Treatment of Severe Chronic Illness: What Explains Cost and Quality Variations? Should We Be Concerned?
Alliance for Health Reform, National Institute for Health Care Management and Robert Wood Johnson Foundation
September 8, 2006

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ED HOWARD: I'm Ed Howard. Thank you for coming and welcome to a briefing that we hope is going to open your eyes on some issues of very large importance, the huge variation in costs, quality and service usage among American health facilities. We're just particularly pleased to have two partners in today's program. One is the National Institute for Health Care Management, NIHCM, for your acronym freaks, an organization that has been doing good work for a range of issues including health care quality for many years. We're very pleased to have NICHM's CEO, Nancy Chockley, with us today. We'll hear from her in just a second.

Also supporting today's briefing, and supporting the research that's being highlighted today as a matter of fact, is the Robert Wood Johnson Foundation. The largest philanthropy devoted solely to health and health care for all Americans, and we want to thank Risa Lavizzo-Mourey, David Colby and the others at RWJ who support so much of not just our activity, but of good work that's being done in health and health care generally.

I think today's briefing is really designed to shock you out of your complacency about our health care system. I know you've heard the saying, "You get what you pay for." Well, whoever said it wasn't talking about the American

health care system. We're going to examine the latest studies from the Dartmouth Atlas Project that are showing huge variations in cost with no connection to the quality of the care given. Think about that. From hospital to hospital, from one state to another, from one region to another, across town in the same city, it is striking and it has policy implications in both the public and private sector that we want people to understand more fully.

A few logistical items before we get to our program. In your packets, obviously, you are going to find a lot of background information including the slides from the speakers and biographical information more extensive than the intro's I'll have time to give. Tomorrow you can watch a web cast of this briefing on kaisernetwork.org. On Monday you'll be able to watch a web cast on kaisernetwork.org, for which I frankly, am quite grateful. It's good to go back and find out what they really said. What you think they said might not be the same thing. Then if you wait a couple more days you can check the exact words on a transcript that will be available both on kaisernetwork.org and on the Alliance website. All of the materials that you find in your packets are available on both those websites as well. You'll find also, a blue evaluation form which we desperately want you to fill out so that we can make these briefings even more

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responsive to your needs and a green question card, which at the appropriate time you can fill out and pass to one of the staff people, in addition to coming to one of the microphones that are available to ask the questions that don't get answered in the formal presentations.

As I noted, we have today with us, Nancy Chockley of NIHCM, who convinced us that this topic was one our audience needed to hear about. Her background is very distinguished. I refer you to the biographical information I mentioned, and we're very pleased to have NIHCM and Nancy with us today. Nancy.

NANCY CHOCKLEY: Thank you Ed. I'm delighted to join Ed Howard and welcome you all here today to talk about what I think is one of the most important studies that have come out this year. It's the work on Jack Winberg [misspelled?] and Elliott Fisher on the staggering variations in terms of the utilization of care in this country. What is so surprising, as Ed mentioned, is that more care does not mean better health outcomes, and that is a very important concept to get out. The other really important concept to get out is that what's driving this is more the supply of resources themselves. That's another very important concept to get out there. So I really commend Elliott, Jack, and all their

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colleagues at Dartmouth for really putting out a whole body of research on this topic.

I'd also like to thank our other distinguished speakers here today, because the question really at hand is what do we do with this research. How can we make it work in the marketplace? We have Sam Nussbaum from WellPoint, the largest health insurer in the country, and Barry Straube from Medicare, from CMS. So very interested in hearing what they have to say. I would throw out a question to all panelists, which is, are we at a tipping point in terms of the quality discussion, that we have better research, thanks to Elliott and Beth McGlynn [misspelled?]and many others out there. We see significant organizations like Medicare and WellPoint taking important steps to address variations. We have health information technology emerging. Is it too optimistic to think that in the next five years or so, that we can see a market difference in the quality of health care being delivered in this country?

Finally, I'd like to thank Ed Howard, Ann Montgomery and the staff here. You guys always do such a great job at pulling together distinguished panelists, a very informed audience to talk about cutting edge research, and we really value the work that you guys do. You do a great job. Thank you.

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ED HOWARD: Thanks very much, Nancy. That means you have to make your questions even sharper and more directed than normal to help us live up to Nancy's comments.

Let's get started with the discussion. Our lead off speaker appropriately enough is one of the leaders of the Dartmouth Atlas Project, Elliott Fisher. Actually, the Alliance has a pretty long association with this project. Jack Winberg, Elliott's colleague was part of a panel briefing Congressional staff on health care quality in 1994. The others on the panel were Beth McGlynn, [misspelled?] Bob Brook, David Eddy, and Paul Cleary. We had an all star lineup back then. We didn't know about Elliott. He'd have been there too. He is a physician. He's a general internist at the VA Medical Center in Vermont. His work on benchmarking and other quality topics puts him right at the top of the list of researchers in the country, examining how our system can function more effectively, and more efficiently. He is one of the principals responsible for the work that we are focusing on today. We are very pleased to have you with us, Elliott Fisher.

ELLIOTT FISHER, M.D., M.P.H.: When I learn how to manage the technology, we'll all be better off, but it's really an honor to be here and to have people like Barry and

Sam here, who are actually trying to put into practice much of what we've learned over the last 20 years.

What I want to try to do and I'll set this up so it runs as a slide show in just a second here. Hey, it's working. Can everybody hear me okay? If I lean forward? Mike's working. Great. What I want to try to do in a few minutes is to try to really summarize 30 years of research that has been led primarily at Dartmouth and at other places, and try to summarize it in a way that lets you understand the underlying causes of the problems that we see.

If you look at a map of the United States and you look at average per capita spending by Medicare beneficiaries across regions, there are two-fold differences across certain communities, and those residence of places shaded red, receive about 60-percent more care. 60-percent higher per capita Medicare spending than other areas, those in the pale areas of the country. Uber Rhinehart looked at this data a number of years ago and said how can the best medical care in the world cost twice as much as the best medical care in the world. So the question that I want to answer first is, is it really the best medical care in the world when you spend more. What I'm going to highlight first is the empirical research that's looked at what higher spending regions, and we found the same thing when we look at hospitals, and the

populations they care for. What do those higher spending systems get when you spend more?

Well, in terms of the content and quality of care, what we find is in fact, on average technical quality measured at the provider level is worse in higher spending regions than in low spending regions. Spend 60-percent more; you do not buy more major elective procedures. You don't buy more by-pass procedures. You don't buy more hip replacements. What you get, is you get to spend more time in the hospital. Identical patients, 60-percent spend twice as much time in the hospital. You see your physicians more frequently. You're much more likely to be referred to a specialist, and of course, if you're spending time in the hospital, or you're seeing specialists, you're going to get many more diagnostic tests, imaging procedures and other things.

We've looked at the outcomes of care, and in fact, what we find there is a paradox that you spend more and on average mortality is slightly worse, survival is slightly worse after adjusting for the characteristics of the patients that enter these delivery systems. And they don't have better outcomes; they don't have better functional outcomes or quality of life. In some recent studies that I've done with John Skinner and some colleagues supported by the

National Institute on Aging, we've interviewed physicians. Physicians describing care in high spending regions say there is worse communication among physicians. The quality of communication among physicians that's required to provide high quality care is worse. They perceive, in high spending regions that it is much more difficult to provide continuity of care to their patients, and when they are asking that a summary judgment of the quality of care they're providing, they report much greater difficulty providing high quality care in high spending regions then in low spending regions.

When you talk to patients, patients report they have lower satisfaction with hospital care in higher spending health systems within California then in lower spending health systems, and when you look across the country, there is substantially worse access to primary care in those red areas in the country compared to in the pale areas.

Finally, we've looked at trends over time, and these are perhaps the most worrying thing as we think about the future of the Medicare program. If you look at the high spending regions of the country and step back 15 years, those are the regions that had the greatest growth in health care spending over the last 15 years, but those are also the areas that had the lowest gains in survival from myocardial infarction. So the more efficient, more parsimonious regions

had spending that grew at a less rapid rate, but the higher spending regions achieved smaller gains in survival. This is why we now are terming it the paradox of plenty. Spend much more, grow faster, things are worse. The important thing to point out here, and we'll be spending some time on this, and Nancy already alluded to it, is that the major difference both in growth and in trends over time is in this category of care that Jack Winberg [misspelled?] and I have come to refer to as supply sensitive care. These are things like physician visits, hospital stays, where you have more capacity; you tend to use those services in the current system.

So the first major point I want to make is that higher spending is largely due to overuse of supply sensitive services. The hospital, ICU stays and more is worse. What explains the differences in practice? We've done a number of studies now and patient preferences cannot explain the differences observed across communities. Capacity and payment are in fact, very important drivers of the differences we see. If you remember that little map, and you look at the pale areas compared to the red areas, per capita supply of hospital beds is 32-percent higher in the red areas, the high spending areas, compared to the pale areas, and the per capita supply of medical specialists is 65-percent higher in the high spending regions compared to the

low spending regions. And if you look at the number of physician visits to cardiologists, if you have more cardiologists, you will have more visits to cardiologists in your community. Whatever capacity is in place will remain fully utilized in our current payment system, so capacity and payment are important drivers, but clinical decision making in the grey areas is the critical determinate of what is going on. If you ask physicians in high spending versus low spending regions, how often do you see your patients for well controlled hypertension, what you see is that the highest spending regions, the frequency with which they are seen, increases dramatically. Half of the physicians will see their patients with well controlled hypertension in three months or less, whereas in the low spending region it's only 20-percent of the time.

So how can we make sense of this? Let me try to put together a story that I think is useful for us as we think about how to reform the health care system. Clinical evidence, randomized trials, guidelines, the kind of work that Beth McGlynn has talked about is critically important, but it is a limited influence on clinical decision making. If we think about physician patient encounter down there, clinical guidelines will help with about 10, maybe 20-percent of the clinical decision we make as physicians. But

physicians practice within a local organizational context and policy environment that profoundly influences their decision making. The capacity of the local delivery system, how many specialists there are on staff at our hospital, how many beds we have, and the payment system rewards us for keeping those systems full. If the current payment system fosters growth, ensures that existing in new capacities is fully utilized. The consequence is that reasonable, individual, clinical and local decisions lead in aggregate to higher costs and inadvertently to worse outcomes. So what's happening is that when we do more diagnostic tests, we detect more things that would not have caused people trouble during their lifetimes, but for having done the diagnostic test. When people spend more time in the hospital compared to areas where there are fewer hospital beds, similar conditions, hospitals are dangerous places, as Don Burwick [misspelled?] and many others have pointed out to us. And as there are more different doctors involved in your care, it's much easier for the slips and mistakes to happen as a natural consequence of having more physicians involved in your care occur. Where there are 65-percent more physicians, there are likely to be much more difficulty communicating, as we heard, and much greater likelihood of errors when physicians are trying to work together.

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So overuse is largely a consequence as reasonable differences in clinical judgment. Not simply errors that arise in response to local organizational attributes, especially in capacity, in policies that promote fragmentation, growth and more care. Current policy initiatives focus largely on individual providers and their silos and do nothing to address the care coordination that is required. They fact substantial technical challenges, limited scope of measurement, risks making bad apples look good, and efficiency measures target brief episodes and largely ignore the role of volume. They, most importantly, ignore the organizational context of care and the decisions about capacity that drive overuse and excess spending. So if we're going to improve efficiency, what we are advocating at Dartmouth, Jack and I, is to foster organizational accountability for quality and costs. Policy initiatives should focus exactly on longitudinal quality and cost. They are two levels at which this could easily happen. Prepaid and multi-specialty group practices are a logical unit of accountability. Groups such as Kaiser, large integrated delivery systems such as Health Partners or Partners in Boston. But in every part of the country hospitals and their affiliated physicians tend to work together. The natural epidemiology of care is for hospitals and their medical staff

to form a logical unit of accountability for longitudinal cost and qualities. Most physicians work in or admit to only one hospital. Chronic disease patients are highly loyal, allowing comparisons of longitudinal costs and quality, and performance measurement and payment reform would create strong incentives for hospitals and their staff to collaborate to improve quality, and this is probably a good point to mention something that I'm sure Barry will be mentioning, the recently announced demonstration for physician hospital collaboration by CMS just earlier this week.

Most importantly, if we're looking at costs, the local hospital and its staff provides an organizational context for capacity management, for decisions about how many physicians should be involved in the care of these patients and how many we need.

Our Dartmouth Atlas provides some preliminary insights into how this might be done. Our goal is to provide hospital specific measures at relative intensity of resource use. The approach is to measure resource use in severely ill patients. We look at patients during their last two years of life when they're all identically ill. There is no issue about case mix when 100-percent of the patients are going to be dead within two years. They're in fact, identical. We

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further adjust, because there are some differences due to cancer patients are treated differently than heart failure patients. And then we look at patients experience during their last two years of life, for these clearly severely ill patients, and see huge differences across systems in how patients are treated.

The importance of looking at this population is that the measures reflect the relative intensity in cost for other populations and provide insight into volume. Let's take an example, Fort Lauderdale, Florida and Sayre, Pennsylvania. These are average Medicare per capita spending in two hospital regions in the United States. There is a two-fold difference almost between these regions. If you look at the care of the patients with severe chronic illness in these regions and look at the average across the hospitals within the Fort Lauderdale region, or the average across the Sayre hospitals, you see that inpatient in Part B spending in the last years of life is $40,000 for those in Fort Lauderdale, but only $26,000 for those in Sayre. We can then split these out actually, and the data that I'm presenting is available on the Dartmouth Atlas website to provide specific information about hospitals within each of those communities. Of the four hospitals I've pointed out were chosen because they were at the high and low ends of the distribution within

these regions. What you see is that for example, within Fort Lauderdale the patients cared for at Del Ray Medical Center, the spending is about $10,000 higher than those cared for by Imperial Net Point Medical Center, but they are twice the level of spending of those cared for in the two hospitals in the Sayre Hospital referral regions.

When we look hospital days per capital, we can look at the characteristics of the services provided. Patients in Del Ray, identical patients in the Fort Lauderdale hospitals spend much more time in the hospital.

We can look at the frequency of physician's visits, and we see that the frequency of primary care visits is higher within the Fort Lauderdale region than within the Sayre region, but that there are few differences in primary care services across these two systems. When we look at medical specialist visits, however, we see the dramatic differences that probably explain the differences in spending, truly remarkable differences in terms of the frequency in which specialists are used in the care of patients with severe chronic illness.

So the final point I really want to make is that the improving efficiency will require policies that foster local accountability, ideally at the level of large medical groups and hospitals with a longitudinal cost and quality of care.

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And performance measurement and payment reform will be critical. I believe that the kinds of efforts that we'll be hearing about from both Barry and from Sam will really give us some examples of the kinds of approaches we can take to really addressing the paradox of plenty. Thank you very much.

ED HOWARD: Thank you Elliott. Pointed array of facts that are very difficult to come to grips with, but the next two panelists that you are going to hear from have to come to grips with them, both in the public sector and in the private sector, and as Elliott said we're going to hear next from Sam Nussbaum. I hope we can make the technical changes here before the – all right. Sam is the Chief Medical Officer and the Executive Vice President of WellPoint, one of the largest health plans in the country. Needless to say, he too is a physician with an impressive record of achievements in both medical management, promotional quality. At WellPoint his responsibilities are pretty broad. They are of critical importance to delivering quality care to WellPoint's members at an affordable cost, and we hope he is going to share with us a bit of WellPoint's strategy for dealing with these variations in care, and their implications for quality. And he can do it – you should take no implications from the fading of the color of your slides.

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MALE SPEAKER: We can go on the other system. There you go. That'll cover that. That'll do it.

SAM NUSSBAUM, M.D.: Thank you Ed, and good afternoon. I'm indeed delighted to be here to be part of this important dialogue, and importantly also to congratulate Elliot and Jack Winberg [misspelled?] and others in the Dartmouth Atlas Project. We've had the privilege of supporting that project in the past throughout our foundation and we'll continue to support it, because ultimately if we look at how to we drive quality and cost in our nation, it will be through this type of investigation that will get us to that promised land.

In many ways, though we live in the best of times and the worst of times in health care. The best of times because we have breathtaking science and technology that we can apply to health care and truly cure and improve the lives of people, but the worst of times because we have health care that is not affordable. It's not of uniform high quality, and in fact, there continue to be significant gaps of care. SO as we look at how we can improve quality and reduce variation, we have to continuously look at these principals. And those principals relate to evidence based decision making. Safety is a priority. Also, and I'll speak to this, is how do we drive better use of services, and we'll talk

about how we can pay for that performance, but ultimately it's about consumers and their physicians sharing freely a flow of information that guides people to better health outcomes.

One of the ways a company like WellPoint, and our peer companies do this also, is to take all of this new information, because health care is driven in part. Health care costs are driven in part by advancing technology applied to an aging population. But how do we take then, this rapid diffusion of new knowledge and apply it to care? To make sure that these technologies are ready for prime time? And the way that we do it is to try to use a scientific basis of clinical care. We work with medical specialty societies. We work with academic centers, and what we do is look at the scientific evidence, and if it is found to be a benefit, we encourage it for our members. If it's ineffective, we make sure as best we can, that it is not taking place.

So let me give some examples of how we can take the application of this variation and at times care that doesn't guide you to great outcomes and look at it. So one way is to look at imaging. We know this is a market that is large and growing. It represents for some of us as much as 10 to 12-percent of all health care costs, and much of this growth is appropriate. Magnetic resonance imaging and PETSCANS can be

absolutely sophisticated important technologies in the care of patients. However, many of these technologies are not applied appropriately. We'll look at some variation in a moment. But how do we get to the answers that we want? One way is to look at standards of care.

Now I've shared with you on this slide some of the variation that we see, and very much like Elliott, we see two and three and four fold variation in care. We have a different issue than Barry has, and that is we contract for these services, so we have actually that type of variation in cost of these services too, something I'll share in a moment. But what you can see here is if we look at MRIs for 1,000 members per year, you have marked variation. You also can see that we've uncovered one of the key industries in New Hampshire. In Manchester and Lebanon, and I suspect that that's related not to some of the imaging centers, but really a standard of care that people are taught as they train. But also take a look at that variation. So how do we go beyond that?

The way to get there is in many ways to look at the local market, to recognize that there are free standing centers, to recognize that there are non-radiologists performing these services as part of their enhanced revenue. But also to recognize that many of these services actually

have an impact on public policy, because as hospitals lose profitable service lines, they will look to make up that difference.

Here's an example of a program that takes all of the guidelines by the American College of Radiology, applies them, the terms that health plan terms aren't as welcoming as they need to be. They are terms like prior authorization or prior certification. But these can be done in a very positive way, and in this program we actually guide people to better care. So if it turns out that a PETSCAN is the right imaging modality based on established criteria, that's what we do, is guide that person to care with their doctor as opposed to doing many other less impactful imaging procedures along the way. You can see that over several years we were able to take a national trend of almost 20-percent and reduce it to near a zero percent trend in use rates and cost, despite the appropriate advancements in technology.

Let's look at coronary artery bypass graft. This is an area that is extremely well studied, and you can see again, marked variation. Terre Haute, Indiana is near the top. I think this is why it's called the heartland of America, of the Midwest, but also look at Denver and Charlottesville, how low those are. Again, six-fold variation in care.

We see variation in cost too, and it's not only in any of the hospital service areas, it's within hospitals, so academic medical centers in general are paid more than community hospitals for these services. I haven't put a scale on that cost, but that also is a four-fold difference. That's what we're always balancing, both of those elements.

How do we take this information and move it in the right way? I know that those of you that are clinicians, or work with the American College of Cardiology, the Society for Thoracic Surgeons, will recognize that these are the metrics that are the right metrics. These are clinical metrics that look at outcomes of care. These are the same metrics that specialized physicians would use. So what we have done is taken those measurements and actually produced cost and quality indices and then guide people to centers of excellence to those indices. Let me show you some data that shows not the variation in costs and use rates, but actually are very harsh endpoint, the variation in death rates from surgery. What you can see in these centers that it varies from approximately one-percent to almost five-percent. Think about that. Five-fold difference likelihood of not surviving surgery.

Now one of the other things that you can notice by this data represented by the red triangles is that there is

no relationship between volumes and outcomes. That's different than conventional wisdom has led us to believe, because often it's thought if you do more, that you get better outcomes, but in some cases that is not the case.

Let me take you to another level here. Now I'm taking all cardiac services. What we've here, it's a slide that I want to walk you through for a moment. We've created a quality index on the Y-axis, and you see at the very top, high quality. Then lower quality on those same 20 measures. Then what you see is a cost index on the X-axis. So higher cost and lower cost. Again, you see that four-fold variation, and it's an index. It's not the cost of coronary bypass surgery. It's catheterization. It's admission for myocardial infarction, for heart attack.

What you can see again is three things. Number one, there is no correlation between quality and cost, so even for a selected intense cardiac services, higher price, higher cost does not mean better outcomes. Number two, again the limited correlation of volume with outcomes. And the third and this is the one is very hard for people to understand, is that this doesn't correlate with those wonderful billboards that you see when you enter each of your communities, when you are home on recess and see that it's the nation's number

one heart hospital. In fact, some of those very top hospitals are in that lower quadrant.

So how do we get to a promised land? One is we can pay for performance, as this can truly save lives. It can eliminate disparities in health. In can reduce cost. You can create the programs to incent IT adoption, and that's what we've done. We have programs for doctors and hospitals that truly reward clinical outcomes. They reward evidence based medical practice. They look at, even issues that are solely based on price like generic prescribing rate, because to us, that's a quality measure if you can make health care more affordable. They look at many, many other elements.

When we start looking at those programs, we entered several years ago into a model with doctors and hospitals where we actually pay more for an index series of health outcomes and health measures. So if you're a hospital working with us today, and our goal is to get to 80-percent, I'll show you where we are today, but you will get an increase based on an indexed series of outcomes of care, not just of doing more service. So let's imagine that there was a 10-percent request that may translate to a two-percent cost of technology and health service increase with three to four to five-percent put at opportunity. You can see in this chart, which you can read better from your seats, how we've

done this across the states where we have market shares that range from 30 to 50-percent. So in some cases like California, almost 100-percent of physicians are in these programs, and these dollars are very significant. They represent about 12-percent of total health care dollars.

Let me conclude by taking a perspective health IT, and also consumer engagement. Where we are today, I'll call these payor sentinel systems. We are able to message, to give information, like I share with you, to physicians, to patients, where we are trying to guide more effective care. I'll show you an example in a minute. Here's the drug you took. You could use a more effective therapy. But our goal is to move us to where we are presenting clinical information at the point of care. We have some projects in Missouri, and rolling out in California where if you are one of our members and go to an emergency room, your whole personal health record is available to the treating physician, seeing your medications, what your conditions are.

Our ultimate goal is to where we can actually get decision support. Seeing the variation in care, seeing why it exists and guiding better care along the way, because I fear today that while we are investing heavily in electronic medical records and health information exchange, that's only going to get us part of the way there. I suspect that we'll

be exchanging and sharing the same marked variation, and less than optimal outcomes of care. That big red bar there, the practiced patterned variation is really what we need to impact. I believe when we do that, we are going to see a narrowing of practice patterned variation. We're going to be seeing more appropriate services and better health outcomes.

Let me close by showing and sharing how we can do that. This is a model that we've used with the state of Massachusetts account and what you can see is it looks like a 401K statement. You see in a personal health report, all of the services that you've received from your office visits to medications, but what's most important is what's on the right side of the slide. And that is that in the red cross and the stethoscope, you're actually being guided to better health outcomes. You're being told, along with your doctor what the evidence is, that you should be receiving certain therapies or certain approaches to care. Those dollar signs represent direct opportunities whether it be generic therapies or others where you can save money. In addition through our health advisor program and you can see this on our website, you can actually see based on your preferences, where you might want to receive care. You see again, public information, net par data on the numbers of procedures done, the outcomes of care and issues that are meaningful to you.

So that's the type of guidance that we are now working to give.

Finally, and these are important numbers for commercial insurance. One-percent of our members drive 25-percent of all health care costs. Five-percent drive 54-percent. Our goal is for those five-percent of people, to involve them in health coaching, disease and care management programs where we can effectively guide care to more capable centers of excellence, to better outcomes of care. We also need to study the outcomes. We're mentioning the work that we've done with the Dartmouth Atlas Project and others, but we actually have a subsidiary company called HealthCore, and the goal is to look at outcome measures of care, to look at pharmaceuticals, and to actually work to make this information the public domain.

So there are many ways that we look to work collaboratively with both physicians, hospitals, and with our members to guide better use of evidence based medicine. We believe that by getting the right amount of care in the right setting by having consumers share in that decision of knowing the outcomes of care, that we will in fact, begin to meet these requirements to remove the 30 or so percent of care that doesn't lead to better health outcomes. It comes about, though there is not a simple solution. It's not just putting

out price lists. It's about working with professional organizations like the American College of Cardiology and primary care physicians groups. It's about paying and rewarding performance. It's about building centers of excellence, but it's most importantly about engaging all of us in understanding their care, following the right health improvement and prevention guidelines and creating a greater knowledge of shared decision making. Thank you very much.

ED HOWARD: Thank you very much, Sam. Let me do a little technology transfer here. Maybe you could pass that monitor down if you would. Thank you. Dastardly little thing that it is. Our last speaker is Barry Straube, who is also Chief Medical Officer for a health plan. In fact, two of the biggest health plans around, Medicare and Medicaid, at the Center for Medicaid and Medicare Services, CMS. He also at CMS directs the Office of Clinical Standards and Quality. He sits astride all of the important coverage and quality decisions at CMS, and on the side he serves as the agencies top advisor in end stage renal disease, which is his professional training. We are very pleased to have you back, Barry, and we're looking forward to your contribution to this very important discussion.

BARRY STRAUBE, M.D.: Thank you very much. It's a pleasure to be with you all. We have been working with many

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of you who staff the various Congressional subcommittees. I think this is going to be a very busy next four to five to six weeks, and we look forward to working with you. I think I'm going to segue into the urgency and the focus that we have at CMS on this very, very important topic. Unlike what Sam was describing, and I use to work at a commercial health plan before I came to work for CMS, we don't have the luxury of being able to so easily contract and construct some of the reimbursements systems and the quality systems that commercial health plans have. We, as you know, operate under federal legislation so many of the reimbursement systems and other systems that we have to oversee the quality of care and the expenditure of care in terms of dollars are driven by statutes. So we clearly need to work closely with all of you and many other people here on the hill to try to get at how can we reduce these variations in cost and quality.

I just wanted to go through a few things to highlight and accentuate what Elliott and Sam have already said. This is a slide that just shows you the growth in terms of Medicare beneficiaries. I'm going to be restricting my comments to Medicare this afternoon, although many of these concepts will apply to Medicaid. You can see there is an exponential growth in the number of people over the ensuing years who will be coming on to the Medicare roles. This

means an increasingly elderly population that will be seeking care. It also means an increasing population with multi-organ involvement and multiple disease states, i.e., the very complicated patients, and the ones that Elliott and Jack Winberg's [misspelled?] data reflects very carefully. You can't see it very well on this slide. The colors are kind of similar, but there are two bars here. The darker purple are the elderly, but the bluish color are the disabled, and people forget that we have a disabled population in the Medicare coverage system. These people have different needs, and will drive costs in a different way, so we have to remember that this is not quite as easy as aggregate cost analysis. We have to drill down into various subsets of the total cost to figure out where the expenditures are going.

There is another segment here that comes from my specialty area, end stage renal disease that doesn't show up on this bar graph right now. But given the fact that there are 20 million Americans with chronic kidney disease currently, and many of those strictly not do something will progress to end stage renal disease. You can understand that there will be an increasing proportion on this slide that will be end stage renal disease, a whole different area of treatment, technology and costs.

This shows, again, I would quibble a little bit with Elliott's slide where he was quoting Uber Rhinehart, in terms of our having the best medical care. That's, I think, arguable. Many of other parts of the country would argue that the care that they render is in fact better than the care in the United States. I think in a number of arenas, that is the case. In many areas we are worse than other parts of the world. In spite of that, as this slide shows, we have, on the left hand side of the bar graph, as a percentage of gross domestic product, as of this year it's about 15-percent of our GDP spent on health care. Our actuaries estimate that's going to be up to 21-percent by 2015. As you can see the other developed nations of the world have significantly less percentage of their expenditures on health care. So here we are spending more and don't have, necessarily, the best health care. In fact in some instances, have less good health care than other parts of the world spending far less.

This one was Beth McGlynn's [misspelled?] study that you've heard alluded to, and again, another little point that I may quibble a little bit with Elliott's characterization, and that is whether there are errors or not. Whether this is just variation with shades of gray of clinical judgment, or whether in fact, we're not doing the things that we should be

doing, i.e., in my mind, that's an error. I think that study clearly shows on this one, 50-percent on the left hand bar here, of patients coming into doctors offices receive the kind of care that they would be expected to get according to typical guidelines that are national consensus driven guidelines. If you look at particular kinds of disease entities that I've listed here, breast cancer, 76-percent of the time, women get recommended care. The converse is in only 24-percent, they don't. That's not acceptable in it of itself. And look down on the right hand side, with hip fractures and pneumonia, only one out of four, or one out of three patients getting recommended care.

So we have a huge problem in terms of getting our care providers to follow national guidelines and to in fact, provide care which doesn't require high technology, health information technology systems and other backup systems to tell people that someone needs an immunization, for instance. That's something you learn in medical school. Very basic, should be done, doesn't need high tech interventions, yet we're not doing that.

This is again, from Elliott and Jack's work. It shows again red areas, high cost Medicare expenditures for hospital care. Light areas, low cost expenditures for hospital care for Medicare patients per year. Contrast, and

again, notice the gross variation across the country. If you contrast this with a similar slide, not from the Dartmouth Atlas, but from ours that shows the dark area are hospital quality outcomes. The dark areas are the worst performing areas. The light areas are the best performing areas. I think you can make a case that there is some overlap here with the worst outcomes being the highest cost areas, the best outcomes being the lower cost areas.

So in summary, in terms of what we're looking at at Medicare, we spend more per capita on health care than any other country in the world. In spite of these expenditures our health care quality is often inferior to other nations, and often doesn't meet expected evidence-based guidelines. There are significant variations in quality and cost that you've heard from all of us that you've heard this morning. We're responsible for the health care of a growing number of persons, particularly the elderly and those who have low incomes. In partnership and collaboration, we feel we have to demonstrate leadership in trying to address this.

So how are we trying to address some of these problems? Well, I'm going to go very quickly in the time remaining through some major elements of our quality roadmap and how we're trying to approach this problem. Going to be talking about the administration and the Secretary of H.A.

Jess' [misspelled?] Transparency Initiative, which we, I believe are the lead at CMS. I won't go too much into Medicare and Medicaid payment reform, but this is a very important piece that we'll talk about briefly, when I mention multiple demonstrations we're doing trying to address this problem. We'll talk about our Quality Improvement Organization program, which tries to improve the quality of care in Medicare that we're going to be reforming to try to align with these issues we're talking about this afternoon. Then finally, health information technology initiatives.

We have five strategies that we enacted starting last summer, which we call the CMS Quality Roadmap, and these are all very important to try to adopt to get at this variation in cost and quality that we've demonstrated for you this afternoon.

The first strategy is to work through partnerships and in collaboration to try to address these problems. We believe that WellPoint working alone, CMS working alone, various other health plans working alone, local folks working alone are not going to substantially impact the problems that we've looked at. We have to all work together to try to address these.

The second is a very seminal piece, and that is that we believe that the quality in cost and pricing information

has to be publicly posted and available to all citizens and to all people who need to use this. Let alone be it consumers, who are purchasing health care or employers and purchasers of health care, or whether it's researchers or, you fill in the box, policy makers, all of us working here in government. But we need to have that information. It has to be publicly available. We have to talk about it, discuss it. We have to deal with it. We have to hold people accountable.

As part of the accountability, we currently have a payment system, particularly in the Medicare Fee for Service system that rewards quantity and not quality. The more you do, the more we pay, regardless of the outcome, regardless of the quality. So one of the key seminal discussions that has started up again now that Congress is back in session, we're intimately involved with is reforming the payment system, particularly in the Medicare system, but this needs to be done in the private sector also, to align payment with quality, efficiency and with value. So this is a very important charge for all of us working in the federal sector.

The fourth strategy is assisting and working with practitioners to make care more effective and less costly. We feel that primary way has been alluded to by Sam, is through the promotion and adoption of health information technology. Although I believe there are errors being made

left and right that we shouldn't be making and don't need fancy equipment to avoid those. Undoubtedly, health information technology will not only help us collect the information that we need for the quality and pricing information to respond to it, but also to give us clinical guidelines, practice based guideline to be able to implement the highest quality of care.

Then finally, Sam went into this also, we're heavily involved of course, with coverage of various technologies, we need to bring effective new treatments to patients more rapidly to help develop better evidence so doctors and patients can use technologies more appropriately.

I want to talk to you about the administration's Transparency Initiative. This, you probably read about, and this is the making, as I've alluded to, public information on the quality and cost more available to consumers, employers and payors of health care. Trying to have this be one factor, in addition to regulation, in addition to payment reform and so forth, to drive better quality of care. This gives the consumer the ability to seek care, hopefully with the most high quality, most efficient providers of health care out there. The President issued an executive order while Congress was recessed at the end of August, and this is charging all federal agencies, particularly CMS to work on

the following three bullets; sharing of information on quality and costs, promoting inoperable health information technology systems and incenting consumers to choose efficient high quality providers. So we're going to be doing that at CMS. The Secretary, Secretary Levin, has been enunciating this. He has four particular goals, but they overlap HIT Standards development for interoperable health standard systems, quality standards, price comparison standards and then they institution of market incentives to incent people to get care with high quality providers and to incent providers to provide higher quality of care. We have been working on a national level with two collaboratives, the Ambulatory Care Quality Alliance known as AQA now, and the Hospital Quality Alliance, known as HQA. These have a number of activities ongoing. The biggest one that I put down here is the last bullet, Beneficiary Quality Improvement pilots, which in fact, are six pilot sights across the United States. In Phoenix, California, Indiana, Minnesota, Wisconsin and Massachusetts, where we have collaborations of providers, payors and consumer advocates, employers and a whole variety of other health care stake holders who are collecting, aggregating and reporting quality and price information publicly, and will be using that to try to improve the quality and efficiency of health care dealing with some of

the issues that Elliott and Sam have already talked about. Where the Secretary wants to expand to 60 sites around the country, the White House would like to go even more. You're going to here about this at the local level as Elliott was talking about earlier.

I don't have time, I have to come to some closure here so we do have time for discussion, but I've listed for you here, a few, only a few of the demonstration projects that we have ongoing. I did not list here that Elliott had mentioned a demonstration we just announced yesterday afternoon, that aligns hospitals and doctors trying to work together to provide efficient health care. The one I do want to mention is the Premiere Hospital demonstration. This has been ongoing for 2.5 years now, and this demonstration looks at five different disease entities, 34 metrics of quality of care. We found after the first two years, where there are payment incentives for those who provide the highest level of care, that all 34 measures, all five domains of health care, five disease states, have shown market improvements overall in the quality of care being given, since the institution of these pay for performance programs. Concomitantly we found that lengths of stay are reduced, readmissions are reduced, patient safety indicator triggering, that is safety episodes in the hospital are reduced, and overall cost of care are

reduced. So once again we are seeing in the hospital setting, high quality care associated with lower costs. We have posting on our website of hospital volume and reimbursement information. We've started a physician voluntary reporting program. We have pay for performance initiatives that we have designed and will be working with the hill in hospitals, doctor offices, skilled nursing facilities, home health agencies, and end stage renal disease facilities. There are several demonstrations I've listed here that come out of the deficit reduction act, which passed at the end of last year and was signed earlier this year. And then last but not least, we have our QIO program, where we have QIOs, Quality Improvement Organizations in each of the 50 states that are to work with health plans, doctor offices and other provider settings to try to improve the quality of care. One of the proposals that I have in our redesign package is in fact, to take the work of Elliott Fisher and Jack Winberg [misspelled?] on regional variation, have the QIOs work with those local providers exactly what Elliott's mentioned earlier, to work at the local level on addressing these variations in cost and quality.

In conclusion here, we have a major problem in quality and resource variation in the United States, although capacity is an important factor, I believe there still are

other factors that we need to delineate. We also looked at methods on how to influence all these drivers, and as I've tried to make, very quickly a case for, the federal system, all of us working together, but working in conjunction with the private sector, needs to focus on transparency, needs to focus on public reporting of quality and price information. We need to focus on HIT information and adoption of HIT. We need to provide information and assistance so that the consumer, employers, and payors of health care can in fact, make informed choices in health care. We have to change very importantly, the provider reimbursement and payment systems. We have to give technical assistance through various channels including the QIO program. And last but not least we clearly need to collaborate so this is a public private collaboration effort. Thanks very much.

ED HOWARD: Thanks very much, Barry. It's your turn, and if you are as relatively unsophisticated in this area as I am, you must have a bunch of questions. You can put that question on a green card, hold it up and someone will snatch it from you, or you can go to one of the microphones that are arrayed around the room. If you did that, please identify yourself and state as succinctly as you can, what your question is. Let me just start on a question I know one of you would ask if you had the opportunity, and directing it to

Elliott. If I'm a Congressional staffer from a particular district or state, can I go on to your website and do comparisons of hospital quality for my area of the country?

ELLIOTT FISHER, M.D., M.P.H.: Absolutely. There are a number of different sources you can go to learn about the quality and cost of care within your systems. First, Barry, Medicare has up and running the Medicare Compare website, which will allow you to identify hospitals within each of your systems, within each of your districts. The Dartmouth Atlas website which the web link is on your handouts, will allow you to look at longitudinal costs and longitudinal costs of care for every hospital that has enough patients in it in the country, and that's 90-percent of them. We also have a link to the Medicare Compare website and some of the Medicare Compare data in the tables themselves, so that you can look at the cost and the quality side by side.

So yes, the data should be there and is regularly updated. Will be updated again in another couple of months with the 2004 and 2005 data as soon as they're available.

ED HOWARD: Thank you.

BARRY STRAUBE, M.D.: Yes, I'd like to add in addition to what Elliott has just mentioned, I had to quickly gloss over it, but we, about a month and a half ago started a very rudimentary first step published on our website for

hospitals across the United States, it's on a separate site other than the Hospital Compare website, but pricing information. And we had to start off by reimbursement, average reimbursement that we give in various counties in each of the states across the country, so people could start to understand the variation in cost at the local level. In addition we had volumes of services there for some of the highest volume services. Again, thinking that it would be interesting for people to know which hospitals had higher volume of services, particularly for procedures, where there is some evidence that the more procedures you do, the better outcomes people get. Practice makes perfect, perhaps. This is only the beginning. This is something through the AQA and HQA that I mentioned. There is going to be, I think, a phenomenal growth in the next year or two of information about what it costs at a hospital, a doctor's office, a nursing home, etc., to get the care, and that's going to be linked with the quality information that Elliott alluded to.

SAM NUSSBAUM, M.D.: Just to add an element on transparency since that has been a theme also, this early discussion, and that is we deeply believe in transparency that it needs to be meaningful to the consumer and on services where they actually have the opportunity to make choices. I say that because to see the actual cost

differential for acute medical services, which we show in some of our states, we found not as meaningful as seeing what it costs to get a drug at the drugstore in their neighborhood, or what we'll call the commoditized health services that can be electively pursued. So I think it's very important that we give people, all this information is wonderful, but that we target it as ways that meaningful, actionable, and will lead to difference of care, because what we've found and this is spoken to by Elliott, that most hospital systems that are aligned. To show that the physician that someone is getting their ongoing care is more costly because the hospital that she or he chooses would be very different than if the person could make an alternative choice. Overtime they may have that selection opportunity, but generally not for acute needs or chronic ongoing illness.

ED HOWARD: Sam, let me just follow up on that. I have family in Cincinnati whom we visited over the Labor Day weekend, and they were talking about the Aetna – I'm sorry, I didn't mean to mention a competitor – a demonstration in Cincinnati where they were sharing with their policyholders price and quality information on individual hospitals and doctors. Do you have something that either is parallel to that or is better than that, or do you think that's a good idea?

SAM NUSSBAUM, M.D.: Yes, I think that Aetna, first of all, I applaud all of these efforts that we and Medicare are doing, because I think we are going to all learn from what is working and what's meaningful to customers. I was sharing some data that our own surveying of consumers, of your constituents and ours, basically say that they look for quality and experience and performance, and while cost is important, it's pretty far down on that list. So I think that what Aetna has done in Cincinnati is they will show that if you are going to get an intermediate doctor visit, that it will tell you what price Aetna reimburses that doctor. I think the real issue though, is if you go to a physician with a suite of symptoms, let's say chest pain; you don't know whether that will relate to take some aspirin and call me or whether you'll end up with a catheterization and cardiac surgery. So it's pretty hard to know that that $82 visit, whether it will translate to $50,000 in care or not. I think it's a step. What we're trying to do and what we have done, those of you that may live in Virginia have seen us do this. We actually put your payment, what it would cost you if you enter a hospital, by hospital for a condition.

On the physician side, to me, it's an important but much less relevant what that individual visit costs than if you have diabetes or an expensive long term illness, what it

would cost for the year of care. What's an average cost there, because as Elliott showed you can bring people back two or three times and some bring people back five times, but it's really that longitudinal care that makes sense. So I would love to see the next time you go to Cincinnati, and hopefully you'll not need care, but if you do that you will know the right place to go for that acute episode that you will get the best outcome that you can.

ED HOWARD: Thank you, I think. We have a question submitted in advance that actually if I was to read it would have me violating the length of time that we give to each of our speakers, but let me try to summarize it, because it is actually addressed to each of our panelists and it involves the substantial proportions of Medicare beneficiaries who have Alzheimer's or other dementias. The question basically is what are the implications of patients with dementia for the bundle of quality variation issues that we've been talking about. Has the Dartmouth Atlas analyzed the impact of Alzheimer's on Medicare spending? Is disease management in WellPoint identifying beneficiaries with dementia, incorporating their needs into the care plans, and what is CMS doing to ensure that beneficiaries are identified who have dementia and are you designing strategies to deal with it. Anyone who would like to start? Elliott?

ELLIOTT FISHER, M.D., M.P.H.: We have not specifically reported on the quality of care or the cost of care for patients with mild cognitive carmeder dementia. We have started to look at some research by one of my colleagues, a geriatrician, at variations across regions in the care of patients with cognitive impairment, and you would not be surprised to hear that there are huge differences across systems in the intensity of care provided to patients with the diagnosis of dementia. Those characteristics do not appear that the higher resource systems are providing better care. If anything the patients look as though they are getting over treated dramatically. So there are huge variations. It's an important problem and the challenges of wise decision making in the setting of cognitive impairment deserves serious attention. But Sam, I'm sure, has figured out how to deal with that.

SAM NUSSBAUM, M.D.: I think we all wish that we weren't dealing with devastating new epidemics of chronic illness in Alzheimer's and other dementias, and cognitive impairment is one of those. Sadly, even with the advancements in pharmaceuticals, and there are many, most have not dramatically altered the natural history or the management of Alzheimer's. When you look at all the disease and care management, there is very little in the industry

targeting Alzheimer's. I think it's become really guiding individual families to the community resources and some of the decisions they need to make for their loved ones, but it is a devastating situation for many families. It is dramatic in cost and I think our only hope is through fundamental research to really understand more about its prevention and management.

BARRY STRAUBE, M.D.: I think on the Medicare side, a couple of responses. One, this is a good example, if you logically go through the sequence of an Alzheimer's or dementia patient; it raises all sorts of issues. Early on, how do you make the diagnosis? What kind of technology is involved with that? Are people ordering the technology appropriately or not? Are they over ordering tests, etc? So you get into that area.

Second thing is cost today of treatments available currently, but there are some with the Medicare Part D benefit; we can now add a pharmaceutical approach to those people who didn't have that benefit before. Same questions though. Are they taking it? Is it being used effectively? Is it being monitored? What happens if it doesn't work? Is it being continued? It goes on and on, and what are the drug costs involved? But then you get into the most important piece in my mind, and that is these patients are going to be

treated in a whole variety of settings, and they're crossing over from home to doctor's office to hospital to skilled nursing facility, home health agency may be involved, a lot of different provider settings. I think that gets back to why the longitudinal resource use is so important, as opposed to focusing on each of the silos of care settings. We have to look at what are the total costs as a human being goes among all those provider sites, and how might we be more efficient. From the Medicare side, how might we reform the payment system to incent the most efficient highest quality of care? Again, currently we are paying different rates in each of those different settings, and we may be incenting people going to a given setting because that's more profitable for someone, or to put it conversely, that they don't lose as much money by being in a specific setting. Is that the best care for the patient? Is the outcome the best? Is it best for the family? So I think this particular area is a good one to look at, and we have a number of demonstrations again, that are looking at chronic disease management. Sam can speak to this too for WellPoint, but chronic disease management, care management, continuity of care across the spectrum continuum of care that we have lots to learn in the next few years.

ED HOWARD: Thank you. Yes sir, you want to identify yourself.

JIM RASHOWSKI: Sure. I'm Jim Rashowski from the Center for Studying Health System Change. Elliott made the point that a lot of the variation, geographic variation and cost is driven by the supply sensitive services, and it seems to me that one of the problems that Medicare has is that it pays an equal amount across the nation, only adjusted by input cost. From an econ 101 standpoint, it would make sense to actually reduce payments in those areas that have a larger supply by altering the conversion factor or something like that. So Barry, has CMS considered a geographic variation in payment to address the disparity that Elliott talked about? And then for Sam, I'd like to ask whether this is something that is done in the private sector. Do you alter payment for physicians and perhaps hospitals based on the local supply and demand factors.

BARRY STRAUBE, M.D.: I'm sure Elliott will want to chime in on this one too. For my question, I'll answer, and that is, yes, of course we're looking at this. As I alluded to we've been talking with Elliott and Jack Winberg [misspelled?] in terms of how we might bring an approach into the Medicare system t focus on longitudinal resource use and the findings that they have. We don't have the details yet.

I think of how we can respond, but we'll be looking at that over the next couple of years. I do think though, that getting back to the core tenant that Elliott talks about, and what I was alluding to also, we pay for quantity, not quality. Ed mentioned this in the beginning; you get what you pay for. So you pay for quantity, you get quantity. You don't necessarily get good quality. So we fundamentally have to change the reimbursement systems, where we're not rewarding people to do more procedures. It's just accentuated when you have an area that does have over capacity, where people need to drive the revenue stream. I think, again, our pay for performance efforts are the main way we're going to look at this, but I do think I agree with Elliott, that we have to drill down to the local level. Look at the variation there. and as I alluded to on my last slide, I think in addition to over capacity, there are other factors locally that we have to look at, including people just don't know the right way to treat things and we have to figure out how we can educate folks in that setting.

SAM NUSSBAUM, M.D.: We believe, just briefly, in responsible payment for the clinically important services. So we have not taken the approach that you suggest in terms of lowering payment for those areas where we see higher services. In fact, one of the concerns that we've seen, is

if you lower payment, you actually get more services. That's been studied in a lot of different environments. So we really have to be mindful of paying responsibly for the services that are of value, and it really is where Barry, and I think all of us, really want to go.

ELLIOTT FISHER, M.D., M.P.H.: I really do want to emphasize for the audience in general that it's very important to distinguish the notion of the price of a specific service from the volume of services that are provided in different regions. Our data would be consistent with what Sam just said that as you lower the price of a specific service, if the physicians in that community need to maintain their incomes, as they do, they will find other ways to maintain their incomes, whether it's by adopting new high technology or new services. So that I think both Sam's and Barry's points about moving toward measures that focus on the longitudinal use of services over time, and the care provided the volume, as much as the price, will allow us to shift from the narrow focus on the price of a specific service to a cost of episodes of care where you can start to reward on improved quality and improved efficiency.

The IOM committee, on which I participated and had a performance measures report, called strongly for a focus on longitudinal measurement and shared accountability for

exactly this reason. That is the focus on discrete treatments distorts the care that patients receive, rewards the fragmentation, leads to the kind of multiple care transitions that are the cause of the errors that are happening in the current system.

ED HOWARD: Can I just ask Elliott or any of the panelists, how close are you to be able to hem to the ways and means and commerce and finance committee members, the information, the analysis, the tools they need to turn the reimbursement schemes around so that you can get to that?

ELLIOTT FISHER, M.D., M.P.H.: Well, these are the [inaudible] on performance measurement and improvement programs has its third report scheduled for release in a couple of weeks. At that point, the report will go to CMS first and to the members who solicited the report with very strong recommendations about a path forward in this very difficult area. So I think there will be guidance coming, but I can’t speak about it now.

BARRY STRAUBE, M.D.: We at CMS, again, have been working for the last year and a half on a variety of pay for performance plans, if you will. They are not fully completed yet, but I think they look at what Congress has done historically, namely asking first for providers to report quality information and pricing information, which in fact

has been something we still don't have. So if you look at the hospital setting, Congress enacted an MMA a .4-percent addition to the annual payment update that hospitals receive should they provide 10 quality measures to CMS that we publicly report on all the hospitals in the country, and that was increased to 2-percent under the Deficit Reduction Act. I would envision that that's going to happen in the physician setting and in other provider settings as we go forward, and the logical next step for all of the above is to switch to a pay for performance mode. I think it's not – we are charged under the Deficit Reduction Act, we present into Congress by January 1, 2008, a value based purchasing scheme or design for hospitals and home health agencies. We know we have to come up with a presentation to Congress for those two different types. I think it's really going to depend on the political will of both parties, this session and after the elections in the next session in terms of how rapidly they feel this is an issue we should progress to.

ED HOWARD: Yes sir, go ahead.

BRETT COCKLIN: Hi, I have a question for Elliott.

ED HOWARD: You are?

BRETT COCKLIN: Oh, my name is Brett Cocklin and I write insidehealthpolicy.com, Inside CMS. The question is what do you think of the design of the current Physician

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Group Practice demonstration project of which, I think, Dartmouth Hitchcock, is a member. And talk about the challenges that have to do with risk adjustment, attribution of services and the idea of how you're going to deal with patients who, despite the best efforts of the physicians or caregiver, don't follow a treatment of care, which I think are all challenges to pay for performance.

ELLIOTT FISHER, M.D., M.P.H.: Those are great questions. Luckily, I don't represent Dartmouth Hitchcock and so therefore, neither responsible for the PGP demo up there, or for the high rates of MRI imaging that Sam kindly presented this morning. But I think that the Physician Group Practice demonstration is actually a wonderful model of how we're going to start to learn how to improve the care for patients in the Medicare program. For those of you who may not be aware of the Physician Group Practice demonstration program and it's structure, it basically identifies 10 groups around the country where there are large physician groups of integrated, specialist and primary care physicians, for whom it is possible using the Medicare claims data to identify the populations they are predominately responsible for. For whom it is possible to attribute to the group, a population of Medicare beneficiaries. Those beneficiaries are then followed over time, and if the group practices improve the

care of their of the populations that have been empirically assigned to them, on a number of quality measures, they then become eligible for capturing additional revenues from savings that they achieve as well. So that if the growth in spending within the patients cared for by the system is not as great as projected or compared to some controls, the systems can capture some of those savings.

I think it's a tremendously promising model, and if you think about the difficulty attributing individual patients to individual physicians, when most Medicare patients see five physicians in a given year, the challenges of attribution to individual physicians is much, much more difficult then the attribution of groups. So I think it's a promising model. It has tremendous potential. It is difficult around the edges. Certainly the doctors at Dartmouth Hitchcock do not feel particularly comfortable being held responsible for patients that assigned to them, who were cared for by other practices and who don't spend much time at Dartmouth. But they are judged on their average performance. They know who those patients are and they can actually reach out to those other providers to help them improve their performance. So I think it puts in place a set of incentives that are nicely aligned with improving the performance and care for Medicare beneficiaries and is a

model that I'm sure CMS is going to evaluate carefully, and offers real potential to improve the care. I'm quite excited about the model. I think the new demonstration that is proposed that puts hospitals together with their physician groups, to think about aligning care for collaboration and better outcomes for hospitalized patients is a similar, very wise approach to addressing this very difficult problem.

SAM NUSSBAUM, M.D.: I think whenever we look at new payment models we want to be innovative and bold, and with those models will come lots of unattended consequences. We just need to be mindful of those. I think for example, those surgeons who might serve safety net populations, who may see because of their own skills, patients with more complex illness, need to be accounted for. So rather than not take these steps, I think the right thing is taking place, and applaud Barry for that, but then to assess them and see where we need to refine the measurement or the model, whether it be risk adjustment, whether it be outliers or whether to recognize that we want to be sure that physicians are caring for complex [inaudible] patients.

BARRY STRAUBE, M.D.: Yes, just to add to that too. One, I have a bias as a physician that is probably a minority opinion, but it is somewhat facile to sometimes knee jerkily go and say that the patient is non compliant, and didn't

follow the advice that I gave that patient. To me, I was taught in medical school, and took it as a badge of honor, that part of my job was to try to motivate and stimulate, and influence to do a better job of following my advice, so that in some instances, not all, the problem there again, is on the provider side. They haven't done a good job of educating the patient as to the importance of the treatment that they should be doing, and perhaps of having follow up to make sure that they do adhere to treatment as much as possible.

Now having said that, clearly human behavior dictates that in many, many instances, in spite of all the best efforts, people don't comply with medical advice, and I think that there are a number of ways that both in the private and public sector, of people trying to incent that. Again, the White House and the administration, as part of their transparency initiative, are clearly promoting the use of high deductible health plans, consumer driven health plans, if you will, where premiums are very, very low for health insurance, very, very high deductible, and for the first several thousand, $5,000 or more the onnes is put on by the patient to pay out of pocket for those. The thinking is that patients will not only choose health care providers efficiently, but they will follow up with their medical care

to avoid complications that would cause them more out of pocket money.

There are a variety of other things that we've been talking about internally; again, we have to revise the statute, where you can incent patients. I know in the private sector again, in PPO settings there are several innovative programs where people are reducing co-payments for instance, for patients if they do seek certain kinds of services. In fact, Congress voted in several preventive care services in the Medicare program, where the co-payment is waived, and is trying to encourage patients to do it. So there are monetary or other rewards that sometimes can be potentially given to beneficiaries also. Ultimately, I suppose the final thing is just to, in addition to patient rights, there are patient responsibilities, and I think we all are talking more and more about educating patients on the fact that they need to be responsible for playing in their health care. Again, some of our demonstrations are focused on that particularly topic.

ED HOWARD: Sam, innovation in the private sector?

SAM NUSSBAUM, M.D.: Yes, I think we really would like emphasize creativity of program and product design. For example, in our luminous HSA product, we actually put money into a member's health savings account if they follow a

health risk assessment, they get several hundred dollars. If they then go through a coaching program, where they're expanding their knowledge of their illness, if they have a chronic disease, they get additional money. And when they graduate, they get money. So we're talking about $500 that we're adding to their HSA. In addition, we have programs that if you take medications for again, significant illness, we make those, if they're generic and as good as the branded, we make them available for free for four to six months, to again, have compliance and persistency, but also to show that you can get more affordable medications. More and more of those initiatives are emerging in the private sector and as you heard, in the public sector.

ED HOWARD: I want to forewarn you, we have time for a few more questions and I just want to make sure that you remember that your rights and responsibilities as audience members include filling out your blue evaluation forms, which I would urge you to do.

SAM NUSSBAUM, M.D.: Is there a financial incentive for that too?

ED HOWARD: We're working on that. We actually have a couple of other consumer oriented questions that would like the panel to grapple with that people have sent forward. Have either the Dartmouth Atlas Project or CMS given thought

to real consumer friendly technologies, animated flash videos for example, or simple public announcements to get the word out about this important information to the general public who don't go to websites?

ELLIOTT FISHER, M.D., M.P.H.: The Dartmouth Atlas Project is actually, with substantial help from the Robert Wood Johnson Foundation, thinking very seriously about how best to improve its communication strategy. Primarily focused on improving the website, but I think there is also – but you did get us, exactly. Good question, Ed, and good question whoever asked it. So we are working with to try to figure out what's the best way to get this information passed the various barriers we have to the public. We're talking with a couple of potential folks to join us at Dartmouth to try to think more clearly about our communication strategy, and to reach out. It's clearly a very important question. We have not done well enough.

BARRY STRAUBE, M.D.: That's an excellent point, I think that's raised. We're doing a variety of things, but still not enough. One aspect is in addition to our website which I think has a wealth of information and will grow as time goes on, we do have the 1-800-MEDICARE number, where any beneficiary or family member or interested party, looking out for a beneficiary can actually call 24 hours a day, seven

days a week, 365 days a year, and ask any question that may pertain to that patient. So if it's trying to get information that would be on our website, the operators can in fact, relay that information via the 1-800 toll free call.

We also have a system of our regional offices. We have 10 regional offices that do community outreach on a regular basis, promoting this and other aspects of the Medicare program and the Medicaid programs. We work with collaboration with a whole variety of community based organizations. The most notable one, although I've never heard of it until I came to work for CMS, are the SHIPS, it stands for the State Health Insurance Assistance Programs. These are programs in each state that have volunteers, usually Medicare beneficiaries who counsel people who come to these SHIPS and ask for advice, and that could include the kind of information we're talking today. But I think having said all of that, this is a real challenge. There is a growing number of our beneficiaries who do use websites. My mother and mother-in-law use them very nicely, but there are a lot of people who don't, so I think we have to put our thinking caps on.

ED HOWARD: Presumably including some of those folks with dementia that we were talking about earlier as well.

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SAM NUSSBAUM, M.D.: I think also, Ed, just to emphasize that people respond to information in different ways, and while we focused on the web, I think the idea of disease management, care management, care navigation, that very personal guidance that we hope to provide to 10 to 15-percent of our members as we expand those programs is useful. Then also, we commercial payors and Medicare provide this explanation of a benefit after services is used, I think that that is really one of the best ways to get information. I shared some of what we can do, and I'd just ask us all to look at ways that we can turn what is an almost uninterpretable statement, that often leads to more questions and to something that is meaningful and can advance care to health improvement statement.

ED HOWARD: Barry.

BARRY STRAUBE, M.D.: Yes, you know one interesting thought in this regard, this came up, we've been investigating, I'm a nephrologist as you heard, and a transplant physician by training. And the transplant programs in the United States have recently come under scrutiny, particularly in California by the Los Angeles Times because of some centers that have very low volumes of transplants below what our Medicare criteria are and some outcomes that are below what our criteria are. We're in the

process of writing a final rule for transplant centers that should be coming out in about three or four months. One of the things as we're debating the final rule has to do with how do you get information about outcomes and potentially cost to patients who are coming, in this case, to a transplant center for referral. One of the ways we can do that is to require through conditions of participation that when a patient is referred to a specialized center or to any provider, that some of this information, which typically hasn't been part of a medical office visit, ought to be shared with consumers. If you go to your stock broker, or you go to your financial advisor and they say, "Oh, I think you should invest in this stock," most of us would say, "Well, why are you saying that? Tell me more." As opposed to, "Where do you think I should go for my transplant," and you're told and you just go. So I think at the provider level, people will overtime start questioning providers as we look at individual provider quality and outcomes, and cost information, people will be questioning their providers as to why are you sending me to that hospital. Why are you sending me to that physician? I think that's a way of communicating some of this information.

ED HOWARD: Nancy?

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NANCY CHOCKLEY: I'd like to go back to the question that I started out with, which is, are we close to being at a tipping point in this quality discussion. I think we're much better at articulating the problem than we are at articulating all the solutions to it. There is tremendous activity at CMS, in the private sector. There are great researchers thinking about this. There is the Campaign to Save 100,000 Lives. We've got HIT coming on. There's lots of things that are happening, but are we really talking about small movements around the margins still? Or do you see something coming together that we're really going to break through and really improve the quality of care in this country?

ELLIOTT FISHER, M.D., M.P.H.: Maybe if we go this way Barry gets the last word, but I'm happy to weigh in. Certainly my experience on the IOM Committee makes me think that we're getting close. That is that we've learned – I've looked at the progress of my career and the progress of improvement of the health care system over the last 25 years, and it's clear I've had no impact whatsoever, on anything. Health care costs have gone up. Errors seem just as bad. Access to care has gotten worse. But when I said that, told that to some friends and colleagues, they said no, look at where we are. I think the key place that we've made

tremendous progress is in both understanding the underlying causes of our problems and in the capacity of performance measurement to be put in place comprehensively right now, that would really drive us to be able to make wise choices about what providers we use and to reform the payment system. So I think we could be close, and I think it's enabled by the capacity we have for performance measurement which will then allow us to change the payment system to really reward better outcomes rather than just more care.

SAM NUSSBAUM, M.D.: Nancy, I'm very optimistic. And I'm optimistic because it's the perfect, not storm, but confluence of health information technology, of agreement on quality measurement, on physicians recognizing that life long learning is now a very vital component of their practice. I think we're seeing a changing demographic of health providers. I believe that a lot of the collaborative projects that you've heard about from demonstration to AQA, to private sector ideas are being expanded. I think that as all of these become toward fruition, and become real, we're going to see a synergistic effect of one upon the other, because what each of us does, while it needs to be more highly coordinated, there is a halo effect, that hospital quality data, that we're rewarding hospitals on, and remember when you're talking about a hospital that we're paying four,

500 million a year, and put in four, five-percent, that's $20 million. We are looking at performance, not just for WellPoint, or Anthem Net members, it's their Medicaid and Medicare beneficiaries, it's all commercial. So we're asking them to report and improve on care for all members. And as others do that, I think that we will get better. I think that the Premiere Project, I think in California, those of you who are familiar with IHA, where all the physician groups and insurers have gotten together and said we're going to measure these quality elements and reward you on it, have really shown impact. So I'm encouraged. I believe the transparency, if done right and in a meaningful way, can now engage the consumer in a manner that he or she has not been engaged before.

BARRY STRAUBE, M.D.: Well last maybe, but probably not, and Elliott, is you think you haven't influenced anything; you've influenced me, so.

ELLIOTT FISHER, M.D., M.P.H.: You guys are too nice.

BARRY STRAUBE, M.D.: Nancy, I think if we're not that close to the tipping point, we may in fact just be over the tipping point. I think we're there because even though some could say they're waiting for Congress to enact major payment reform, I think Congress has already sent a message. Congress is saying we won't keep upping payment for various

provider settings indefinitely. We won't correct physician sustainable growth rate formulas etc., until we see some evidence that CMS, the provider communities, health care stake holders are serious about collecting data on quality. Reporting data on quality and doing something to improve it. So there is this tension that is there now, and it's inevitably going to, I think it's already pushed things where we are going to keep going in that direction. I think this is accentuated by the employer community, and Sam will feel this more than I do, which is just Secretary Levit, likes to use the phrase, the employer community, there hair is on fire whenever he talks to them. And it's critical, when you have a company like General Motors or some of the other big auto makers, or many other companies where health care is such a huge proportion, and it's only going to grow as the retired workforce that they've promised pension funds and health care funds in perpetuity until they die, to, they cannot afford to do this. And as Medicare, the trust fund becomes threatened, the workforce has fewer people supporting the Medicare population and all the various factors, we have to do something about this. I think we're beyond the tipping point perhaps.

ED HOWARD: Herb Stein, the former Chairman of the Economic Advisories once said, "Things that are impossible,

tend not to happen." So it reinforces your view of the trend. And I would say to Elliott, that his encomiums from his fellow panelist are shared by at least this moderator. Senator Rockefeller points out that after 15 years of concentrating on reducing the number of uninsured people and holding down costs in the United States, the Alliance is looking at 50-percent increases in the number of uninsured and costs that are heading to a quarter of our GDP, so maybe we ought to make this the last Alliance briefing.

If it can be a very brief question, you can ask it.

CAROL MCGOTHWYN: Yes.

ED HOWARD: And you are?

CAROL MCGOTHWYN: Carol McGothwyn with the Institute for Public Research. You guys are cheering me up. Thank you. I did want to ask Dr. Straube, CMS funded some preliminary work on testing quality related measures of efficiency and one of the preliminary findings with a very disintegrated data base, was lack of coordination of care led to poor outcomes and high costs. Is there any thread going forward to move that along with some of the other initiatives that are going on?

BARRY STRAUBE, M.D.: Yes, I had some slides, but not enough time to go into that today, but it's a good question. We've been formally over the last six to eight to nine months

been looking at a variety of the grouper systems that are commercially available, first of all, out there to try to see if we can adapt them and use them in the Medicare system. That analysis isn't complete yet and we're going to be looking at a whole variety of groups and as I said, I'm a fan of Winberg and Elliott. So looking at their longitudinal resource use, which is a bit different in my mind, it's something that we want to look at also. We've been looking also at providing some – we believe that we can come up with physician's level measures of care that could be reported that may be meaningful. We're clearly convinced at the group level we can, and we've been looking at reports to physicians of resource use. Many of the health plans have been doing this for some period of time. We've tired it on the Medicare system. So far the results of that have not been real great. There is a lot of skepticism on the quality of the data; people don't use it unless it's linked to reimbursement for some way. So we're also looking at a variety of reports that we could use back to patients so, I guess my answer to your question is we're looking at efficiency reports, and we're looking at episode groupers and all sorts of other things. We're doing these pilot projects that I mentioned to you, which are going to grow and we'll learn a lot from those.

We've got the demonstrations going, but not a ton of information quite yet.

ED HOWARD: So Barry, you got the last word twice. I like that.

Let me just say very quickly, that I want to thank Nancy Chockley and the folks at the National Institute for Health Care Management, and our friends at the Robert Wood Johnson Foundation for making sure that we could do this program. I want to thank you for sitting through some stuff that's not exactly the easiest content to slog through, and especially I want to thank our panel, and ask you help me join in thanking them for a very fine presentation.

[APPLAUSE]

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