Pay for Performance: Taking Healthcare Quality Improvement to the Next Level
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ED HOWARD: . . . and on behalf of our Chairman, Jay Rockefeller, our Vice-Chairman, Bill Frist and the rest of the board. I want to thank you for coming to this briefing on pay-for-performance. It is rather a strange experience for us to do this topic. In almost every other field of economic endeavor the idea of paying people more if they do a better job doesn’t seem to create much controversy, but in healthcare we seem to be having difficulty getting to that position. Where we are in that debate is what we hope to uncover a little bit this afternoon.

We’re very happy to have as our partner in this briefing the Robert Wood Johnson Foundation, the country’s largest healthcare philanthropy. Actually, the divide the world into health and healthcare, and the deputy director of the healthcare group–so he’s in charge of that half of our entire healthcare system and should be held accountable for it–is David Colby, as I said the deputy director of the healthcare group. He also may be know to some of you from his days here in Washington as a senior staff member at MEDPAC, PPRC, predecessor commissions, somebody with a lot of background in health policy, particularly the policies involved with the programs like Medicare and Medicaid, where we’re talking about major initiatives in pay-for-performance.

We’re very happy to have David with us today, and let me
recognize him at this point.

DAVID COLBY: I’d like to welcome you all on behalf of the Robert Wood Johnson Foundation. Yesterday the Pennsylvania Cost Containment Council released a report in which they said that about 12,000 hospital acquired infections happened in Pennsylvania hospitals. They also had increased mortality of about 1500 - 1500 deaths due to these infections and about $2 billion in added hospital costs due to these infections. The CDC has estimated that there are 2 million hospital infections each year and about 90,000 deaths, and I think there will probably be arguments over these numbers; I’d be actually shocked if there weren’t arguments over these numbers, but I think we have to focus on the most important part of this, and that is that these are exactly what they say they are. These are preventable deaths, and that is, they are preventable. These are preventable, and that is, they are preventable. So I think whether the number is 90,000, 115,000, 8,000, I think it’s very important to pay attention to this. We also know from Beth McGlynn’s [misspelled?] work that about half the time we get the recommended care, so it’s not just whether we get ill in the hospital or whether we die in the hospital, we don’t get the recommended care that is recommended by medical groups.

One of the goals of the Robert Wood Johnson

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Foundation is to improve the quality of care, and after the Institute of Medicine Report on Crossing the Quality Chasm, the Foundation decided to do some work about aligning incentives for quality of care. We developed, along with the California Healthcare Foundation and a $9 million project called Rewarding Results, and you’ll hear some of the experience of Rewarding Results in this panel. It idea was to redesign the payment system to improve quality. AHRQ has funded an evaluation of this experience.

As we think about pay-for-performance, I think we should also remember another IOM lesson, and that is, quality is a system problem, so in addition to pay-for-performance, we need to use all the tools in our toolbox to improve quality of care. We need to use information systems, what we know about the chronic care model, we need to help consumers to co-manage their diseases. I’m looking forward to the discussions today and the folks who have all the experience on the ground doing it.

ED HOWARD: Thanks very much, Dave. Let me just cover a couple of logistical items. You have a set of materials in front of you that include, I think, the slide presentations of the speakers who have them. There is a webcast of this event that will be available on kaisernetwork.org as of, what, 10 AM Monday. Thank you. And a couple of days after that you’ll find a transcript of the
even available both there and on our website at allhealth.org. In your packets there is a green card that you can use for questions at the appropriate time. There is also a blue evaluation form, which I strongly urge you to fill out before you leave so that we can make these briefings the best we can for you. Two other quick things: Please turn off your cellphones and pagers, or at least put them to vibrate so that we can carry on this discussion. I just want to say, I know some of you folks were standing outside waiting for the thing to get going because you didn’t register in advance. We do the registration as a way of trying to make sure that the folks who are really interested in it get in and have a chance to hear it. I apologize if you were inconvenienced. I urge you to register so that you can join the scores of congressional staffers and reporters and others that take the time to do that, to make sure that we get the numbers of materials and seats that we need to accommodate you and make it a little more comfortable. Thank you.

The speakers are terrific that we have lined up with the help of our friends at NCQA, and the Foundation. I’m not going to be able to do justice to them in my introductions. I’m not going to try. There is information about the biographical backgrounds of each of them in your packets, but let’s get started, appropriately enough with Terris King. He...
serves now as the Deputy Director of the Office of Clinical Standards and Quality within HHS’s Center for Medicare and Medicaid Services. He’s a veteran of service in the Department. He’s been there for 16 years and has held a variety of positions therein. This is the seat of activity of actual use of pay-for-performance in the federal government. The head of CMS, Mark McClellan is deeply interested in it; that’s why we got the senior person, Terris King to start us off with a description of the importance of this issue within the federal government. Terris, thank you for being with us.

TERRIS KING: Thank you for the introduction. Such an appropriate topic, and when you teed it up in terms of this being the seat of activity, I echo those sentiments, because without question, pay-for-performance—and I’m going to walk through the pieces and parts of how we’re pushing forward the management of this process—and CMS has definitely been my life over since April the 1st, when I came to CMS to this position. Prior to that I served as the Deputy Associate Commissioner of Quality for the Social Security Administration, and I will tell you, in terms of activity, there is absolutely no comparison between the two agencies in respect to the amount of work that we are doing. In fact, the significance of what we’re doing in pay-for-performance is a mammoth task. I want to walk through today and give you some sense of this particular initiative as

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a priority for CMS, where it fits under the umbrella of quality activities for our administrator, and indeed, for our agency. My role is one as the Chief Operating Officer or Deputy in the Office of Clinical Standards and Quality, and therefore, it’s my job, in working with a laundry list of very talented clinicians to bring their creative ideas, both those internal, and many of those that I see in this room that have been involved for years with the issues around measurement and quality within our clinical environments to bring those from creative approaches and ideas to actual implementation. That’s a part of what we’re going to talk about today.

The first piece is just to start out to make sure that we’re all on the same page. You can read what’s there in terms of the Agency for Healthcare Research and the perspective or definition on what quality is all about. Within the confines of CMS we really view this in terms of our perspective as right care for every person, every time, and this is how we look at the quality initiatives, whether pay-for-performance, or breakthrough initiatives, or whatever the venue may be to move quality forward within CMS. A part of what we have adopted is really a spring-off of what the Institute of Medicine gives us in that six-prong quadrant around safety, effectiveness, efficiency, patient-centered, timeliness and equity. There are some challenges with this process, and we’re going to walk through some of what the challenges are, and in addition to

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that how CMS is attacking those with some demonstration projects and evaluating those, and how we’re moving forward with our pay-for-performance initiative.

Just kind of looking at the slide, these are things that echo to me, and I want to say off the top that the presentation I’m giving today is really a subset of one that was given almost a year ago, that gave the framework for where CMS was going on this initiative. Today, these slides really speak to me in terms of the heart of this process. This process is really operational out of—just to give you some sense of the inner workings of CMS—about quality council. The quality council within CMS includes all of the boxtops or heads of the major components of our agency, where we discuss quality issues. I’ve been asked about a month or so ago, in addition to my responsibilities as Deputy Director of Clinical Standards and Quality, as if we didn't have enough to do there, to take on responsibilities as well as Executive Director of the pay-for-performance as part of that quality council. Really, what Dr. McClellan wanted me to do on that end is to push forward, continue to work with the parties, many of which are in this room, in terms of collaboration and discussion about what the measures should be and how they will be applied. But, Terris, get those initiatives on a track where we can quickly move to implementation. So we talk here about what the problems are in terms of meeting expectations, incomplete assessment of
performance, and the infrastructure which really undergirds what we need to do in terms of health IT and how we know what the providers are doing, and sharing of that information so it is transparent to the public as well is one of our challenges.

Equality problems: The piece I want to point you to on this particular slide is the latter line, that in my mind, really where we’re going is from a process where we’re paying for volume to paying for performance and the fact that there is little linkage between those two. Our objective once again is that last line about improving quality and the link between that and performance.

This [inaudible] may be a little busy in your book, and I’ll pick it up later on in this discussion, but basically, what it gives you is a framework of what we’re attempting to do and that is extremely important, having to do with partnerships and working with the stakeholders in this process, representative groups, beneficiary groups, to make sure that whatever we’re doing has the kind of consistency across the board and the impact that we’re looking for. Look at the priorities, develop the measures, collect and analyze the data, and then identify the improvement efforts that we can take. That’s really the bottom part of this chart that goes in to supporting methods, once again, collaboration, and I cannot emphasize that piece enough, which is why I was really excited about coming here today, because I’m looking forward to the
kind of exchange and ideas that we can have today, because it’s about using those in terms of moving this process forward internal to CMS. Working with the doctors, working with the clinicians, in terms of providing technical assistance, on that end, that’s where I think about our quality improvement organizations really working with the providers across the country with technical assistance. Once again, being transparent in this process, and linking this once again to the payment process with the awards and the incentives that are also included in developing standards.

These are the issues. The primary issue is one of trust, and we can just pause and identify that one. That is one that we’re working through with time, to ensure that the kind of process that we set up has the intended results that we planned. How do you get there? The only way is through continued conversation, collaboration, wherever possible, consensus decision-making in the process, and we’re working through that. Many times that takes time to work through those processes. It cannot be rushed, and that’s part of what we’re doing now, but there is a window of opportunity that we must seize, because as was said before me, this is a critical issue that we must move through quickly.

Issues to consider: How do we get this done? In terms of information that has to be collected, disseminated. Financial rewards is a part that we’ll touch on later, in terms

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of providing the incentives and removing the hindrances in terms of moving forward with this process.

What do we want to reward? Of course, quality. Quality, and we already defined up front what we were talking about in terms of quality, and we want to ensure that there’s equitable quality across socioeconomic lines; we want to make sure that it’s once again, safe, effective, efficient, timely. These are all the pieces that we’re focusing on.

Threshold: Determining the threshold, moving for improvement, financing this across the board. Where the incentives don’t work, in terms of bonus process, you have to have penalties as part of the process as well.

Benefits of the process: Even though they seem apparent on the surface, just to go over a few to make sure we’re all on the same page, rewarding superior performance and encouraging overall improvement is a big issue, aligning the financial model with the goals that we have. Focusing on volume is to diminish. As I stated earlier, we’re moving from a pay-for-volume process to a pay-for-performance process where quality is what is emphasized and highlighted as we move forward with this initiative. There are a host—and I won’t go into all the details with these—but a host of activities. This is not simply a concept. This is more than an idea, but there are already demonstration projects and activities that are operative within CMS working with providers to test, evaluate,
and analyze the ideas that we collaboratively structured. Some of those are listed on this chart. Whether it’s what we’re doing with hospital quality where we have over 300 participants looking at 34 measures, this being started back in March of 2003, whether we look at any of those, 649, 646 that were mandated through MMA, looking at things like health IT. These are all pieces and parts where we are testing demos now. I believe I have another list going into ESRID, and talking about that three-year initiative as well around ESRID, and moving to an expanded bundle on that piece.

One of the things I want to say about these demos that I’m doing as we pull these pieces together, and working with the quality council, we want to be able to look at all of the demonstration projects and initiatives that we’ve launched in terms of pay-for-performance and list those based on the impact of those initiatives in terms of value and the scope in terms of their effect. So that’s one of the things that we’re doing, to be able to calibrate.

This last slide really goes into some additional initiatives that are going on with Premier. That’s one of our initiatives that has really taken off. The final piece that I want to give you has to do with a strategy or approach that we are taking with this initiative. Really, we’re mirroring here the settings. We’re taking a look at this in terms of—even though we’re starting with a setting focus, in terms of pay-
for-performance, we want to move this process to exactly what I opened up with that goes back to the OIM’s six-prong piece, talking about a patient-centered approach. We’re starting short-term in terms of looking at it from a setting approach, looking at it from a hospital, physician office, ESRID. We’re looking from that approach, but then we’re going to move it to patient-centered. What are we doing? We have leads for each of these areas internal to CMS and we’re running them through a rubric in terms of planning that goes through these five steps. Each of these settings has to consider quality performance. How does that tie in? The infrastructure. What do we need to do in terms of preparation around IT? Not just the health IT, but internal to CMS, what type of infrastructure, what type of data elements are we going to need? How are we going to start this process? In likelihood, it’ll be a pay-for-reporting, and then moving in sequence to a pay-for-performance process. We may start with claims data and move to clinical data. These are some of the ideas that we’re working with internal to our process. You need a system that takes a look at the payment mechanisms and how that process is going to work. Whatever information we receive from providers, of course we have to ensure that that information is valid, and once again, the impact that we were looking for, the consequences, that we get what we expect.

And the last piece has to do with value, which is what
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I talked about earlier, as it relates to some of our demonstration projects. We want to be able to look at this in terms of impact and what are the actual savings that are coming from the demonstration projects, and with the overall initiative as a whole.

That’s the end of the presentation. I really thank your for your attentiveness, and I look forward to the Q’s and A’s.

ED HOWARD: Thank you very much, Terris. This is a lot of ground to cover, and you did a good job. There is a lot of additional background about some of these programs in the materials that we’ve put in people’s hands from CMS. Next let’s turn to Peggy O’Kane. She is the president and founder of the National Committee for Quality Assurance. NCQA, I think it’s fair to say, is regarded as the source of best information by which to judge health plans and increasingly other institutions and providers in the area of the quality of care that gets delivered. She’s also, I am very pleased to say, the veteran of several Alliance programs, and in part, the architect of this one. She and her staff, Richard Sorian in particular, have been very helpful in identifying the best folks and the best issues and the best materials, so, Peggy, thanks for being with us, and thanks for helping us make this possible.

MARGARET O’KANE: Thanks very much, Ed. I’m really
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happy to be here today, and I think one of the comments that I heard when we were just sort of talking before the session started, there was some concern that we might all be singing from the same hymnal, and I think that’s refreshing, actually—

ED HOWARD: It is!

MARGARET O’KANE: —given what usually goes on in controversial new areas. So, I’ delighted to be part of this panel and to reflect a little bit on what I see as the issues here. I need the clicker.

ED HOWARD: Oh, my fault!

MARGARET O’KANE: Thank you. So who is NCQA? I think many of you are familiar with us, but we are a private non-profit quality organization, a 501c3. We’re an independent organization that’s been operating since 1990. We measure and report on healthcare quality. If you’ve heard of HEDIS reports, for example, in the Washington Post health section on the ratings of health plans, that’s our data. That system, I’m proud to say, has resulted in about 50 percent improvement on some of the very important clinical areas that we’re reporting one. We accredit about half of the HMO model health plans in the country, but they account for about 75 percent of the HMO lives. I’m not really going to talk about the health plan part of this today, because I think where the issues really need to be worked out now are at the physician level, so that’s what I’m going to focus on.

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Our mission is to improve the quality of healthcare. That’s a very simple and yet not at all simple vision, and we propose to do that through measurement transparency and accountability. I think one of the issues maybe we could talk about in this discussion is, what is the framework for accountability when we’re talking about the system level, because I think having the notion of accountable health plans had a certain simplicity to it that really helped us move the technical parts of measurement forward, but I think it’s very important to think about the accountability framework.

So what is quality? “It’s never an accident,” John Ruskin said. “It’s always the result of intelligent effort,” and there’s just been too much going on in healthcare that’s been kind of haphazard or the result of no one really paying attention. We have here the IOM definition, which you’re familiar with, and Terris had another very good definition, which I think has a nice simple quality to it that we can all get our mind around easily.

I think the IOM has done a great job of giving us a road map for where we need to go, and one of their major encouragements was that we needed to align payment incentives. I just think it’s thrilling that we are having this conversation. One of the points I want to make—and I think David raised one of the issues that I think we all ought to be very sobered by, which is medical errors, and particularly

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infections—is that we do not have a neutral payment system today; we have a payment system today that actually rewards poor performance. So the fact that people make more money when a patient gets infected in the hospital is something that we really need to try to approach carefully and deliberately, but it really is not acceptable. This sending a message to delivery systems through the payment system is absolutely one of the most important things that’s happened in the history of quality, and we’re very happy to be a part of it. We’re also very impressed with the work MEDTECH has done to really encourage CMS to move forward in this important area. I think if you’ve read their report from March, it really offers a very thoughtful and detailed set of recommendations and I know that CMS is paying really strong attention to those. So, it just feels like a moment when there’s really a lot of alignment of effort and a lot of good collaboration going on, and I think that is absolutely crucial as we move into what is obviously a highly complex area.

We’ve been involved with a number of demonstration programs and with Bridges to Excellence. Bridges to Excellence has launched, as you know, in Louisville, Cincinnati, Boston, Albany and Schenectady, and there are a whole bunch of new sites that are coming online, and basically, it’s BTE employers in these markets rewarding physicians and medical groups that are meeting the requirements of our recognition programs, so
it’s a great collaboration. It is, after all, the private sector purchasers that have moved NCQA’s agenda in the past, and we’re excited now about the alignment between the private and the public sector, and working to keep that alignment going. We have been partners to CMS in the collection of HEDIS data on plans, but we’re very excited about this new work.

Our programs are being used in a doctor office quality demonstration, in the care management demonstration, the DOQIT demonstration—and we can define those later; I won’t go into it. There’s a slight variance. The DOQ means obviously, at the practice level, and IT with more of a focus on information technology—and with the IHA project that Dr. Bangasser will be telling you about. These are all really, I think, very thoughtfully put together, and it really has been impressive to see the kind of partnership that’s been developed between all the parties at the table and the really proactive stance of the physicians involved, that I think is really noteworthy and deserves a lot of recognition.

So, we have three provider recognition programs at this time. We have our heart/stroke recognition program done jointly with the American Heart Association, our diabetes program, jointly with the American Diabetes Association, and then our Physician Practice Connections program, which BTE calls Physician Office Link, which is really looking at what the systems are at the practice delivery level. Remember,
going back to the idea that systems are what helps individuals perform in a very predictable and excellent and consistent way across the board.

We have a variety of leverages for these recognition programs. The health plans themselves have been very important leverages. They really have stepped in; you’ve probably heard many announcements about the BlueCross/BlueShield Association adopting these programs, but there is a whole range of activity, including displaying the recognition seals in directories to helping the physicians’ offices with data collection to paying rewards for those that are recognized, and to active steerage to narrower networks, you know, elite, high-performance networks using these as one of the criteria.

Just to sort of go back to the reality, outside of some of these important pilots that are going on, this is from 2003, and I think there may have been some changes since then, but this is a study that the Commonwealth Fund funded, and an article that was published in June of this year. It really shows us that we have to be realistic about how we approach this. According to this nationwide survey, 85 percent of physicians don’t have the capability of generating registry lists by test results or by current medications. So when you have a Vioxx recall, that’s an issue. When you are thinking about how to manage your diabetics, if you don’t know who your diabetics are, that’s a problem. Thirty-three percent of

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physicians repeat tests because results are unavailable, so there is actually some real opportunity for removing some of the waste in the system by having better systems at the practice level. Fifteen percent of observed abnormal test results are not followed up, and this, Ladies and Gentlemen, ties to the malpractice issue very directly. The number one cause of malpractice suits, at least in one state that I’m familiar with where they had really good data is failure to follow up on breast cancer screenings - Number one issue. Only 18 percent of physicians have data on patients’ outcomes, and only 13 percent can generate their own performance measures, so there is, I think, an opportunity here.

The systematic practice will have systematic inputs on for this patient, what’s the medical evidence on what works? The complete data on you at the time that you’re seeing your doctor, customized reminders and self-management resources. Remember, it is the doctor and the patient who really drive the ultimate outcome, so we have to have tools for patients as well. What we see this as is kind of a platform for meaningful doctor/patient relationship. I think you may have heard the notion of we’re moving into a paradigm out of kind of visit-based or hospital day-based care to relationship-based care that really is more ongoing.

Systematic followup and outcomes, patient reminders, tests and referrals followup, e-prescribing, disease
management, performance measurement and feedback and quality improvement. I know that is sounding like a tall order. Let me just talk for a minute. The way this works in our current program is that physicians can fill out a web-based tool and then they report the information to us, and we have a sample of physicians that get audited. Oh, I think I’m going to skip, because I see I have 31 seconds left [laughter]. I’m getting nervous.

ED HOWARD: Really fast.

MARGARET O’KANE: So anyway, you can see this in your handouts, but the practice collects that data, submits it to NCQA, we evaluate and score, although our web-based tool actually has a self-scoring function so that the physician actually knows how they’re going to do before they submit. So we actually in our recognition programs don’t have people that flunk. By the time they’ve submitted the information, they know how they’re going to do. We report on the PATS [misspelled?] only, and in the BTE example, we send a monthly data feed to BTE and to health plans. That’s a screen shot of our web tool. I think I’m going to skip that.

We actually have tremendous enthusiasm from the physicians that have gone through the program, which is as you might expect. One of the interesting stories we heard is that even in some of the practices with electronic health records, they had functions that they hadn’t turned on because they were...
still using them like a paper record. So the ability of an evaluation program to drive change is one of the interesting by-products here. I’m not going to go into detail here, but, going back to that Commonwealth Fund study, recognizing that we need to meet the physician community where they are and need to bring them along. We have different levels here, and I think that’s one of the issues that CMS will have to think about, if they decide that they’re going to use this kind of systems-based approach for evaluating practices.

A couple of cautionary notes: We think we need to have collaboration here, and we need to be working together, so the idea of each specialty society kind of having its own set of measure and so on ultimately won’t work. We’re very pleased so say that we’ve been in active dialog with many of the specialty societies, with the AMA, PCPI, and we’re very optimistic that it’s going to work very well.

We need to keep measurement and payment activities separate, so we don’t want to muddle this too much. Maybe Ron can comment on that a little, because it really is one of the issues that came up in California.

We have to realize that this has to be user-friendly. Behavior cannot change over night, but we need to be very deliberate and put a stake in the ground and say, “This is what we’re expecting, and these expectations will be changing and rising over the years.”
And we have to make sure that our requirements are not a bar on innovation. We don’t want to lock into one set of measures or one framework, so this is a balancing act. We really look forward to the next couple of years, because I think it’s very exciting. Thank you so much [applause].

ED HOWARD: Thank you Peggy. I really appreciate it. Next we’re going to hear from Jeff Hanson. He is a senior official at Verizon Communications in charge of health benefits in this part of the world. You heard Peggy talking about Bridges to Excellence, BTE. There’s one more acronym you have to learn before you can leave the room. It’s the Coalition, as Peggy had described it, or various stakeholders and interested parties involved with improving quality delivered by physicians. Jeff is also a leader in the Leapfrog Group, which does similar kinds of things in a similar coalition aimed at improving hospital quality care. He is uniquely qualified to give us a view from the private sector, and we’re very pleased to have you here. Jeff?

JEFFREY HANSON, MPH: Thank you Ed, very much. I want to just say how pleased I am as well, as Peggy stated earlier, to be on the panel with some strategically aligned partners, and in particular for me, with Peggy. As she’s mentioned, NCQA has been an extraordinary strategic partner with Bridges to Excellence’s concept. As Ed mentioned, I’m the Regional Healthcare Manager for Verizon Communications, and I also serve...
currently as president of the Bridges to Excellence Initiative. I want to thank you for giving me the opportunity to share with you today what private companies are doing in the area of pay-for-performance.

Verizon provides healthcare coverage to nearly 800,000 employees, retirees and family members costing the company over $3.2 billion a year. The quality of healthcare received by our employees, retirees and their family members is of paramount importance to the corporation. As one of the largest employers in the country, Verizon is committed to ensuring that the people we cover and all consumers have access to the highest quality care options available, at affordable prices. To that goal, Verizon has taken a leadership position to advance a proactive public policy agenda for healthcare reform through widespread deployment of interoperable health information technology and pay-for-performance, our two important pieces of our strategy.

Verizon CEO Ivan Seidenberg is a member of the President’s Commission on Systemic Operability, and in that position is exercising a leadership role in advancing health information technology deployment. We have learned the value of information technology in our industry, and are working with the healthcare industry to improve their quality and efficiency through the use of these tools. Ultimately, a more efficient healthcare system will produce long-term value for employers
and employees alike.

One of the cornerstones toward transforming the healthcare system is provider quality differentiation, transparency of quality data, and the realignment of the provider payment system based on standardized quality performance indices. The number of pay-for-performance programs has increased rapidly over the past two years, now numbering over 100 programs across the country. Verizon as an employer participates either directly or indirectly with many of these programs. We are a founding player in two of the more prominent ones, Bridges to Excellence and the Leapfrog Hospitals inpatient safety and rewards program, both of which provide incentives to the provider community based on nationally recognized quality metrics.

These two initiatives found their Genesis in two high-profile reports mentioned earlier by the Institute of Medicine, To Err Is Human, and Crossing the Quality Chasm. These reports grabbed the attention of most CEOs across the country, and it was literally a wake-up call. In the 2001 report Crossing the Quality Chasm, the Institute of Medicine identified six key attributes around which the healthcare system should be redesigned. They said the system needs to be more safe, timely, effective, efficient, equitable and patient-centered, and Terris made excellent comments regarding all of these six areas.

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In one major recommendation, the Institute of Medicine said payment for care should be redesigned to encourage providers to make positive changes to their care processes. In response to this challenge, a group of employers, physicians, health plans and patients have come together to create Bridges to Excellence. Bridges to Excellence is a non-profit employer-driven health initiative organized to create significant advances in the quality of healthcare through programs that encourage the recognition of healthcare providers who have implemented changes to their delivery of care to achieve better patient outcomes.

Currently the Bridges to Excellence program is comprised of three program components integral to which are the NCQA recognition programs that Peggy just spoke about. The Physician Office Link Program enables physician office sites to qualify for bonuses based on their implementation of specific processes to reduce errors and increase quality, the key components of which are the adoption of health information technology tools and processes. They can earn up to $50 a year for each patient covered by a participating employer or health plan. In addition, a report card for each physician describes their performance on the program measures and has been made available to the public.

The Diabetes Care Link Program enables physicians to achieve one-year or three-year recognition for high-performance
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in diabetes care. Qualifying physicians receive up to $80 for each diabetic patient covered by a participating employer or plan, and in addition the program offers a suite of products and tools to help the diabetic patient get engaged in their own care, achieve better outcomes and identify local physicians that meet high performance measures.

The Cardiac Care Link Program enables physicians to achieve three-year recognition for high performance in cardiac care. Qualifying physicians are eligible to receive up to $160 for each cardiac patient covered by a participating employer or plan, and again, the program offers a suite of products and tools to help the individual cardiac patient get engaged in their own care, achieve better outcomes and identify local physicians that meet high performance measures.

Bridges to Excellence programs are currently underway in four markets, Cincinnati, Louisville, Boston, and Albany. To date these programs are all employer-driven, and reward monies being paid to the physicians are being paid by the employer participants. Recently, health plans have expressed interest in and have licensed the Bridge to Excellence program, and we are working with them to launch BTE in several new markets, including Phoenix, Houston and Omaha, to name only three.

To date the Bridges to Excellence results of our pilot markets have been very encouraging. We have 383 recognized
physicians in our Diabetes Care Link Program and 669 recognized
doctors in the Physician Office Link Program. We have
distributed $1.9 million in physician rewards. Early program
analyses show that the physicians rewarded for our diabetes
program are approximately 15 percent more effective and
efficient in their delivery of care to their diabetic patients
than doctors who are not recognized through the program.
Further, our analyses indicate that physicians who are
recognized through the Physician Office Link Program are almost
10 percent more efficient than doctors not recognized.

Bridges to Excellence has already identified other
areas for expansion in their clinical program efforts. These
include musculoskeletal, low back pain, oncology, and primary
care. We continue to engage all stakeholders in our strategic
planning, quality measures development and program deployment.
This collaboration has been critical to our success to date and
will be key to our successes moving forward.

In addition, Bridges to Excellence is coordinating
efforts with other employer organizations in their pay-for-
performance efforts, including the Leapfrog Groups hospital
incentive and rewards program, the CMS Medicare Management
Project, which is being launched in four markets around the
country, and we are working collectively to align our provider
quality measures, to promote all stakeholders work together to
transform the healthcare system and to do so using mutually

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developed standards.

The private sector has begun to use its leverage as a purchaser to provide incentives to physicians and hospitals to install quality improvements in their operations much as we have in our daily business activities in the industries that we work in. The federal government, with its powers as a purchaser for Medicare, and to some extent Medicaid, should continue to work closely with the private sector on these initiatives to synchronize efforts to reward the same quality improvement objectives. In an age of rapidly high rising healthcare costs, combined with little or no system accountability, there is a greater risk than ever for purchaser, patients and providers to find their interests at odds; this is unacceptable and people’s lives are at risk. We need to work collaboratively to solve these systemic problems. Verizon, along with other employers and employer coalitions has recognized this and are involved, and we hope that other stakeholders, including the federal government will join in our efforts. We feel that taking the steps now to encourage better performance and reduce inefficiencies will erase this gridlock we face and pave the way for a better system of care, one that meets the goals of purchaser and providers, that most importantly provides better outcomes for our patients.

I want to thank you for the opportunity to be with you today, and I look forward to your questions. Thank you.
ED HOWARD: Thanks very much, Jeff. We’ve heard a lot so far about the importance of getting physicians bought into this whole concept of pay-for-performance, and after all, it is their pay in large part we’re talking about. We’re very pleased, therefore, to have with us Dr. Ron Bangasser. He’s a board certified family physician, active in the Beaver Medical Group in Redlands, California, where I understand it’s even hotter than it is in Washington DC.

RONALD BANGASSER, M.D.: It’s dry heat, though.

ED HOWARD: Can’t feel it. It’s only 110. He’s also a former president of the California Medical Association and one of the leaders of the Integrated Healthcare Association, which has been active for over a decade in California, engaging all of the important healthcare stakeholders in an attempt to bring about quality improvement. So we’re very pleased to have Dr. Bangasser with us today to kind of bat cleanup on this discussion. Ron?

RONALD BANGASSER, M.D.: Well, thank you very much, Ed. My name is Ron Bangasser. I’m a family practice physician, and I see patients. That’s what I do. I’ve had a couple of opportunities, though, as Ed mentioned the work I get to do at the IHA in pay-for-performance, and certainly all the health plans are involved, but more importantly, I think what you should know is that 35,000 physicians are involved in that program in California, as well as a 6.2 million patients. Those
are HMO patients under 65 years old. I need the button too, so if you can pass that while I start here. There are 215 medical groups involved, and the payout this year on 2004 data for performance improvement is planned to be around $80 million. It’s very significant. I’m not going to take any more time on that. I would refer you to the iha.org website to find all the information about that, and also, we have a public reporting of all the medical groups in California—not individual physicians, but all the medical groups, and that’s on the opa.ca.gov website. That’s the office of Patient Advocate in California. How we got all the groups together and how we got the Office of Patient Advocate together, and how we got the health plans together all on the same page with the business community and the consumers is a very interesting story, but I’m not going to tell you that today.

You know, when I talk to physicians about pay-for-performance everybody says, “Well, I do great quality. Why do I need to get paid for performance? Why should we even get paid for performance? This is a dumb idea. I don’t want to participate.” And certainly I would say that not every physician is buying into this process, but I would also tell you that the American Medical Association, and in my case, the California Medical Association and many other state medical associations and the leadership in those organizations are very much involved in creating the pay-for-performance processes
that were talked about today. Certainly I appreciate the credit that Peggy gave me earlier in regards to the NCQA work. I sit on her committee on performance measures and I am pleased to have that opportunity. I had the chance to sit on the AMA’s task force on pay-for-performance guidelines and principles, which was set up this last winter and passed by the House of Delegates in June.

We can’t keep track of everything we do on every patient. This is the easiest argument I have with physicians about why pay-for-performance is necessary. It’s not that specific time that we get to spend with the patient in the room, it’s what you do with that time, and how you have systems in place that don’t allow patients to slip through the cracks. There were mentioned already comments about registries and how important they are. Registries are a good start, and that’s a good way for people to get involved in a pay-for-performance initiative, but we have to have the systems in place that are going to reduce errors, improve care, prevent patients from slipping through the cracks. We’ve got to have data systems to help us.

I’m in a 145 multi-specialty medical group, and what we do in our group is get reports all the time, actual real-time reports when I want to look up an individual patient. And we can not only look at what we do in the outpatient side in our medical group, but we can look at what we do on the inpatient

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side in the same format. That’s really an improvement in what we can do with quality at the time we see the patient in the office or in the hospital. We’ve got to reduce errors. I can’t take any more hassle. I constantly talk to my staff about another piece of paper, another piece of paper. It’s just constantly more paper shuffling that I have to do. We’ve got to reduce costs, and we can do that. There’s return on investment on these things, and I’ll talk about that, but how do we accomplish all those things?

Quality measures have been around a long time. I started working in the improving quality arena in my hospital in 1979. That’s been a long time ago. I started talking about outcomes measures in 1983, so this isn’t something that’s new, it’s just that the way that we’re going to change and improve quality quicker is that we’re going to find a way, and put a little money behind it to try and improve more quickly what people perceive and need to do for our patients to make sure that quality improves. My quote is, “If a physician thinks a measure is a good idea, putting a little money behind it will speed up quality improvement.” I’ve shown that in our medical group with two movie tickets when we needed to have more patients seen during a bad flu season as payment for improvement in efficiency in the doctor’s practice. It doesn’t take a lot, okay? It’s significant, but it doesn’t take a lot.

I’ll also give you this one: If a physician thinks the
measure is not going to improve quality, and I’ll say a million dollars won’t change my behavior.

Really, what we’re talking about here is convincing physicians to change the way they practice, to change their behavior, to improve quality in the right way. We talked earlier about how the payment system is a perverse payment system. The more you do, the more you get paid for. I agree with that. I also think if we removed all the way to just paying for quality, that’s a perverse payment system, too, because what will happen is, I’ll get rid of the sicker patients in my practice so that I don’t have to get measured on those sick patients or the ones who are not quite so cooperative, and we all have those to deal with. So, it has to be a combination of a base salary, plus a volume component, plus a quality improvements piece to the payment scheme.

Now, let’s talk about clinical measures for just one minute. They must be valid, accurate, have to mean something to the physicians—I mentioned that—but they also have to mean something to our patients. They have to be important for public health improvement, they have to be economical to collect, because there’s no way a chart review is going to solve this problem. They have to have a positive impact on patients and practice must exceed negatives. What that means is, we have to make sure that what we’re doing is going to be positive in every respect. There’s a lot of downside that you
can do on pay-for-performance if you’re not careful. There have to be stable measures over time, and it has to get tougher over time.

Now, those comments about physicians collaborating, and I couldn’t agree more, and it’s not uniquely just physicians. The success of IHA in California is simply related to an independent third-party non-profit coordinator who got everybody at the table, and CMS has to do the same thing in this process. We talked about how we’re going to solve performance improvement for patients; we have to get everybody at the table. It has to be all the specialties that are involved, but it’s not uniquely a specialty involved. I agree with Peggy on that.

All the health plans were involved. It was easier to do that. We got a bigger denominator for aggregating data. If you talk about an individual physician or even a group of physicians, to get a significant denominator is a difficult task when you’re looking at claims data. Adding CMS’s data will certainly get a bigger denominator, but when you get down to the individual physician level, if you’re talking about a specific portion of a specific disease process, getting a significant denominator is going to be really difficult to do, and I would contend that there’s probably not 20 good measure sets that would fit into my family practice, let alone as you get into specific surgical procedures, or surgical practice.
To find significant denominators is difficult. We’ve tried to do that at our hospital, we’ve tried to do that in our medical group, and I can tell you, those are hard numbers to find. So that’s the individual physician level.

Now, how many measures do you start with? I’ll show you our measures set for IHA right now, and people will say, “It’s not very robust. There are not enough measures! Do more, quickly!” I agree with doing more, but you’ve got to start, and I believe not only do you start with the demonstration projects that CMS has got on the table right now, but when you start using this on a mass scale, you’ve got to start with a few number of measures to start with. They have to be fully tested, fully vetted. And let me tell you, creating measures is not nearly as difficult as implementing measures when you get it down to the individual or the group model of physician and patient relations.

A good place to start is with patient satisfaction surveys. There are some good questions in patient satisfaction surveys, and bad ones. I would look towards the ones that would talk about, “Did my physician as me about whether I quit smoking or if I smoke. Did I get a flu shot?” rather than what’s the color of the office and do I like it. So I think you have to use the right patient satisfaction questions in the survey.

One of the things that IHA has that I think is going to...
be an important component that has been talked about this morning is the IT component of paying-for-performance. There has to be an information technology component to paying-for-performance that allows for communication between CMS and the physician, in this case when you’re talking about Medicare, and also at the physician level so that data is available when the physician sees the patient. I mentioned that earlier and how important that is in my practice. It’s really important when we talk about every physician’s practice, and there has to be a component of payment for that. IT is expensive, and one of the things that we found with IHA in California is that the groups of physicians are not nearly as robust with their IT systems as people would like to think. The first year we had 215 groups involved in the IHA pay-for-performance initiative, and every one of them could have participated in the IT component, which paid 20 percent of the total pay out in dollars to the groups who could qualify. Do you know how many groups actually tried to participate in that program that they were reporting themselves? Of the 215 groups only 100 of the groups tried. Only 100 thought that they could even make the basic IT standard. Of the ones who tried, 26 of them didn’t get any credit at all. Only 67 groups were able to qualify, communicating up to the health plan and down to the individual physician and individual patient that first year. This year there’s a 53 percent improvement in that number, but it’s still
way lower than what people’s expectations are.

Here’s a set of clinical measures. You can look at these. You can like them or not like them. These are the ones we’re using with IHA. They’re a good start, and they’re certainly applicable in many ways. Childhood immunization probably not so good with the senior population, but there are immunizations for seniors, I can tell you that. I got my pneumonia vac shot this year, so I know that about seniors. So there are things that can be done.

And it’s not just under-utilization measures. There are over-utilization measures that need to be involved as well as misuse, and the one that I like to talk about a little bit in the acute care, in the over-utilization, there is inappropriate use of antibiotics and children for upper respiratory infections. Now, you can make an applicable measures that for seniors in the same way, so there are ways that we can do this. Of course, the clinical measure sets on diseases like asthma, diabetes and heart disease are pretty well known and pretty well established. What we’re talking about, though, is also the outcome measure there on what the number of hemoglobin A1C, it’s not just how many were done, and the number of LDLs.

Most of these measures, as you look at them, are primary care, but there are specialty measures that are out there and can be tested. The one I like to talk about here
just as an example in a specialty measure is hip fracture. Rather than a hip replacement measure gives no choice to the physician as to how sick the patient was when the patient came in and had the fracture. Hip replacement, you could choose a population of well patients and get a better outcome. What this does is looks within the outcome of those, the infection rates, the dehiscent rates. My practice in family practice now is almost limited to complicated non-healing wounds and I see those wound dehiscents on mostly diabetics, paraplegics, quadriplegics. It’s kind of a tough practice, but I get to see the results of that, and I know those are measurable.

Well, we have to get the data from somewhere, and we also have to believe that the data that we get is good and valid, so we have to completely test. When CMS comes out with a program these have to be completely tested to make sure they’re valid measurements and that the data can be collected in a valid way. Again, I mention that chart review is not the solution here, because there’s no way you’re going to be able to validate that, and it’s very much too expensive. An EMR, though, I would contend is not completely necessary when you start out this process. A first step is simply to have a registry. Just having the knowledge of who your patients are is the most important piece of information to begin a quality improvement program. Patients who have atrial fibrillation must be on a medicine called Coumadin unless there is some

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overriding reason why they shouldn’t be. If you don’t know which patients in your practice have the diagnosis of atriofib, how can you possibly tell which ones are on Coumadin, not only whether they’re on the right dose, but whether they’re even on Coumadin. You have to have that kind of a registry. Where should we get the data? Once you know the patients who have a diagnosis of a specific type, then you can add the lab data that would say—or the pharmacy data, if you can do that—that would say the patient had the lab test done. Not what the lab test number is, but had the lab test done. That’s a good way to start. What is does is give you the idea that you need to do that extra test. Some people say that’s going to raise costs. Every one of the programs that are looking at return on investment for how much it costs to do these kinds of programs and do the preventive care and do the real-time testing that needs to be done show that the improvement on clinical measures is either 2 to 1 or 2.5 to 1. Not a huge savings, but a savings, nonetheless. Mainly in preventive care and doing the right thing early so that the patients don’t end up in a sicker situation with more hospitalization.

Now, there are going to be some errors in the data, but basically we’re gonna be pretty much okay. I know I’m running out of time, and I’m gonna finish up here. In your paper there it gives you some information about what the measures sets
work. It’s very simple, and again I would say, even though they’re very simple, not many groups could qualify. This is how the payouts were made for IHA in pay-for-performance, clinical measure sets getting now 50 percent of the measures, because it could be 50 percent of the payout because now there are more measures. Patient experience gets 30 percent, IT improvement 20 percent, and then there’s an override bonus for individual physician payments.

Let me just finish with this slide. If you don’t believe that information technology improvement makes a difference, here’s a slide that shows it. Now, you would say it’s intuitive that if you have better information technology systems you’re going to get better clinical quality outcomes, but we actually were able to show that. If you look at the bottom line and you see where that bottom line goes up on that graph, either in your handout or on the screen there, you’ll see that that’s where we’re talking about clinical improvement over time with IT system qualification. The ones who have better IT got better clinical improvement.

Well, there’s a lot to cover and there’s a lot of information. I’m sure you have a lot of questions, and I know we’re going to take the rest of the time to do that. I certainly appreciate the opportunity to spend some time with you today. Sorry I ran over a few minutes, but I was trying to cram in a lot of information for you from the physician.
perspective. Thank you very much [applause].

ED HOWARD: Thanks Ron. Absolutely. It’s actually a pleasure to spend more time than you expect to with a physician, so—

RONALD BANGASSER, M.D.: [Laughs] Come to my office; it will be the same way there.

ED HOWARD: Let me remind you, you have a green card on which you can write a question. There are microphones some of you are already standing at from which you can ask the questions and be sure they get asked the way you want them to. Let me just remind you, if you do have to leave that you should fill out that blue evaluation form. I ask the questioners to be as brief as they can, to identify themselves, and I ask the responders to be as brief as they can and be responsive so that we can get to as many of these questions as we have. I think we have more questions submitted in advance than we have for a briefing in a couple of years, so, it’s a high-question environment. Yes, go ahead, Alan.

ALAN GLASS: Alan Glass with Senator Biden’s office. I also happen to be a physician. One quick comment and then a question for Dr. King. The comment is that I think that I would venture to guess that many of the behaviors that you’re trying to affect were learned in medical school and residency, and I think you could get a bigger bang for your buck if you started to focus in on trying to inculcate those habits at an
early stage rather than waiting until people are already in practice.

My question for Dr. King is, Medicare physician payments operate under a cost-containment mechanism you’re familiar with involving the sustainable growth rate and an aggregate physician expenditure target. How do you envision paying for quality or performance being applied to that? Will you keep the same target mechanism and just divide up the pie differently based on quality? Will you adjust the size of the pie and include quality, the overall quality of the healthcare to adjust the expenditure target output, or do you do away with the expenditure target completely?

TERRIS KING: . . .question. There haven’t been at this point discussions about doing away with SGR. Really, more of the discussions up until this point have been about how we’re going to divide the current pie differently, and with that, the type of things that we talked about earlier around emphasis on incentives and if necessary the penalty. I think one of the critical pieces to move us along that line are the kind of discussions that we’re having here today, and noting that continued collaboration and these kind of discussions are necessary to decide exactly what mechanisms we will use, what kind of formulas we will use to bring that to fruition. We all know that there are, external to the internal processes that we’re moving forward with in CMS currently, a probability of,
whether it’s legislation, what have you, that could impact what we’re talking about today. But at this juncture, it’s dividing the current pie differently that is really our focus.

RONALD BANGASSER, M.D.: I’d like to respond to that a little bit too. One of the things that I want to emphasize is that not only should you be looking towards paying for quality, but paying for quality improvement. I think it’s really important to make sure that we try to raise all the boats. If you just say the top physicians will survive, or the top groups survive like we talked about initially in California, then you have an access problem. I also would be concerned about the penalty phase of this, because, what we worked with is simply the carrot in California to try and improve quality and I think that’s where CMS should look, too, because if you have a penalty phase, that goes against raising all the boats. The people who are on the low end need to be able to work towards improvement and anticipate that there’s going to be some value for doing that. Where to look for that is in the return on investment, and I won’t go into the Part A/Part B silo and problems that are involved with that, or even with the Part B outpatient hospital side versus the Part B outpatients’ physician’s side where improving on the outpatient side, like I did with the moving patients from wound care from an inpatient setting to an outpatient setting not only improved care, but was much in the way of cost savings, none of which came back to
the physician side on that.

    ED HOWARD:  Let me just pick up from something that someone wrote on one of the question cards. They direct it to Jeff and to Ron, asking whether the incentive payments in your systems are funded out of deductions in provider payments, or are they in addition to existing payments?

    JEFFREY HANSON, MPH:  Well, I’ll speak to this first. They are additions to the payments. The payments thus far in the Bridges to Excellence Programs come directly from employers. It’s above and beyond what we may be paying to the health plan for a premium or what we may be paying to the doctor for specific procedures.

    RONALD BANGASSER, M.D.:  Now, the pay-for-performance initiative, where the money comes from is from the portion of the increase in premiums that the health plans are collecting in California, and that money is a portion of that increase that’s set aside from the contracts with the physicians to be able to make sure that that money stays in a separate bucket for pay-for-performance improvement. That’s really an important concept, and when there is an SGR solution, and there is an appropriate increase in the physician payment for Medicare patients, some of that increase should be looked at as a possible source for some of that pay-for-performance money. The other source, as I mentioned, is that return on investment that we anticipate, not only from the outpatient side, but also
from the hospital savings.

   ED HOWARD: And I should say that in your packets there’s a good deal of information about proposed legislation that would have an impact on whether or not this is a zero-sum game or other aspects of the design of these programs in a federal sense. Yes, go ahead.

   TONY HELSNER: Hi. Tony Helsner [misspelled?] with CMS. I work in the Medicare Advantage program, and we’ve been studying issues related to pay-for-performance in Medicare Advantage, one of the issues being whether you pay at the plan level or the provider level, or both. One of the other things we’re interested in doing is looking at models that predict how pay-for-performance variables will affect the Medicare Advantage plan program.

   My question to several of you is, what evidence do we have, what kinds of predictions have we already made in terms of what different pay-for-performance variables might have on Medicare Advantage or the managed care programs?

   MARGARET O’KANE: I’m not sure I understand that last part of the question. You mean in terms of ROI?

   TONY HELSNER: Yeah. I think that’s particularly where I’m getting at. I’m interested in the evidence that we already have, or what predictions we’ve made that would tell us what the return on investment would be for pay-for-performance variables.

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MARGARET O’KANE: I don’t know that there’s a single answer to that question because I think it depends on the market, it depends on the number of excess hospital beds. If you’re in a situation where all the hospital beds are filled—I heard this story about a hospital executive saying, “You get all the diabetics out of my hospital, I’ll do more elective knee surgeries.” I think the CCIP may give us some ability to answer the question, the evaluation [inaudible] care improvement. In the first part. Go ahead, you’re looking puzzled.

TONY HELSNER: I was thinking like NCQA has given some return on investments just in terms of the quality measures.

MARGARET O’KANE: That’s based on commercial populations, and they’re actually from the Hewitt Actuaries and were done for BTE. The numbers look pretty good; $350 I think, per patient for a chronic disease, and it doesn’t matter which chronic disease. I assume at least the opportunity would be higher, but when you’re Medicare and you’re that big a part of the payment system, it’s not like BTE where you’re a smaller part, and you’re not going to liberate that many hospital beds.

RONALD BANGASSER, M.D.: Let me give you two examples that I think might help you. On the flu vaccine, for every flu vaccine that a senior gets there’s a savings of about $250 to $350 depending on which report you look at. That’s a combination of not getting sick, not ending up in the hospital,
and that’s where you can show those savings. That’s a pretty well known statistic. I want to give you another example. In our medical group we did a little bit of extra work on asthma, and this is simply what we did. We took all the patients who had been admitted to the hospital over a specific period of time, put them through an evaluation by a pulmonary specialist on their breathing capabilities, made sure they got their medicine, and knew how to use it. What we found—not only in our study, but also in the study that was done by one of the health plans—that we ended up with more patients who came to see us because we had this quality asthma program—so we got a perverse incentive there, with a more difficult population—but we actually had a nine times less hospitalization rate on that because we simply did three simple steps that I mentioned on that asthma program. So there’s actually data that’s out there. Now, is it applicable to the seniors? In that case it was, because those were also the over-55 population and the under-17. Those were the two groups we used. So there are examples like that out there.

MARGARET O’KANE: I might go back to the first part of your question about if it’s health plans or providers and [inaudible]. I think it should both, because the patients that are in the health plans, the proportions of the physician’s practice that’s related to the health plan, the health plans are doing a lot in terms of disease management, frail elderly

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programs, catastrophic care that you do not want to disincent. I think it’s really important to have a strategy that’s not a black-and-white strategy, but depending on where the bene is...

**TONY HELSNER:** Okay, thank you.

**PHIL DUNN:** Thanks Ed. Phil Dunn from the National Quality Forum. Thank you to the Alliance for presenting an excellent panel. I would like to just ask, seeing that we’re talking about healthcare performed on patients, who are sometimes known as consumers, to what extent do consumers need input on the kind of measures that are being used to gauge quality? Should they be considered stakeholders?

**MARGARET O’KANE:** As much as we can get it from them. I think consumers need to be actively drawn into this conversation, and I’m talking actually, about basic rank and file consumers as opposed to consumer organizations. We have been very active in working with the consumer organizations and getting their input, and they give us incredibly valuable input. The National Partnership for Women and Families, AARP, Consumer’s Union, the National Consumer’s League, all of these organizations have worked with us and with others. I think, though, we really need to take the conversation to the beneficiary level and really have an attempt to educate the public more that quality matters, that it varies a lot, that is has a huge impact on you if you don’t get the right quality of care.

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RONALD BANGASSER, M.D.: I think the patients I see need as much information as they can have. I just can’t say consumer, I’m sorry. They’re my patients. I mentioned earlier that on the group website there’s a publication that we put out, and put in the pharmacies so that patients can get this information. Part of the problem is that we know from our survey data that we’ve done on our website—that opa.ca.gov website—is that the number one group of people who look at that are—Is there somebody in the audience that can guess? This is the measurement of the medical groups now. What’s the number one group that would look at this? Medical groups. What’s the number two group? Health plans. What’s number three? Patients. And we have to get that point across, that the information is available. Now, if you haven’t looked, go on a website and look up your doctor or look up your medical group tonight, and there’s a lot of different ways we’ve been evaluated. Part of the problem, I think, is that a lot of that has been garbage. Look at your hospital, too. A lot of it’s been garbage, and what we have to do is, we have to get a believable, trusted, consumer report out there before consumers are going to use it, and I believe that CMS would be the one that could start to do that.

ED HOWARD: Can I just follow up with that? The Commonwealth survey Peggy cited in her presentation had another finding that I found fascinating. It was that two-thirds of
the docs said, “For God’s sake, don’t share these clinical quality data with the general public!” And there’s a piece in the material citing the New York experience, where the tough cases had a tough time finding care because of that.

RONALD BANGASSER, M.D.: No.

MARGARET O’KANE: Actually, they didn’t in [inaudible] took easier cases [inaudible].

ED HOWARD: Okay. Well, the question is, how do you get past this?

RONALD BANGASSER, M.D.: I got a response. I can’t resist. We just did a survey that was conducted on the physicians who were involved in the pay-for-performance initiative in California. It was done by RAND and by UC-Berkley, and the interviewed, not only the leaders of the medical groups for their opinions, but also individual physicians about what their opinion was, and it was amazing how people said, “Showing that information made me change my behavior.” So there are a lot of different kinds of incentives here. Certainly you have to do it, and there has to be a trust, a feeling that it’s done in the right way. You’re going to get huge pushback from physicians if they don’t feel that they’re involved in the process of setting up that public reporting. But let me tell you, step-by-step through that process, there are ways that physicians will agree, not only that public reporting is that it’s okay, but that it’s good for
them to help change their practice behavior.

MARGARET O’KANE: It’s a very gentle challenge that
it’s different to have it reported for your medical group than
it is to have it—

RONALD BANGASSER, M.D.: But I’m talking about at the
individual physician level, too. I mean, it’s a step-by-step
process at the group level, it’s a step-by-step process at the
individual physician level. No one’s done that to the extent
that physicians are comfortable with it. That’s why I say this
is a golden opportunity for CMS to do it in a step-by-step
process and do it right.

ED HOWARD: If I can ask for some forbearance at the
rear microphone, I do want to pick up on one of these questions
from the audience on a card. It’s directed to Terris King,
wondering what the CMS view is of using pay-for-performance
rewards and penalties on states’ performance for patients and
spending with their Medicaid plans?

TERRIS KING: Part of the process in looking at pay-
for-performance includes Medicaid. Here’s the way we’re going
at it, at least starting in that process: We’re taking a look
at the pay-for-performance efforts that are currently operative
in states, and using them, really, as a model for others to
glean from. We’re planning within our process to begin over
the next month or so to really gear our efforts up around the
Medicaid portion of our pay-for-performance efforts. Primarily

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today I’ve talked about where we are in terms of Medicare and how we’re directed around the settings and moving towards the patient-centered. Same objective with Medicaid, and so, what we have right now are at least a half-dozen states that have moved forward in some strategic efforts that we really feel across the country can really spread. I’ve heard a few more here today that give us prime examples, and so that’s the beginning of our process. What we hope, what I hope is over the next couple months I’ll be able to give you the same kind of detailed plan around the Medicaid portion of our pay-for-performance efforts as we’re talking about today with Medicare. So that is part of the plan.

I want to go back, as well, to the other piece around including the patients in terms of gleaning information from them as we move forward with both developing our measures and implementing our process. I couldn’t agree with that more, in terms of being a priority, and I really feel, based on experience with the process and in talking with several patients just in terms of what we’re doing with the Premier demo and having that information on the website, where you can go in and take a look at hospital performance. I think one of the keys for me is to make sure that as we establish information on a website that it’s easily accessible, that it’s easy to comprehend what we’re saying in terms of quality of service and easy to differentiate the quality providers from...
those that are at the bottom tier so that consumers can take that information, patients can take that information and glean from it the information that they need to take the appropriate action.

I also see on another end, as the Chief Medical Officer and I continue our discussions—I emphasized four or five times about a collaboration, but the groups that we’re collaborating with are more often than not examples or representatives of the beneficiary patient group that we’re talking about today. Just Friday I had a conference with a group representing the frail and the elderly. As part of that conversation they let us know that there are exceptions to our measurement discussions with that particular group, and that we need to take particular emphasis with that group on issues like falls because of the impact that it has on the frail and elderly. So, we are moving in the direction that we talked about today. We recognize that as a priority, and that’s a piece that we will continue to push in terms of that kind of conversation.

ED HOWARD: Maybe I can ask either Terris or the other panel members also, we’ve gotten a couple of questions submitted about trying to fit these pay-for-performance criteria around the increased morbidity and presence of chronic disease in people from disadvantaged and neglected communities, and more broadly, people with chronic conditions.
and multiple chronic conditions. How do you deal with that kind of complicated situation?

**TERRIS KING:** I think there are a couple pieces that we have going now that will speak to that issue. I think one of the issues has to do with the MMA 646 demo; that will speak to that issue of equity of service. As 649 speaks to the health IT, 646 speaks specifically to the issue of best practices, safety and equity of service. The kinds of things that you’re talking about in terms of measures around morbidity, of course, those types of issues are included in many of the measures that we’ve put before the National Quality Forum in QF, and the kind that we’ve talked about in the Ambulatory Quality Alliance. We are very aware of those as being some of the primary pieces that we need to take a look at, and some of our demonstration projects are really geared towards addressing those kind of issues specifically.

**MARGARET O’KANE:** I think when you have patients that have multiple conditions, the need for systems becomes even more paramount, and so, I think kind of a systems-based approach is actually a very good platform there, as opposed to the individual diabetes, or those kinds of things. They can be integrated with each other to address the multiple situations, but I think the real platform is the systems platform.

I want to add to that. You’re absolutely correct. Of course, there are a couple—we do have that chronically ill demo
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we’re doing as well. The reason it is such an important and paramount issue is, when you have a couple diseases, I’m sure as the doctor would attest to, you have to have the kind of IT system that will give you the warnings around things like prescriptions, to ensure that the reaction of the prescriptions that the patient is about to receive is at the forefront of what that physician has in the way of knowledge when these areas are addressed. So, the infrastructure, the IT piece is critical to those that have multiple ailments or symptoms. That is a primary issue.

RONALD BANGASSER, M.D.: I have to agree on that. Now I use my PDA. I can’t get along without it. It’s got Hippocrates on it, and I’m using this and I’m looking up the drugs, and my patients say, “What are you doing, Dr. Bangasser,” while I’m sitting at the beside with them. “Well, I’m looking up for interactions on your combination of drugs,” and they say, “Wow! That’s pretty neat!” I say, “Yeah, had to do it in my head before!” Now I’ve got some systems in place. But I think there has to be a better job done on risk adjustment. What we’re looking at is for the severity of illness, the patients that have high indices, multiple chronic disease processes. All my patients over 65 years-old that come in to see me on a regular basis have hypertension, diabetes, congestive heart failure and arthritis, at least, if not status-post cancer 1, 2, or 3. My mother has had two different

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kinds of cancer, and she’s still living at 84 years old, and has a multitude of problems. All those have to be addressed, and if you can think that you can sit there and use your brain during the time that you’re trying to take care of that patient, you’ll think of every possible thing that could happen to them, drug interactions, what medicines—even if they got them, even if they could afford to get them—what medicines they’re taking, and what their allergies are on a constant and ongoing basis. It’s an incredible challenge, and we try to address that the best way we can every day, but you just can’t be as good as a system can be in that. The other part of that question begs the issue of what do you do with significantly different populations? In my practice, that’s a 34 percent Hispanic population. I have two American Indian reservations in my area that I take care of, with their complicated non-healing wounds. Fifty percent of them have diabetes. Many of them have amputations; many could have been prevented. Now, that requires, and what we’re looking at for IHA and pay-for-performance—not just because of my practice, but because of the way physicians practice over the State of California with the diverse population—that there be an adjustment multiplier that’s put into effect. Now, it’s not a large number. It’s no more than 1.0 or 1.2 as a multiplier, but it gives some credit, recognition for those difficult populations of patients with cultural diversity that we all have to some degree in our

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practice, and some a lot more than others, and we have to take that into account.

**MARGARET O’KANE:** I think this is really such a crucial question, and it raises the issue of the accountability model, because if you remember Elliot Fisher’s work about where Medicare spends much more money, in those markets where we see nine different physicians taking care of patients at the end of life, and the quality of care being lower. It really begs the question of who’s in charge here, so I think that the frail elderly really bring home this idea that there needs to be somebody that’s kind of looking at the whole patient and really trying to make the right things happen.

**ED HOWARD:** There’s another accountability aspect raised in a question we’ve gotten here. I didn’t mean to discourage the person who was standing at the back microphone. They should go back to it at any time, and I’ll get you up. But, this is an intriguing question. It calls into question, it seems to me, some basic aspects of the way these programs are put together. The question is, what information specifically is used to assess performance, and how do you account for factors that may compromise the validity of this information, such as, exaggerated provider reports, patient reports that are biased due to unpreventable outcomes by even the highest quality of care, or patient outcomes that are affected—as Ron might have mentioned—by the failure by patients...
to amply comply with treatment measures? How do you weight those if you do, and how do you filter them out of the measurements quality that you use for compensation?

**TERRIS KING:** You saw this listed when I went through the rubric that each of the settings within CMS have to attend to when implementing a pay-for-performance process, that validation was on that list. It’s a critical piece. It’s such a critical piece that in terms of moving forward with funding and really gaining some ideas around exactly how, at the end of the day, we’re going to assure the trust that we have in the data that we’ve received. Just as of last evening we were talking about how we’re going to get this done? Who is going to do this for us? What kind of information will we need? How will we set this up, establish this in a way where the validity of the data, not only from a statistical validity, to say, do you have enough data to be able to glean from that the kind of information that you need to make some decisions, but how sure are you that the data is clean? That is a piece that’s at the forefront for CMS, because we have to have that. Without that, the whole process is contaminated, and what you would do is implement a payment process that then would have the reverse consequence, because the system will be gamed up front. So that’s why we’re moving through this process in a prudent way, and that’s part of the tension in this process. Whenever you want to strike while the iron is hot, and while the issue is
really at the forefront of everyone’s mind, and from a management perspective, of course I’m pushing that piece, but in addition to that, at the same time, you have to have the kind of analysis up front, you have to slow the process down enough so that you ensure your outcomes are really what you wanted them and what you predicted that they would be. And so, that’s a primary focus for us now. How will we ensure the validity of the process? So once again, in the same way that we worked in terms of talking and having conversations collaboratively with advisors and providers and representative groups around forming measures, we’re working through the same process on the validation piece of the process. So that’s part of the process that we’re ready to move forward with very soon.

JEFFREY HANSON, MPH: I was just going to say from my perspective on Bridges to Excellence, the details behind that and validating or maybe auditing the information that you get on any given basis—clearly from our perspective one of the big components of assuring up front that you have guy-in to the measures and that there’s not going to be a gaming of the system is to get all the stakeholders at the table to begin with. With the invitation of the physician communities to the establishment of the measures and having everybody there talking about it, I think you preemptively strike on a lot of what we’ve seen in other venues where some of this has come top-down, or from outside-in, from external sources and imposed

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Ronald Bangasser, M.D.: Let me just say a couple of things. In IHA we had an independent third-party aggregator that was gathering the data from all the health plans and medical groups and sharing it back after there was an auditing process through NCQA in place to make sure that the process was a valid process that we could all believe in, and also that the use of the data was being done properly, that the patients, the health plans, and the medical groups, down to the individual physician level got the information back.

Now, let me address the difficult patient, the one that is non-compliant, if you will, or not as compliant as you’d like to see. What I tell my staff in wound care is that if we had the world’s best patients we’d be out of business, because these patients wouldn’t have their sugars out of control, they wouldn’t have the complications that come with their diabetes, at least at an early age as they do now, and I’m talking about patients who are seniors at 37 years-old. They are hugely difficult patients, and it takes a lot of extra time and a lot of extra effort, and you don’t always win. There has to be an accommodation for that, and I believe that improving the risk adjustment, as I mentioned earlier, is the first step to that.

Let me also bring up one other thing, and that’s the attribution issue of who’s responsible at the end. Peggy
brought it up. I can’t resist the opportunity to speak to that. I think what we have to do when we talk about attribution, which physician’s responsible, is to create a process that does what I call a total ownership of care piece. What it does is it attributes the total cost of care, inpatient, outpatient and every part of the process that that patient was involved with, and attributes it to every single physician that was involved in that patient’s care over a specified period of time. What that actually does then is, you get a cost per patient, per diagnosis, per physician. In primary care, like, for myself, in family practice, what you would do is compare myself and the cost of the diabetes care average for my patients with the other doctors who are in primary care who see diabetic patients. No data is going to be perfect, but that’s one way that you can actually get people physicians who aren’t integrated groups to work together, to be able to say, “Well, gee, if we can do this, maybe we won’t have to repeat that test,” or, “We won’t have to do two MRIs or CT-scans,” or get them out of the hospital a day sooner. And it creates an efficiency in the system where physicians are more communicative with each other and can actually do a better job in patient care.

**TERRIS KING:** Can I add one other piece? Coming back to his point, Jeff really reached it in terms of the need for conversation. There is a three-prong approach. I guess if we
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start with a premise that an audit process at the end of line to determine whether the information we’ve received is valid is insufficient in and of itself, because that’s a segmented process that really doesn’t get to the holistic issue of why the information was put in the way it was, the need for cultural change that I know Peggy brought up earlier on, which is also extremely important, and then still having with that a back-end piece around the validity of the data at the end of the day. Part of what we’re going with our quality improvement organizations has to do with at least a couple of those prongs, that have to do with bringing the QIOs in a greater fashion with the A-scope of work into the provider settings and having the kind of conversations around cultural change, which is really one of the primary tasks within the A-scope of work—focusing on that piece, and then also having some conversation around the education and training piece around the IT pieces that we’ve talked about today, as relates to the data. Who’s providing that data? Where does that data come from? Minimizing the probability of errors because all errors aren’t intentional errors, of course, and seeing what we can do to minimize those, and then still including in that the back-end piece. What we need to have is an in-line process to ensure validity as well as an end-of-line process, and with that a more holistic approach that will ensure to a greater degree that the data we’ve received is valid and correct.
I think the data need to be audited and I like Terris’ idea that it needs to be both up front and at the end, however, that’s done; it sounds complicated, but I think it’s a great idea.

ED HOWARD: Well, I think you got the last word. It’s a great idea [laughs]! I want to remind you that we’d very much appreciate you filling out that evaluation form so that we can do quality improvement in the Alliance programming. I want to thank David Colby and the Robert Wood Johnson Foundation for their active participation and for their support of this briefing. I want to thank you for coming and learning on a topic that a lot of members of Congress are very interested in. I’m sorry we didn’t get to all of your written questions, but that’s what the microphones are there for.

RONALD BANGASSER, M.D.: Maybe if you share those, we could get some of that back to you, and you could put those up later.

ED HOWARD: Delighted to do that. And finally, I’d like to ask you to join me in thanking our panelists for a very enlightening discussion [applause].

[END RECORDING]