before about the way in which, even within a state, even within a region, even within a city, there is also tremendous variation and we need to know more about how to measure and understand that. But what I think is also interesting here – Sheila mentioned the capacity to improve. The second map here shows median relative improvement in the provision of effective care to Medicare fee-for-service

beneficiaries, again by quartile. So what's interesting is that this doesn't exactly map – some of the states that performed more poorly actually were able to improve over this period of time, from 1998-99 to 2000-2001, which shows us that there may be lessons in those states that come from looking at ones own data, setting targets as a few had challenged us to do, and aiming for ways to create improvement. The overall message though is that we're not uniformly doing a good job and we could do much better.

I want to then look at a few conditions and in particular, point out the difference between conditions where there's a specific medical diagnosis, where it can be coded by Medicare and understood by Medicare and frankly paid for by Medicare. So, for example, stroke here is one of the highest performing areas and average across all conditions and end of life care is one of the lowest performing.

Now end of life care involves a whole broad spectrum of healthcare disciplines, healthcare specialties. People who are dying die of multiple different kinds of conditions: Heart disease, cancer and other things. Alzheimer's disease is a major complicating factor for many older people. So the need to be the coordination of care entity is where we often fall down in these quality metrics.

You can see that here by type of condition, where geriatric conditions also perform very badly. Geriatric

conditions are things like frailty. We are able to identify patients who are at very high risk, for having complications of their illness, of their treatment, and also of hospitalization, which I want to mention in just a moment. But without geriatric expertise, it's hard to perform well on those conditions.

Similarly, by domain of care - here we have prevention diagnosis, treatment and follow-up – and interestingly, treatment performs the best, 81%. That's because we pay for it. Prevention, we pay for some identified preventative services, but not for the kind of coordination of care that prevents complications and exacerbations of existing chronic condition. So as we look across the spectrum in a general way, I think we'll find that if we identify things specifically and figure out a way to measure those and pay for them with the Medicare program, we can in fact improve them.

Here's an example of where frailty in elderly patients leads to worse outcomes and leads to patients being at much higher risk. We have a number of models for why older people are at higher risk for complications of hospitalization. I'm sure all of you who have older families know that people are always worried about the risks of hospitalization and indeed that is a reasonable risk.

But here, you can see the risk adjusted rates of potentially preventable adverse events and complication for

people at different ages. And the striped bar is age 85 and over, which are the people who are higher risk of the greatest frailty. But if you look, infections are relatively well controlled. But blood clot related illnesses and pressure sores, which are preventable and very devastating complications of hospitalization, increase dramatically with age. That's where having preventive services in the hospital which help people to get out of bed sooner, maintain strength, and importantly, go home instead of to a nursing home, need to be examined and probably used more frequently.

One place that has done that is a transitional care program in Philadelphia. This slide shows you a comparison with patients who have congestive heart failure, one of the leading causes of hospitalization for patients in Medicare and it's well demonstrated that you can dramatically reduce the number of hospitalizations for people with Medicare, if you coordinate their care better, work with them with homecare, patient education, et cetera. But the high-risk period is right after the patient's discharged from the hospital.

In this project, nurse practitioners got involved to help with that transition and were able to dramatically reduce the average cost of care as well as the number of hospital readmissions and the number of patients who were re-hospitalized or died.

Finally, end of life care - again, Sheila mention this,

but it's important to understand that end of life care is an important challenge for the Medicare program. Palliative care needs to be improved for patients throughout the lifespan who are facing life-threatening illness. But the success of our society is that we are all living longer, and so for most of us, we can expect to face the end of life at an old, or very old age. And yet, the Medicare hospice program wasn't really designed with that in mind, and so palliative care really needs to be a particularly important focus of improving Medicare services.

I just want to point out in this slide the areas where there were the largest gaps – 50% of people said they had inadequate emotional support – that's the patient and the family; a third said they had inadequate physician contact; and a similar third said they had inadequate information – I expect those two are related. One out of four had inadequate pain treatment, even in this day and age where we really understand how to deliver adequate pain treatment.

So in summary, I think the important message is that we do now have the knowledge of how to provide this care, and what we need is the ability to use it and to use it effectively. Thank you Ed.

ED HOWARD: Thanks very much, Chris. Where going to turn now to John Rother. He's director of policy and strategy for the organization formerly known as the American Association

of Retired Persons, now just simply AARP. On aging issues, especially Medicare, John has very few peers in this town or in this country on his political and policy analysis skills. He headed the staff of the Senate Aging Committee - right around the corner in this building, as a matter of fact, on this floor – under the chairmanship of Senator John Heinz. He's a lawyer by training. He likes nothing better than to marshal AARP's considerable resources on behalf of vulnerable Americans, actually of any age. If you get the right question, they'll be there. And we're very pleased that he's here and it's not the first time. John, thanks very much.

JOHN ROTHER: Well thank you Ed. I want to start, before I turn to some slides, thanking the Commonwealth Fun and Sheila and Doug for tremendous and timely work. To me, this is a wakeup call. And it's a wakeup call that I'd like to address from the point of view of a patient advocate.

I think that much of what's documented here is unacceptable for 21st century American medicine. We are letting people die unnecessarily; we have unjustified variations; we have evidence based for processes in medicine that we're not following; and the result is people are at risk.

The good news I suppose is we can document some improvement, and also the good news is that Medicare, compared to the rest of our healthcare system is actually performing better. But I think that overall, I would say this is a cause

for putting quality improvement at a much higher level of priority in our national effort.

I want to reinforce what Chris said too about the need to focus on Medicare patients because they are the most vulnerable. They are the most frequent users of our healthcare system and particular for those over 75, with multiple chronic conditions that are heavily interacting with a healthcare system that does not do a very good job in too many cases of coordinating their care or making sure they're getting appropriate care.

I think the "opportunities for improvement" are widespread and I'm glad to see that there are improvements being made, but I do think you have to walk away from this report with a feeling that we cannot just continue on our current course, that we have to really make a much more intensive effort, because we're wasting not only dollars here, we're wasting lives.

So a message that I would take away from this for Medicare beneficiaries is to be much more aggressive partners in your care. Question your physician and probably even more importantly, have someone with you when you seek medical treatment or when you're in the hospital whose prepared to ask a lot of questions because it's obvious that for too many Americans, especially those who are the most vulnerable, we're simply not delivering optimum quality healthcare.

So I'm going to speak to three non-clinical aspects of Medicare and the first is the financial barrier to the prescription drugs. And it's obvious what the relevance is here. Thank God we have a prescription drug benefit in Medicare on the way, even though it is limited. But I think that this slide shows, first of all how important that assistance is, especially to seniors who today do not have prescription drug coverage. Among seniors without prescription drug coverage, they are twice as likely as others, either not to fill a prescription in the past year because it was too expensive, or to skip the medication in order to make the prescription last longer. So one-quarter of seniors without prescription drug coverage today are either not filling their prescriptions or skipping, and combined, over a third. So that's truly alarming and I hope we make major progress on that in January, as we hope most of these people will be covered under a Medicare drug benefit.

But I think the other thing to say is that even those with coverage, too many are not filling their prescriptions. And when we look at the combined category, whether you're looking at those under 65 or those over 65 with coverage, about one-fifth are either skipping prescriptions or not filling at all. And I think that points to the need to be very careful in cost sharing. We often talk about cost sharing in this country as if there's no clinical impact from that. But what this data

points to is a real concern, even for those with coverage, that costs are still a barrier to necessary care.

Now the second slide is actually, in my mind, a very good slide and it shows that we're doing better both by age group and by type of coverage in having a usual source of care, usually physician, for older folks. And we see that already because of their frequent interaction with the healthcare system, that older people are more likely to have a usual source of care than are those under 65. But it's particularly heartening to see that on the right side of this, that regardless of whether you have Medicare and private coverage, we're getting down to fewer than 5% with no usual source of care. This is extremely important for an older population, again, much more likely to have multiple chronic conditions and it's critical that there's one place, a "medical home" if you will, where a physician or an organization is capable of coordinating their care. So that's good news.

The next slide is not so good news. We have a major challenge in terms of helping people understand their healthcare program, and particularly in Medicare. Now we don't have comparative data here for the under 65 population; I'm prepared to believe that it's probably worse there. But within Medicare, there's been an improvement in four years in terms of people who say that they have all or most of what they need to know. But it's still less than half of the Medicare population

reporting that they have most of what they need to know about their Medicare program. And a quarter saying that they have none or little of what they need to know. And from all the other information we have, we know how important patient information and knowledge is, if they're going to appropriately use healthcare and this again is a major opportunity for improvement.

One of the things that we have seen is a bigger effort on the part of CMS to make information available and certainly AARP is doing what we can as well. Unfortunately, the studies by the GAO of the 1-800-MEDICARE toll free line showed that we still have quite a ways to go in terms of making sure that the information that we provide to people when they do call is accurate. Only 60% of the time, according to the GAO, are we providing accurate information.

So we have a long way to go and we have not much time to get there because I think as I'm sure everyone in this room is aware, the implementation of the Medicare Modernization Act and drug benefit that starts with the open season this fall and then a full benefit in January is going to present major challenges in terms of beneficiary understanding, making appropriate choices, confronting new types of health organizations and benefit designs that they've never encountered before in their lifetime.

And this is a great concern to me that we are starting

out with a low level of beneficiary knowledge and we're not doing a good job of delivering accurate information. So I think the challenge is right there in front of us and I hope that we can redouble our efforts to meet this challenge in the next few months. Thank you.

ED HOWARD: John, the consumer aspect of this that you've helped us to emphasize are just so important. I'm very glad to get that aspect of it front and center in this discussion.

Our final presentation is from Glenn Hackbarth who also holds a law degree I discovered. I think the lawyers have the docs outnumbered on the panel slightly. Perhaps of more relevance, he chairs the Medicare Payment Advisory Commission, MedPAC. Those of you who are in the room – and I suspect a lot of the folks watching as well – know that MedPAC's advice to Congress on Medicare policy, which is it's job, is both widely respected and widely followed, for good reason as a matter of fact.

Now Glenn has been a senior official at the US agency that runs the Medicare program. He himself run one of the most prestigious multispecialty medical practices in the country at Harvard Vanguard. He's now an independent consulting living in Bend, Oregon, so he might even vie with Sheila for the "Came the biggest distance" prize for the panel. And we're very pleased that you did Glenn. Thanks very much for coming.

GLENN HACKBARTH: Thank you Ed. And let me add my thanks to Commonwealth and to Sheila and Doug for this really excellent piece of work. It's a terrific overview of the issues facing us.

I have two teenagers and I often say to them that people judge you not by what you say, but by what you do. And if we apply that test to our healthcare system as it applies to Medicare beneficiaries, we can surmise what we value as a society by what we do.

We seem to value very highly free choice of provider for Medicare beneficiaries and for Americans in general. We also value very highly clinician autonomy; and some would say, clinician incomes. Clearly we value more visits and more procedures and more prescriptions. We value short waiting times, both for office visits and for surgical procedures of various sorts. And we also value technological sophistication and advancement in care.

What we don't seem to value is quality. Quality defined as consistent performance, adherence to evidence-based standards of care and avoidance of errors. And we get what we pay for. Now let me make a distinction here – very important distinction. It's not to say that we don't derive great benefit from the Medicare program or from our healthcare system in general; of course we do. Mark McClellan and David Cutler, among many others, have tried to estimate the value to society

of the advancement in healthcare over the last fifty years, and the gains are enormous. The gains are enormous even relative to the very substantial increase in cost. Mark and David have argued that in fact the gains from just a couple areas, improvements in treatment of heart disease and low birth weight infants, are so large that arguably, they outweigh all of the increase in costs over the last fifty years. That's a stunning statement.

But we can't be satisfied with that and I think that's the message of today. We could do so much more to reduce death, disability, pain and suffering for Medicare beneficiaries in the population at large. And that's the challenge before us.

A number of speakers have mentioned that the averages are not great, but there is substantial variation around the average, and this is another illustration of that point. This is research done by people at Dartmouth, but it's very similar to some work that we at MedPAC did. And what it does is compare quality rankings using the same measures that I think Chris referred to earlier that were developed as part of the QUI program, and develops a ranking for each of the states and then compares that quality ranking with Medicare cost per beneficiary in that state.

And the striking thing is that high quality does not correlate with high cost. In fact there's an inverse

relationship. The highest quality states tend to be lower cost states. At the same time, the poorest quality states tend to be the highest cost states, and that's why we see this downward sloping line from left to right. That's not good news. Just one other observation about this – in my capacity at MedPAC, we often talk to members of Congress and their staff – for people in states up in the upper left hand quadrant, including my state of Oregon and Montana and Minnesota, those places, and they say, "Well Medicare's inequitable. We spend a whole lot more in Florida, in Louisiana, in Texas, the states in the lower right hand. And we need to be paid more in Oregon."

No, that's not what we need. What we need is not to move Oregon from the upper left hand quadrant over to the upper right hand quadrant where we pay a lot more for high quality. What we need to do is get much better performance out of Texas and Louisiana, both improving quality and reducing cost.

This next chart deals with trends in hospital mortality. And this is work that is in fact published in one of the MedPAC reports. Here, we are indebted to ARC for developing quality indicators that we could apply to the Medicare claims discharge database. And we did that for four years, as you can see here, 1995, 1998, 2000, 2002.

On the left hand side of this, we have risk adjusted inpatient mortality rates for a number of different conditions and procedures. And for inpatient mortality, the picture is

generally very good news. We see declining rates of mortality over this time horizon. On the right hand side though, the picture becomes more mixed. On the right hand side, the measure used is not inpatient mortality, but thirty-day posted mission mortality, so we're capturing, in addition to the inpatient stays, post acute care or homecare. And there you see that over the period from 1995 to 2002, the rate of decline is slower in that we actually had an increase in thirty-day mortality in the period from 2000-2002.

Now why is that? We can't be sure. A reasonable hypothesis might be that there are some inadequacies in post acute care and/or the way we educate patients and their families about what they need to do for themselves after a hospital admission.

This next chart is also based on ARC measures. And here the subject is hospitalizations for ambulatory care sensitive conditions. These are potentially avoidable admissions, if the patients get appropriate ambulatory care. And here again, we see some cause for concern and further investigation. Five out of the ten indicators shown here show increases in potentially avoidable admissions over the period from 1995 to 2002.

So in this important dimension, we're missing an opportunity not just to provide better care for the patient and reduce their illness and discomfort and whatnot, but also

potentially reduce cost to the Medicare program. These are conditions in many cases where disease management has some potential, and we're excited about the pilot that is upcoming for disease management and Medicare, as well as improvements in immunization and the like, as Chris mentioned. It also is true that potentially investment in information technology, to the extent that it can help physicians coordinate care, remind patients about needed service, follow-up care and the like, IT could help in this area.

This last chart deals with trends in adverse events and complications that occurred during a hospital visit, and this also is based on the ARC tools, looking at the entire Medicare database. This is work done by MedPAC staff. Here again, we have disturbing news. From 1995 to 2002, the rate of potentially avoidable adverse events and complications increased – increased – for seven out of ten of these measures.

Now, if you think about these data for a second, a question that immediately leaps to mind is, are the adverse events and complications really increasing or does this have to do with changes in reporting, coding and the like? And it's not possible for us to give an absolute definitive answer to that question, but we did spend time talking to experts about these data. And what we heard from them was changes in coding and reporting may be part of what's happening here, but it's very unlikely that that explains all of this very adverse

trend.

So what should we do about these trends and these problems? Let me present a brief list for discussion. Number one is we need to continue to invest, increase investment and research it, will produce more evidence-based standards and quality measures of performance. Second, we need to develop institutions that can serve as respected arbiters of when standards are ready for primetime, as it were, for example, inclusion in a pay-for-performance system. Third, we need to expand our efforts to publish comparative data and make it clear to the American people, including Medicare beneficiaries, that not all healthcare providers are equal. Fourth, we believe that we need to link payment to performance on quality so that we send clear signals that investment and improving quality is valued by the Medicare program. And we think through doing that, we will also encourage investment in tools like information technology that could help improve care.

We need to, in addition, encourage better integration and coordination of care. And there are a whole lot of different paths that might take. Some have to do with adjusting how we pay physicians. And, for example, potentially rewarding physicians, like geriatricians, for their involvement in coordinating care for patients. Investment in IT can help improve integration and coordination, disease management. Some private plans offered to Medicare beneficiaries have

demonstrated capacities in that area, as Chris has mentioned. And we need to continue to explore, develop new payment methods for the traditional fee-for-service program, a demonstration that is of particular interest to MedPAC is the new group practice demonstration, which tries to reward organized system of care for both better managing cost and improving quality.

The good news is that there is work underway in all of these areas that I just mentioned. But the level of focus, the level of investment, the level of intensity of the effort needs to increase markedly if we are to have this sort of healthcare system that our Medicare beneficiaries deserve, as well as the American people. Thank you very much.

ED HOWARD: Excellent conclusion to the presentations. Thank you very much Glenn. We're now at the question and answer phase of this program. I want to make sure that, as I mentioned, I encourage you to direct your questions to any of the members of the panel.

I also encourage Karen Davis to chime in where it's appropriate and I also want to recognize Doug McCarthy whom I mentioned before, Sheila's coauthor on the chart book. He's the President of Issues Research Incorporated. He's a veteran of twenty years of research in policymaking and management in both the public and private sectors. He's been head of the United Health Group's center for healthcare quality and evaluation. I suspect that might have something to do with his

collaboration with Sheila at some point in his career.

So use the microphones. I see there are some people at the microphones and we have some questions already on the cards. If you have a new one, hold it up and somebody will take it from you and bring it up front. Yes? Would you identify yourself and please keep your questions as brief as you can.

ALAN GLASS: Alan Glass with Senator Biden's office. This is for anybody who wants to take a crack at it. Do you think that a change in Medicare from a single centralized government run program to a decentralized network of multiple private health plans would make it easier or harder to achieve and enforce high quality standards?

ED HOWARD: John?

JOHN ROTHER: I think we are about to find out and for better or for worse, I think it's going to be very important to track how the various new plan options in Medicare perform on quality, compared to the traditional program.

And I think we'll have an answer to your question in the next year or two. And I would like to believe that competition would actually raise the bar for everyone in that there is a spillover effect and the more emphasis on quality, the better job everyone would do. But I think the jury's out and I think we'll have an answer soon.

ED HOWARD: Glenn?

GLENN HACKBARTH: I think that private plans have the potential to improve quality in various respects. They have tools at their disposal that a national program doesn't always have in terms of integrating care and the like. But we do need to hold them strictly accountable for performance.

I don't think we can assume that simple because something wears the label "private" that it is inherently better than the traditional Medicare program. Some will be better. Others will be worse. And so the advent of this expanded experiment with private plans I think does require increased vigilance and increased standards of accountability, if we're to get the right ratio of benefit to costs out of the program.

SHEILA LEATHERMAN: I think the real issue there is in the studies that have gone on the last several decades, there's a wealth of quality data in the US. What you see is mixed performance. So my guess is that you would continue to see that. I think what is incumbent upon the federal government and the Medicare program to do is to maintain some central power and accountability, which I think is what Glenn's point is – the ability to garner attention and to make these individual plans be accountable and perform at a certain level.

ED HOWARD: Here's a question that just came from the floor, if I can, and then we'll go back to the microphone. "With all the publicity on flu vaccine shortages this year, how

come the same two-thirds of the elderly got shots?"

CHRISTINE CASSEL, MD, PhD: First of all, we don't know that it was the same two-thirds. I think what we have are systems of care where there's a reasonable amount of effectiveness through simple mechanisms like reminder systems and they don't have to be high tech systems, but where people make flu shots available and reach out to patients to provide them when the patient comes in for some other reason. That's I think a sort of best standard mechanism.

And I think in fact this year the message went out during the vaccine shortage, which as you know was short lived and not altogether really as short as we thought it was. But during that time when we worried about it, there was a message that only people who are at high risk should get this, and I think actually the American people did respect that and found ways to make it available, at least in the places where I was interacting with clinical systems, they had very organized approaches trying to get the vaccine to the people who needed it the most.

ED HOWARD: I'm sorry. Please identify yourself.

PILITUS MARIS: Pilitus Maris [misspelled?] with the Senate Finance Committee and I want to back up a little bit and touch on the comments about health plans and quality. Under the Medicare Plus Choice Program, plans to actually have to submit a number of data elements on HETIS, they have been doing

that for a while and they'll continue to do that under the Medicare Advantage Program.

And I also wanted to point out that studies actually show and we were having a conversation at our table about the data because the data that you're using is simply fee-for-service and there's no comparison actually to what the plans have accomplished under Medicare Plus Choice and there are studies that show that plans actually do a better job on many of those measures that you highlighted here today. So I just wanted to point that out.

And also, there is a high level of accountability with CMS for the plans, as I said, under Medicare Plus Choice and that will continue under the Medicare Advantage program.

ED HOWARD: Glenn, go ahead.

GLENN HACKBARTH: Two quick reactions to that. It is absolutely true that on some of these measures, private plans are far better performers than the fee-for-service average. And therein is the potential that I referred to earlier to improve care to Medicare beneficiaries - many of the Kaiser Permanente plans. My old colleagues in Boston at Harvard Pilgrim Healthcare, personally I have no doubt that they are offering outstanding care relative to the fee-for-service care in their communities.

But it's also true that if you look at the HETIS scores for private plans, there is substantial variation. If you look

at the top of the list, yes you see Kaiser Permanente over and over again, you see Harvard Pilgrim and Group Health [inaudible] and some of the other well known organizations. But their scores are altogether different from many of the private plans currently being offered to Medicare beneficiaries. So the performance in private plans is not uniform any more than the performance and the fee-for-service sector is uniform.

ED HOWARD: Karen and then Doug.

KAREN DAVIS: I might just mention some forthcoming work of Anne-Marie that shows that quality processes are very much linked to the size of practice. So when Glenn mentioned some of the large health systems that have done well, that may be the effect that they are managed care plans. It may be that they are large systems of care that have IT systems; that have care improvement processes in place. And I think the real challenge for Medicare, whether it's through Medicare Advantage or the fee-for-service program is how we improve quality of care in the solo physician practice, the small group practices and how we can help them get the tools that it takes to really reach the same quality levels that we see in some of the larger group practices.

DOUG McCARTHY: I should just mention too there are a few charts in the chart book with data from these data of managed care quality published by NCQA, so that data is there.

We purposely did not make direct comparisons between fee-for-service and managed care on some other clinical quality measures that you saw here because we had a concern that those measures are not comparable due to the way that measures are defined and/or the data that's being used to populate those measures.

In some cases, health plans are able to get in and use medical records and you get a much more accurate rate that those measure portray, but it would not be comparable to data from the fee-for-service sector collected from just claims data. So those kinds of caveats need to be understood when you're looking at those two sources of information.

ED HOWARD: And let me just follow-up because there's a question on a card that's on the same subject – is that going to continue to be the case? Is there any prospective ways that we can get the data we need to make those kinds of comparisons? Yes?

GLENN HACKBARTH: I'm not the right person to address the technical issues too, but we do think – in fact at our most recent meeting, one of MedPAC's recommendations is that we work towards having more comparable measures of performance so that Medicare beneficiaries making this difficult decision that John referred to earlier would have some data to say on quality, this is what I might get in a private plan versus what exists in fee-for-service. But technically, I'm sure Doug is right

that this is a challenging thing to do.

ED HOWARD: I've got two questions here that actually follow-up on something that a couple of our speakers have mentioned, that is the QIO's, quality improvement organizations, any comments on the effectiveness of those programs? What changes would you like to see in the program or in general, CMS's approach to monitoring healthcare quality? Chris?

CHRISTINE CASSEL, MD, PhD: I can tell you from the perspective of physician practices, that the QIO's are really the only bit of regional organization that is really charged with quality measurement and improvement, and to helping people on the ground delivering care, figure out how to improve care. And I think they have been very valuable in that respect.

I'll just mention that the certifying boards for not just internal medicine, but all of the specialties, have now made a commitment to use practice performance assessment as part of their recertification requirements for physicians. So this is a strong incentive, although it's voluntary, most physicians do want to remain board certified and it's a strong incentive for physicians to get more interested even, as Karen said, than the small practices or even solo practices in finding ways to measure their data. That said, they don't have the infrastructure to do that and we've been having active discussions with the QIO's about ways in which they could be a

resource to practicing physicians in doing that.

ED HOWARD: Anne-Marie then John.

ANNE-MARIE AUDET, MD: Thank you. Interesting question. When you look at the sixty charts in the report, you really see that there's really no consistency in terms of where we're doing well and where we're not doing well. So that's one of the sad conclusions from the report is that we can't really guarantee quality for all Medicare beneficiaries regardless of their medical condition.

So when you start to look at the results, if you're someone with angina or heart disease, actually you're in pretty good shape because that's where most of the quality improvement efforts and the level of performance has been achieved. If you're someone with diabetes, you're also likely to get pretty good care.

On the other hand, if you have hypertension; if you have osteoporosis; if you're at the end of your life, there you're less likely to get good care. But it's not predictable. We can't really know. There's no consistent thread across these diseases.

What's interesting though, if you look at the diseases I've mentioned, diabetes and coronary artery disease, these are two area where there's been really private and public sector major focus on this through the work of CMS and the QIO program. Several year's ago there was a cardiovascular

cooperative project that focused on care of patients admitted to the hospital with coronary artery disease. This whole issue has also been a focus of NCQA measures, as well as major other initiatives in the private sector. The same can be said about diabetes, where there's been, also with CMS and other groups that's been the focus of attention.

I'd like also to mention two things about these two disease, is that we now have standards of practice through NQF and other agencies and through the CMS QIO program, they also have standard of performance. So not only do we have standards of care, but we also have established standards of performance to what we need to achieve in this country. And I think that's a very important message that I would like to come across from the results of this chart book, is when this country gets together and focuses attention on an area, sets performance standards as well as clinical standards, we can really make some major progress.

So I think really now the challenge for us is to apply this to many more categories so we don't only benefit a certain number of diseases, but we have those same achievements and improvements and levels of performance for all patients and all beneficiaries.

JOHN ROTHER: Well I'll second what's been said. I think in medicine, like many other places, the only thing that counts is what you can count. And if we don't measure, we're

likely not to see quality improvement. I'm a huge fan of the QIO programs and efforts, but they need more. They need more resources, they need to have consistent ways of measuring performance, they have been and should continue to, work with a national quality forum in developing those measure.

And I agree with Glenn that we need to move more towards pay-for-performance based on valid measures so that there will be real incentives to change behavior because changing behavior, especially physician behavior, is really what has to happen and until we get serious about doing that, we're not going to see big changes.

The third thing I'd add in addition to resources and measures is there is an opportunity to work directly with patients and consumers as partners in improving quality. It's not all top down. Patients do have a role to play, compliance measures, communications, there's a lot there in between the patient and the physician that needs greater attention as well and I think QIO's could start to look at that and see some big payoffs.

ED HOWARD: Both Sheila and Anne-Marie have now talked about setting specific targets and the question on the card that I just handed to Sheila and was addressed to her targets for whom – is it targets for hospitals or health plans or physician practices or how do we go about making that a little more specific?

SHEILA LEATHERMAN: It's a very good question. And I think one of the reasons that I speak to this with enthusiasm is that the work that I'm involved in, in the UK, which granted is a different type of healthcare system, but over the past eight years of using numerical targets there, you can see in condition after condition disease area and even population that the performance is improving and even the hospitals and physicians of the UK who have been really discomforted by this approach being used by the government, had said that it is working.

So in the US I think it could be done in the following manner: That the federal government, or perhaps MedPAC Glenn, could set national goals. MedPAC – and I will editorialize a bit here – MedPAC is for Payment Advisory Commission, but I think it could be more broadly the Performance Advisory Commission - you wouldn't even have to give up your brand, and it needs to play a much more forceful role actually in improving quality as well.

So MedPAC, which CMS could set some national goals. And they could be straightforward – vaccinations for flu vaccine, pushing it up to 75%, reducing avoidable complications in hospitals like pressure ulcers by 20%. And these do not necessarily require high tech solutions. So if you set the goals at the federal government, they get pushed down into the quality improvement organizations and I think we need to ask

questions about the QIO's. Certainly they're effective in a number states, but they look like they are not effective in a number of states as well, so the light needs to shine upon those low performing QIO's.

Then it actually falls to the hospital if it's related to hospitalization events or to clinics, health plans, and physicians. But I want to just point out how simple some of these solutions, or at least remedial efforts, can be. For example, on vaccinations, we have research that shows that post-it notes, little post-it notes on the chart that say, "This patient needs to be vaccinated" actually work.

Using a low tech flow sheet on the front of a chart for a patient that walks in with depression, that the doctor can go through, or the nurse, and say, "Okay, are they on drugs? How long have they been on? Are they getting regular follow-up?" These are effective tools that are not hard to implement. We just need the will to do it.

ED HOWARD: Okay, before we go to the microphone, let me just remind people, we have about fifteen minutes of Q&A that we have time for in our allotted period, and I would ask you to fill out those blue evaluation forms as we're finishing up here so that we can make these programs more responsive to what you want to get out of them, cover the topics you want to get out of them, cover the topics you want to hear, and the way you want to hear them. Yes, go ahead now.

NORIS TIBBER: Hi. I'm Noris Tibber [misspelled?] with the National Health Policy Forum. My question was for Glenn Hackbarth and anyone else on the panel. Glenn, when you were looking at the chart with the states and how they crisscross, I was wondering those that were in the lower quadrant seemed to be states that have less generous Medicaid programs and I wondered if the people that put that data together ever controlled for that, if there was any cost shifting there.

I know some of the Medicare spending tended to be at least in the 90s in the home health area, and if there was any consideration there, especially as we see this spending going to duals with the drug benefit and if you have ever looked at that at MedPAC and the effects of Medicaid to Medicare spending?

GLENN HACKBARTH: With regard to the first part, did the researchers look at Medicaid and the potential impact there? I think the answer to that is no, both with regard to the Dartmouth researchers and in our work, at MedPAC that's similar.

We do have an interest in the relationship between Medicaid and Medicare and it is embodied by the dual eligibles. And it's not been something that we've done a lot of detailed investigation on in the past, but I think it well could be in the future. The implications for cost and quality are very large indeed.

ED HOWARD: Chris?

CHRISTINE CASSEL, MD, PhD: If I could just add, there's one arena where I'm sure that is very ripe for that kind of research and that has to do with the interface between long-term care facilities and Medicare programs because one of the things that happens when frail elderly patients are vulnerable – elderly that John pointed out – get complications in their hospital course, become deconditioned or are unable to do simple things like get themselves to the bathroom or feed themselves, that may be the tipping point where they end up going to a nursing home instead of going home.

And then as you know, after a very short period of time, that becomes a Medicaid problem and doesn't appear in the Medicare data. So whatever the targets that we're setting going forward, which I endorse, we need to find a way to look at both parts of that picture.

ED HOWARD: Yes, and by the way we've got just tons of cards with questions on them. Thank you, nicely timed Brendan. And I would urge you if you want to get your question asked for sure, to do as this gentleman will do in just a second and ask it yourself orally. Before that, Karen had a comment.

KAREN DAVIS: CBO did an analysis on that state data and found that Medicare costs are higher in states with more uninsured. And they weren't clear whether that was just a random, but statistically significant, association. But I

think in addition to looking at Medicaid, it's going to be important to look at care prior to going on Medicare and whether that affects costs once they're Medicare beneficiaries.

ED HOWARD: There were several charts in your pack that showed a striking difference between utilization before 65 and over 65. Yes sir? You've been patient.

MALE SPEAKER: Thank you all for the forum today. It was very interesting. I have a question about what Secretary Leavitt said on Monday about living wills, when he said that it could save Medicare money if Medicare directed doctors to counsel on living wills or even provided incentive to physicians to talk to patients about living wills. A lot of people disagree on whether or not it would save Medicare money. Do you have any opinions and do you think it should at least be a factor in pay-for-performance?

ED HOWARD: Anybody have any opinions? Chris, John?

CHRISTINE CASSEL, MD, PhD: I'll take that one. I'm sure John does. I think that would be a real tough pay-for-performance target to get the America public to embrace – I mean to say it that way. I am someone who worked in the area of improving end of life care and I wholeheartedly endorse the Secretary intention here, which is that every person should think about end of life issues, have a conversation not only with their physician, but also with their family and we should have much clearer ideas about how our care at the end of life

reflects our own personal values. That's the goal here.

There have been a number of studies over more than a decade trying to answer this question – does it cost less if you have an advanced directive and if you have active palliative care? And the data is pretty mixed. In fact it probably doesn't cost a whole lot less because good palliative care is not cheap and is not free either, it just is better for the patient. It means that they get more comfort and more dignity and more opportunity to have that profound moment at the end of life to be meaningful for them and their families.

I think that there are some important observations though about end of life care that often are confused in the popular press and so I just wanted to point one thing out about that. This idea that a large percentage of Medicare dollars goes to people in the last year or the last six months of life, is in fact true, but as Ruby Rinehart once put it, death is nature's way of telling you you've been very sick – that those people are very sick. And some of them die and some of them don't and people have tried, researchers have tried to sort out how much of that care is unnecessary or even contraindicated care. And I think that's hard to do by just looking at the cost. That's the point In want to make. You have to actually study the quality of care that's being delivered.

ED HOWARD: John, and then Glenn.

JOHN ROTHER: Well as usual, Chris covered it very well

– much better than I could. So I'll just add a personal perspective, and that is I'm sure many other people in this room have cared for a parent in terminal illness, and what's important is not saving money, what's important is how well people experience life and experience death. And living wills and statements of intent and being sure that you're respecting that is worth a lot. And that's a high valued thing, regardless of whether it saves money.

So I think the Secretary should be commended. But it's not because it saves money, it's because it improves quality of everyone's life and it's to be treasured, not measured by dollars.

GLENN HACKBARTH: I absolutely agree with that. That is the right reason and why it is so important to do. I believe there has been research, whoever, on showing variations and patterns for people at the end of life. And as is often the case, what they find is a correlation between the resources available and the community or the institution and the type of care that people receive. So if there's a lot of specialists around and ICU beds and the like, people in those communities, those settings, tend to receive a lot more care at the end of life than people in different types of communities and settings.

So what's too weak right now is the signal from the patient and their family about what they want. We could do a

much better job. There is a financial component in this, an economic component in it, but that's not the right reason to be focusing on advanced directives and the like.

ED HOWARD: Go ahead.

CHRISTINE CASSEL, MD, PhD: That Dartmouth data, which is very striking – I agree with you Glenn about that – in this area points to the sort of demand-driven or supply-driven demand, and you mentioned you use the term that people, where there are more ICUs receive more care. I would say they receive more ICU treatment. It doesn't necessarily translate into more care from the patient's perspective and may be in fact not what they want.

But the other important supply issue is the supply of community-based hospice care, nursing care, homecare, that in a place like your home, Oregon, which I think has the lowest hospital utilization and as of care utilization at the end of life, has extensive community-based resources for patients in that same area. So it's both too many resources in one respect, and not enough in others.

ED HOWARD: It's only fair to quote in this – there's a Washington Post article on this today – I quote Mike Leavitt's spokesman who says, "He did not intend to link living wills to the issue of costs." So we've come full circle in that conversation I guess. Yes sir? You want to identify yourself?

RICH BRANDWELL: It's Rich Brandwell [misspelled?] with

the National Health Policy Group. I had a question as it relates to what appeared to be declining rates for caring for people with ambulatory care sensitive chronic conditions and people with multiple conditions. Research from Johns Hopkins shows that Medicare expenditures - 68% of Medicare expenditures – are people with five or more chronic conditions, and that people with five or more chronic conditions have a ninety-nine times probability of being hospitalized for a condition that could have better been treated in an outpatient setting.

Dr. Castle and Dr. Freed and others have written extensively about the relationship of comorbidity and frailty and disability and the kind of complications that occurs not only in managing care cost settings, but in diagnosing and treating that, as well as, I would suggest, in looking at quality measurement. And so with the specific focus on quality measurement, my question is, what can or should be done for looking at the quality measurement of people with multiple conditions where these conditions are highly interactive and involve multiple treatment interventions and not simply one?

CHRISTINE CASSEL, MD, PhD: Thank you for asking that question. I think that is absolutely urgent right now, particularly as we move to pay-for-performance because the good news is that you can improve when you measure things, but a recent VA study showed that that's all that improved. The rest of care doesn't tend to improve.

So my worry is that because the most robust measures are these disease specific measures and even the disease management pilot projects are looking pretty much at disease specific outcomes - diabetes, hypertension, et cetera – that the poor patient who also has osteoporosis, fractures, alzheimer's disease, and a range of other chronic malignant conditions, et cetera, that those conditions will be at risk of being neglected because people are going to really drive this laser-like focus on a few lab tests.

And you can set up even a solo doctor's office to really make sure you're hitting those lab tests and not really overall take such good care of the patient. So a lot of people are aware of this and I think feel that there's a very urgent need to develop measures of comprehensiveness care or longitudinality of care. It's harder to do. There aren't as many that have been as well tested, but it's a very important area.

ED HOWARD: Well I think we are just about at the end of our time. If any of the panelists have a quick comment to make at this point, we'd be delighted to hear it. Anne-Maria, go ahead.

ANNE-MARIE AUDET, MD: I just want to thank Sheila, Doug and our panelists for a really fantastic discussion and I guess we'll hear from you, from all your questions. If you have any questions, please come up and speak with us. Thank

you for your attention.

ED HOWARD: Okay, and let me just remind you we would like you to fill out those evaluation forms. We also want to thank our panelists who've done a wonderful job. Thanks to the Commonwealth Fund for its interest in and support of this topic and others. I want to thank the staff of the fund and the staff of the Alliance who've done a very nice job in putting this program together. And I want to call your attention to the fact that we're going to be doing a couple more Medicare related programs in the next few weeks, including one on pay-for-performance and a sort of basic session that's scheduled for a week from Monday on the 16th. So keep an eye out for the e-mails announcing those. And I want to once again ask you to help me to tell our panelists how we felt about the richness and usefulness of this discussion.

[END RECORDING]