Pay for Performance: Taking Healthcare Quality Improvement to the Next Level
July 15, 2005

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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

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 us 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

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

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

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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

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

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

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.

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

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

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 in to 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

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[1] kaisernetwork.org makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded
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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.

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

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

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 asa 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

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 things 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

pneuma 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

overriding reason why they shouldn't be. If you don't know

which patients in your practice have the diagnosis of atrio

fib, 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 pay out 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.

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

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.

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

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

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

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 s 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

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

on one particular component of the system.

  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 as 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

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]