

MEDICARE PAYMENT ADVISORY COMMISSION

PUBLIC MEETING

Ronald Reagan Building  
International Trade Center  
Horizon Ballroom  
1300 13th Street, N.W.  
Washington, D.C.

**Friday, December 5, 2003**  
**9:05 a.m.**

COMMISSIONERS PRESENT:

GLENN M. HACKBARTH, Chair  
ROBERT D. REISCHAUER, Ph.D., Vice Chair  
SHEILA P. BURKE  
NANCY-ANN DePARLE  
DAVID F. DURENBERGER  
RALPH W. MULLER  
ALAN R. NELSON, M.D.  
CAROL RAPHAEL  
ALICE ROSENBLATT  
DAVID A. SMITH  
RAY A. STOWERS, D.O.  
NICHOLAS J. WOLTER, M.D.

**AGENDA ITEM:****Quality of care provided to Medicare beneficiaries****-- Karen Milgate, Sharon Cheng, David Glass, Sarah Lowery**

## P R O C E E D I N G S

MR. HACKBARTH: Good morning. Our first topic for this morning is quality of care.

MS. MILGATE: What we're going to do in this session is provide you some data on the quality of care Medicare beneficiaries receive. We're excited about presenting these data for, as a recent article noted, surprisingly little has been written or presented about the quality of care Medicare beneficiaries receive, even though they represent 40 percent of all health care expenditures.

While the data we'll present to you do not provide a comprehensive view of beneficiary quality, they do include information on clinical effectiveness, patient safety, timeliness, and the patient-centeredness of care, which are the four primary dimensions that the IOM has identified as the dimensions of quality.

The data here are primarily on hospitals and ambulatory care so inpatient and ambulatory care. However in the chapter we will be presenting more information than just this information on hospitals and on physicians. For example, we'll be including the QIO data that CMS has collected on clinical effectiveness through the process measures that they collect. And we'll also be hopefully presenting upon the data, we're having some data issues with our ACE-PRO analysis, that looked at the provision of clinically necessary services in the ambulatory setting.

We will also be including in the March chapter on quality, some information on quality and home health agencies, skilled nursing facilities, dialysis facilities, and Medicare+Choice plans.

These data are useful to the Commission for several reasons. First of all, it helps us examine care in specific settings. But I think, as the discussion showed yesterday, there's a lot of interest in how we might go forward and continue to find ways to put in place

incentives in various settings to improve quality. So it also gives us some sense of what settings might be most important to target, as well as the types of quality problems within those settings that would be important for any incentives program to actually focus on.

The third reason that we feel this information is useful to the Commission is that we have in our quality agenda wanting to explore the relationship in various settings between the cost of care and the quality of care to really look if there is a relationship or not or what that relationship looks like. As you may recall, we did that last June in the dialysis facilities and we were hoping to also explore that in home health and SNF for this June report. So this gives us also some indicators that we could use for that project.

So let's go ahead.

First of all, what are the indicators we're going to look at? Before we go any further on what they actually are, I think it's important to note that it really would not be possible to be presenting these data or to be looking at administrative data in this way without the leadership of John Eisenberg and then continued with Carolyn Clancy at the Agency for Health Care Research and Quality. I think it's important to note that all four of these indicator sets were developed by AHRQ over a period of several years and they have now become very useful for applying them to the Medicare program.

The first three data sets provide information on mortality by condition and procedure, patient safety, and potentially avoidable admissions. They were designed to run on administrative data, first of all by AHRQ to run on their dataset, which is the Health Care Cost and Utilization Project data, which is hospital discharge data that's reported to the states. I think they have about 30 states in their database now.

But the folks that developed these sets were also instructed to make sure that the indicators were able to run on any type of administrative dataset, so that it would be possible for people like ourselves to take this and also run it on Medicare claims. Which is what we did.

The claims that we ran them on was the MedPAR file, which is the hospital discharge file. We ran it on 100 percent of all claims in the hospital file because many of the patient safety indicators are very small. There's a very small rate and so it was really important for us to be able to actually get a larger sample for those. So we ran everything that we did then on the 100 percent if MedPAR.

We did exclude some of the indicators that were not relevant to Medicare, such as those that applied to pediatric care. And then a very few of them we found when we ran the data had very low occurrence. And so we don't present the data for those here. So those are the difference between what we did and what AHRQ did, in terms of the actual indicators we included.

I also wanted to note, particularly on the first two, the mortality and the patient safety indicators, that these are, of course, a different data source than you'll find in the QIO data. The QIO data are based on medical record abstractions. So usually you have smaller samples, they're harder to collect. But as Nick points out, in fact, possibly provide a little bit more direct information to hospitals on what they might do to actually improve on those indicators. But they are somewhat different and I just want people to keep that in mind as we go through our discussion as what you might do with these indicators and these data that we have.

MR. DURENBERGER: [off microphone.] Karen, could you explain that, the importance of that?

MS. MILGATE: The importance of the distinction, I guess, is I assume people will use some of these indicators to say well, hospitals should maybe report this or would we base an incentives initiative on these data or that data. And I just want it to be clear that the data that we ran, basically you can collect separate from requiring the hospital to do anything, because it's simply a part of their claims process to get paid, that they report information that is coded in the ICD codes.

And then what AHRQ did was take various ways of putting those codes together to say patients that were coded this way should be excluded. And that they develop

their mortality rates. So someone else can actually extract the data, read it, and see how useful it is.

The QIO data is, in some ways, for quality measurement -- I don't know if I want to use the term more precise. But it's things like did you give a beta blocker when you should have, hospital? So they are, in some ways, a step up in that they aren't indicators that a problem could be there. They actually are measures of something that should have happened. So they give the hospital the ability to change something more directly. But they still both measure problems. They're harder to collect because the hospital has to go into the record or somebody and find those things. So it's just much more burdensome but provides probably more precise information.

The fourth set here is a survey which we spoke about at the October meeting and also Cristina talked about in her presentation on physician access yesterday. And that's the CAHPS survey, the Consumer Assessment of Health Plans Survey. This was originally developed by AHRQ for private plans and then revised so that it could then be applied to Medicare+Choice plans, and then revised again so it could be applied to Medicare fee-for-service.

So what this gives us, because it's such a large survey, so it's between 100,000 and 120,000 beneficiaries are surveyed every year, at least they have been for the last three, is some pretty good information on how beneficiaries perceive their access and quality of care. So we presented some information on access at the October meeting, and here we'll be presenting some information from the questions that relate more directly to quality in this meeting.

You see before you the team of folks that have looked at these data. So each of us will report on a particular indicator set. Sharon?

MS. CHENG: The first set of indicators that we have here this morning are for inpatient quality. Inpatient hospitals are certainly an important setting in which to measure quality. They provide about 10 million hospitalizations to Medicare beneficiaries annually.

This set of indicators reflects the quality of inpatient hospital care by measuring the rate of death among beneficiaries in the hospital and 30 days from admission to the hospital. The indicators on the screen here are ordered by the number of in-hospital deaths, which is shown in the last column.

We measured it two ways, in-hospital and 30 day. The in-hospital mortality is perhaps more directly attributable to the hospital because it's all within the hospital setting. The 30-day rate could indeed be influenced by the quality of settings that a beneficiary uses after a hospitalization, especially post-acute care providers. But it's also a useful way to look at mortality because it's going to be less affected by the discharge patterns of the hospitals, whether there's a short or long stay for that beneficiary, determining whether they would experience mortality 30 days after the admission in the hospital or whether they were discharged and experienced it outside the hospital.

MR. HACKBARTH: Sharon, could you remind us why these? Why this list of eight, as opposed to some other list of eight?

MS. CHENG: AHRQ chose these particular types of mortality because of the evidence that they could gather for these mortality. They're a little bit of a mix. The top of the list are conditions. The bottom of the list are actual procedures.

For each one of these there was a bulk of evidence that showed that the rate of mortality did vary with some aspect of the hospital. In general, that aspect was volume. Higher volume hospitals with similar patients had a lower rate of mortality. But also, especially for some of the procedures, there was evidence that linked the procedures in the hospital to the rate of mortality for similar patients. I'm going to talk about that a little bit more in the next slide.

MR. HACKBARTH: And these represent what percentage of Medicare admissions?

MS. CHENG: I have to get back to you with the number. They're pretty common admissions so it's a large portion of hospitalizations.

The rates of mortality here are risk adjusted by age, sex, and the severity of the patient's condition using the APR-DRG measure of severity.

In summary, the in-hospital mortality rates improved across the board from 1995 to 2000, which is to say that the rate of mortality dropped for each indicator that we measured. The most substantial improvements occurred for CHF and for GI hemorrhage.

The 30 day mortality also improved for every indicator except two: pneumonia, which was the most common precedent of mortality among those that we measured and for craniotomy.

Patients with the same condition or procedure die outside the hospital more frequently than in the hospital. The greatest difference between the in-hospital rate and the 30 day rate occurred for patients with CHF. There were two exceptions to this pattern, for AAA repair, which is abdominal aortic aneurysm and for CABG.

The trend in these mortality rates from 2000 to 2002 is the same trend as from 1995 to 2002 for in-hospital mortality. However, all but one of the 30 day mortality rates increased from 2000 to 2002, the opposite of the longer-term trend.

As we suggested, they chose these mortality rates because of the evidence that was behind them. In most cases that was volume. In some cases that was a procedure. For example, evidence showed that surgical teams that could reduce the time to cross-clamping the aorta during a CABG procedure reduced the mortality for similar patients. For teams that used an epidural anesthesia instead of a general anesthesia during hip replacements could also reduce mortality among their patients.

So to the extent that mortality indicators reflect the clinical effectiveness of hospitals, we can conclude that quality has risen from 1995 to 2002.

Next, David and Karen will present evidence that while quality in terms of clinical effectiveness appears to be

rising, quality in terms of patient safety or the quality of ambulatory care that could prevent hospitalizations seems to be moving in the opposite direction.

DR. REISCHAUER: Just a clarification, the pneumonia category there, there are just people who have been admitted to a hospital with pneumonia, as opposed to all of the Medicare patients?

MS. CHENG: That's right.

DR. REISCHAUER: So in that case, obviously not for some of the others, you can have changes in behavior for admission for this diagnosis?

MR. HACKBARTH: [off microphone.] Sicker patients are being admitted.

MS. CHENG: Right, although to try to capture some of the effect that a changing population could have, that's why we did try to risk adjust -- we used 2000 as the base year and then we kept the age, sex, and APR-DRG of the patients constant. So to the extent that that was successful, we're seeing a real trend and a change.

MR. GLASS: Now looking at the patient safety indicators we see a different story. This slide shows eight of the 13 patient safety indicators we analyzed for hospitals with Medicare discharges. Again, they're ordered by the number of observed adverse events in 2000.

It shows the change in the risk adjusted rate from 1995 to 2002. The changes in the rate of adverse events per 10,000 eligible discharges, and for each indicator those eligible only include certain discharges that were at risk for the adverse event.

Further, some discharges were excluded to be sure that the complication observed was a result of what happened in the hospital and wasn't present at admission. For example, decubitus ulcers only include stays of over five days and exclude admissions from other institutions for patients with a paralysis. So these, again, were developed by AHRQ and they've tried to isolate what was going on to be what was happening in the hospital.

As you can see, the rate for seven of the eight indicators increased from 1995 to 2002. Overall, nine of the 13 indicators showed increases and four showed



decreases, as the table that is in your mailing materials shows in detail.

The four indicators with decreasing rates include the two resulting in death, failure to rescue which is second there and death and low mortality DRGs, which isn't shown. That occurred about 3000 times. This accords with the decline in mortality, especially in-hospital mortality that Sharon discussed.

So while it's evident the rate for most of these indicators has increased, we cannot say why. Although we've risk adjusted these numbers by age and sex and comorbidities, it is possible that severity has increased for the population considered for each indicator. So we didn't do the APR-DRG risk adjustment on these because that would have interfered with what they were actually trying to look at, which was complications resulting from the primary diagnosis.

Most of the rates are relatively rare events with rates under 100 events in 10,000 discharges. So one way of looking at that is that post-operative sepsis, if you have 7000 events in 2000 and say you look at 3000 hospitals excluding the smaller ones, that's only two or three per hospital if they were evenly distributed. So these are rare events and that might affect how we want to use this going forward.

The pattern of increases and decreases, the same looking at the changes from 2000 to 2002 as it was from 1995 to 2002. So it's not a passing phase.

Now Karen will look at the next set.

MS. MILGATE: What you see in front of you here switches gears a little bit. While it uses hospital discharge data to create these indicators, this is really an indicator of the quality of care, or it is trying to be an indicator of the quality of care of ambulatory care. So this looks at the outcomes of poor ambulatory care by looking at admissions to the hospital that could possibly have been avoided.

These are conditions for which evidence suggests optimal ambulatory care could have prevented, at least in part, some of these admissions.

Now it's important to note that it's really hard to assign accountability for poor ambulatory care because there are so many different factors that affect the type of care that patients get outside of the hospital. This could be due, for example, to access to appropriate ambulatory care. It could be that patients are actually getting into see physicians but then not getting the appropriate care management. As we know, there are also some lifestyle issues with how, for example, weight gain or smoking could affect a patient's admission to a hospital.

In addition, there are two of these, chronic obstructive pulmonary disease and diabetes, that the prevalence has increased over the last few years. So the prevalence increase could also increase these numbers.

Having given those caveats, what we see here is that of the eight that are shown here five of them did increase fairly significantly between 1995 and 2002. The good news we see, however, is the top one, congestive heart failure, which basically was responsible for 703,000 Medicare beneficiaries being admitted to the hospital in 2000 has gone down just slightly. It had a 1.0 decrease over that period of time, perhaps due to a better quality provision of ambulatory care. Some of the new evidence that ace inhibitors and beta blockers are effective at preventing admissions for this type of condition, it looks like at least that patients are getting those types of drugs potentially.

The top five here, just to note, I guess you can read the slide, are congestive heart failure, pneumonia, COPD, urinary infection, and dehydration.

So this indicates that there are some issues with, again, the quality of ambulatory care. And I think it's interesting, I wanted to stop at this point to say something about how what we see here relates to some of the legislative changes. I don't know that the congressional staff were looking at a slide like this, but you can see with their emphasis in the bill on chronic illness management that those are the kinds of programs that could perhaps target some of these conditions, to provide better quality care to patients in the ambulatory setting. For

example, if they targeted diabetes, COPD, and CHF, which are often talked about as the good targets for disease management, rates could go down on these admissions.

MS. RAPHAEL: For these, did these people have an encounter in the ambulatory system?

MS. MILGATE: We don't know. We could probably link some datasets and find out. What we see here are just their admissions, so it's a pretty basic number of what were you admitted for. So we don't know their ambulatory history.

MR. HACKBARTH: So this is the total number of admissions. We're just looking at the total number of admissions for CHF, is it going up or is it going down?

MS. MILGATE: That's right.

MR. HACKBARTH: This is, in any sense, a subset of CHF.

MS. MILGATE: That's right.

MS. BURKE: I actually was tracking similarly to Carol. Given our discussion about home care, as well as ambulatory care generally, is there anyway to track by matching datasets to what extent we've either seen an increase or a decrease in the treatment for these conditions in the obligatory setting? For example, with respect to home care, is there a way to track whether or not we've seen an uptick or relatively stable number of patients with any of these conditions being treated in a home care setting? The obvious ones are things like dehydration, urinary tract infection, as well as the usual pneumonia and so forth.

But it would be interesting to see whether we're seeing a change in behavior in terms of either no care or traditional care, which is less effective, whether the interventions have altered.

MS. MILGATE: I'm not sure about the home health example but there certainly are ways to link, through using the beneficiary ID, folks that had admissions as well as how much care. And possibly, through our ACE-PROs, even look at clinically necessary care.

MS. BURKE: You mean whether these were people that were essentially being transferred out of nursing homes.

It would be interesting to see whether there is a pattern there, in terms of whether they're being treated or not and whether they're essentially coming out of a setting where they should have anticipated these but did not

MS. MILGATE: So we can look at admissions and source of admission, for example. Yes.

MR. HACKBARTH: It may even be --

MS. MILGATE: Well no, I don't know if it's possible by January but certainly is something we could follow up on. And just a note on urinary infection and dehydration, given they are in the top five, it also tells us there may be some important focus there, right?

MS. BURKE: Right. The sourcing of where they came from, I think, could make a critical difference in terms of our understanding of how they're being treated, whether they're being transferred on. And watching these patterns generally, in terms of encounters, where they're coming from.

MR. HACKBARTH: This is also an interesting time period in that it spans some important changes in payment systems for -- it may even be interesting to look at different time periods within this seven year window.

DR. NELSON: That's one set of issues on how to make the data more precise. But there's a more fundamental issuance and that is the use of administrative data which were submitted for a different purpose. They were submitted to get a claim paid. And trying to interpret those data when the reporting is the real issue, not the occurrence of the events. It's whether they were reported or not. And particularly with the patient safety data, extrapolating 95 numbers to now or 2000 and trying to draw any conclusion when, as a matter of fact, one of the impacts of the IOM patient safety report would be to increase the amount of reporting.

I mean what the IOM said is that the first accomplishment will be if we have errors reported. Henry Krakauer got the IOM going on a series of studies in 1990 and whether or not -- how the Medicare claims database could be used to draw some conclusions about quality. Ken Shine chaired those committees. I was on them.

And the bottom line was that most of our recommendations called for the PROs to go to the blood records because that was the only way you could really be certain that you were getting accurate data.

The use of claims data becomes particularly problematic when you're looking at indicators that are largely subjective such as dehydration. Note that the data are much more aligned if you're looking at a clear objective event like amputation. But is a patient dehydrated or not? If it's reported, is the reporting because they may get more payment if they have a comorbidity including dehydration?

I think any of the indicators that are subjective, in terms of A, being identified; and then B, being reported, should be interpreted with more caution.

I'd be reluctant to publish these data at all because of the uncertainty about the accuracy. Even the IOM patient safety studies were challenged and they involved duplicative chart audits.

MS. BURKE: But wouldn't that be more a case -- I mean, I appreciate what you're saying and there are certainly cases where it could be interpreted in different ways. But it would seem to me that presenting conditions, pneumonia, COPD, urinary tract infections, to what extent are there likely to be errors in judgment about whether or not they were present or not? I mean, dehydration is a variable, but I don't know how you would misrepresent whether someone had a presentation of pneumonia.

DR. NELSON: I guess I'd like to have my comment separated in terms of the mortality reports within the hospital, which I think are pretty good, pretty clear cut.

MS. BURKE: Straightforward, right.

DR. NELSON: And the ambulatory indicators, when you don't have any way to go to the chart and verify what was there, and drawing conclusions. Urinary tract infection, what's a urinary tract infection? Is that cystitis, or is that acute pyelonephritis with something really severe?

I guess if we do report this, I'd sure want to have a lot of caveats in there, for the reasons I've said.

DR. REISCHAUER: Can I comments on this, because I think Alan's concerns are particularly relevant if we were using this kind of information to say Utah does a better job then Minnesota or this group of hospital does a better job then that group of hospitals.

But when you're looking across time at the nation as a whole, these inaccuracies exist. There's no question about them. But the real issue is do they vary tremendously from year to year? And when you see a reduction in one of these measures of 49 percent over a five-year period or something like that, I think you can say with pretty good confidence things are getting better.

When you see them about constant, you don't know. But I mean, I think the purpose of this really is to get a broad picture of changes in quality of care for Medicare over the nation and say something sensible about that. I think you're right to look at these numbers and say don't place a bet on the actual number.

DR. NELSON: Let me respond to Bob, because I think this a critical point. And the thing that triggered my response is that we have been saying, yesterday and today, that these data show that quality is getting worse. It may be. I'm a firm believer in the quality chasm. I'm not apologizing for the quality of care out there.

What I'm saying is that it's hazardous to use these data and infer that quality is getting worse because it may be just that the reporting is getting better. That's all I'm saying.

MR. MULLER: Along those themes, part of what puzzles me about this information is that this is a period in which, by and large, admissions per thousand, any kind of numerator, were going down across the board, because there were less admissions per thousand, whether one attributes that to managed care or movement towards outpatient setting, better anesthesia and so forth, but it was a period in which admissions in general were going down. So it's kind of puzzling to me that they would go up on these conditions. That's one point I'd like to have you comment on.

MS. MILGATE: These are rates.

MR. MULLER: But I'm saying the rates were going down. The rates of hospital admissions were going down in this period.

MR. GLASS: These are rates per 10,000 admissions.

DR. REISCHAUER: [off microphone.] But these are rates of an event or incident.

MR. HACKBARTH: Per 10,000 admissions.

MR. MULLER: But if the rates per 10,000 were going down, why would the rates in general --

MR. HACKBARTH: So if it went down at the same rate as admissions in general, it would be a zero. So if it's going down faster than admissions -- isn't it?

DR. REISCHAUER: [off microphone.] No, it wouldn't.

MS. MILGATE: No, it's just how ever many people were admitted, whether it's a higher number or a lower number. It's just a rate of those that were admitted.

DR. REISCHAUER: [off microphone.] The argument we would make is that as admissions go down, the severity of the average admission goes up but they're making some kind of adjustment for that, so we don't necessarily have to worry about that. So I don't think there's a problem.

MR. MULLER: Wait, we're making an age/sex adjustment, right?

MS. MILGATE: These ones? These are age/sex, yes. They're all risk adjusted by different mechanisms so that's why we have to be careful about that.

MR. HACKBARTH: Could I get you, Karen, to respond to the issue that Alan has raised? In particular, his concluding point, which I think was a nice concise summary. These are going up because we're looking at them and encouraging people to identify problems.

MS. MILGATE: Just a couple of points on that. Alan's point, I think, are particularly important when we looked at the patient safety indicators because I think that's where if you were going to think that hospitals were focusing on a problem that was of high public importance, that's where it would come in. I think that's also the area where the fact that we're relying on administrative data may have more import than the other two indicator sets.

A couple of points there. As we discussed the caveats that were necessarily when thinking about using administrative data, one is that I think that Alan's point is very valid if we were talking about any kind of public reported on safety events. I think it would be clear that we would hope and even expect those rates to go up.

I feel like it would be less the case if you're talking about simply looking at data that were presented for payment of claims essentially, that hospitals would then code more of these events simply because there was more focus on it.

On the other hand, I think there are some other issues with what was going on in coding during those years. One is there was a lot of emphasis on enforcement of fraud and abuse statutes, for example. And so one thing we had thought is perhaps coding became more precise and so these events went up. But on the other hand, there was also sort of a backlash against any kind of upcoding. And these are going to be the coding of the more complicated procedures.

So I guess I see there's various forces that would be at play there.

The other thing though to check to make sure that we were the right numbers, we did look at and compare our rates to what AHRQ had pulled together on their HCUP database, which is all payer. And then, in fact, CMS has also run these indicators on a Medicare population, a little bit different analysis but not that much, and found that our were very similar in magnitude.

Now the HCUP was the all payer, so their rates were somewhat lower. But looking at the trends over time, they went the same direction, up and down. And it was the same thing when we looked at the Medicare data. So it made us feel pretty comfortable at least that everyone was measuring the same way.

And in terms of whether we're using administrative data, I guess like we felt like we had some pushes and pulls that led us to feel pretty comfortable with the data.

MR. MULLER: I want to go to my public arithmetic here with Bob, because if the rate of admission goes down, which I think is what happened during this period, the overall



rate went down, and these rates go up, that's kind of puzzling to me, as to why would the overall rate of admission go down and these ambulatory care sorts of admissions go up. So that's why I'm asking it.

If rates are going down of admission, which implies something is going on, whether it's anesthesia or more outpatient care and so forth, yet the rates for these conditions go up, that's a counter movement. So the question is why would you hypothesize they would go up on -

MR. GLASS: This isn't the rate per population. This is the rate per admission. So we're saying the rate of people with CHF --

DR. REISCHAUER: [off microphone.] Who enter the hospital.

MR. GLASS: It's not the number over the general population. It's the number over the number of total hospital admissions.

MR. MULLER: So this is the proportion of hospital admissions to which -- okay. That's why I want to do math in public.

MS. MILGATE: It does appeared though that these are perhaps a larger percentage of the admissions, even though the admissions have gone down.

MR. MULLER: That's what's puzzling to me because you just said we're not tying this to any ambulatory dataset. So it's just --

MS. MILGATE: Hospital admissions, number of. It's pretty basic, in terms of that. Yes.

MR. MULLER: What's puzzling to me is it's a period in which even prior to the IOM report that Alan referenced, looking at these kind of quality indicators goes back 10 or 12 years and the Joint Commission started pushing this in the late '80s or early '90s.

So to hypothesize at a time when people were pushing more to improve quality of care and unevenly, as certainly the IOM reported indicated, and as Alan said. Nobody wants to be an apologist for what the level of care is. But it's puzzling to me at a time when people are focusing on improving care, that the rate of poorer care would go up.

It's counterintuitive. So in some sense, the more you push for quality, the worse the outcome?

MS. BURKE: But Ralph, let's think individually. Pneumonia could well have been flu. You could see, over the less couple of years, an uptick -- I mean, it would depend on what kind of pneumonia it was. In the case of UTIs or dehydration, it could well be the treatment they were getting in a nursing home. These may not be the fault of a hospital. These may be presented in a hospital setting because of the absence of sufficient care in advance of the admission.

So these are potentially avoidable. It doesn't mean that the hospital has given poor care. It may be that the poor care occurred before they ever got to the hospital.

MR. MULLER: I understand that and I think they qualified that fairly well. My point is it would be surprising to me to say that the health system in general was having more admissions for avoidable conditions at a time they were trying to focus very imperfectly --

MS. BURKE: [off microphone.] The focus was more on the hospital side than it was on the nursing home.

MS. MILGATE: We did see the decrease in mortality. The news is not all bad. I think there was some focus from hospitals and physicians that led to that decrease. It may be that that's an easier problem to focus on. I don't know. But we did see some improvement. And the QIO indicators, as well, the process measures that they look at, did improvement. They improved on 20 out of 22 of them, as David reported. So it's not all a bad news story.

MR. HACKBARTH: And CHF and asthma certainly were two areas of major focus for the ambulatory and they both got better.

DR. NELSON: This list of potentially avoidable admissions, it makes a darn good case for not reducing payments for home care and long-term care for those who subscribe to that theory, that a lot of these -- these are the conditions of people who have run out of gas.

MS. BURKE: [off microphone.] That's my point is trying to understand where the admission is coming from.

You can track it back to an ambulatory setting or to an inpatient skilled nursing facility.

MS. MILGATE: Should we move on?

MR. HACKBARTH: Yes.

MS. MILGATE: We have one last indicator set to present information on. Sarah will present that.

MS. LOWERY: Now we'll look at CAHPS data for Medicare fee-for-service beneficiaries in years 2000 through 2002. As you can see, overall beneficiaries highly rate the health care they've received and the quality of their interactions with their doctors and health care providers. On a scale of one to 10, 10 being the highest, over 80 percent of beneficiaries gave a rating of eight or higher to their personal doctor or nurse, the specialist that they saw most often in the last six months, and all the health care they had gotten in the last six months.

They also highly rate the quality of interactions with their doctor or other health care provider. For example, between 93 and 95 percent of beneficiaries reported that their doctors or other health care providers usually or always listen carefully to them, explain things in a way that they could understand, and showed respect for what they had to say.

Beneficiaries seem slightly less satisfied with the amount of time spent with them, but still over 90 percent are satisfied with this aspect of their health care.

In contrast to these results, we see mixed outcomes when looking at beneficiaries' preventive care and habits. A consistently low percentage of beneficiaries received a flu shot in any of the three years or had ever received a pneumonia shot.

However, data on smoking improved over the three years, as you can see. The number of beneficiaries that had been advised to quit smoking by their doctor or other health care provider on at least one visit in the last six months rose substantially over the three years.

As you will note in lines four and five, data was not available in a couple of 12 years. This essentially means that the questions asked in all three years are not simply comparable. For example, the question of whether

beneficiaries smoked was asked of all beneficiaries in 2000, resulting in a smaller number of smokers than in 2000 and 2001, when the question was just asked of those beneficiaries who had smoked at least 100 cigarettes during their life.

Finally, of the beneficiaries who were physically able to exercise, this is about 83 percent of beneficiaries since over 16 percent cannot exercise due to their health. So of the 83 percent of beneficiaries who can physically exercise, about half exercise for more than 20 minutes at least three times a week.

MS. MILGATE: So what we see here, in summary, is that some indicators are proving, others are worsening. We saw that mortality is improving. It's decreasing as a rate for inpatient mortality, both inpatient measured in the hospital as well as 30 days from admission. We do see, although, some increase in adverse events in inpatient care and some increase in potentially avoidable admissions.

However, beneficiaries are very satisfied with the quality of care they are receiving.

These data provide useful informational on the quality of inpatient ambulatory care and perhaps suggest some ways that we might be able to think about targeting incentives in the Medicare program. I think we had a pretty good discussion on what we might be able to look at in the ambulatory setting, but it also seems to suggest that for hospitals it might be important to look more closely at patient safety in addition to the type of information that can gathered from the current quality inpatient reporting initiative.

At this time, we'd be interested in your comments, in addition to what you've already commented on the data, and questions about the data, as well as what you think these data tell us about Commission work on quality.

MS. ROSENBLATT: I think this is a very good introduction to this whole subject and it's nice to finally have some numbers connected with it.

I have one question on the stuff from the CAHPS survey. Is there a way to compare the members that we're getting on the Medicare beneficiaries with an under-65

population? This isn't very scientific, but my experience in talking to people over 65 is that they're much more willing to view the physician as godlike and it would seem to me that you'd tend to get higher ratings from those over 65 data than under 65. That's just my own personal opinion.

MS. MILGATE: On these actual questions, I don't know. I've ever seen a survey that has this much detailed questioning of those under 65. There is the National Health Interview Survey which does interview all ages and we do see on that survey consistently that Medicare beneficiaries report much fewer access problems, at least.

I'm not aware of a dataset that goes into this much detail on quality.

MS. THOMAS: Joe was just telling me that AHRQ put a warehouse together of private plan members reports on their experiences. So we could definitely take a look at that.

MS. MILGATE: I'm sorry, it was developed for private sector, excuse me. That's true, we could look at that.

MR. HACKBARTH: At Harvard Community Health Plan that was our experience and we had sort of a controlled system so we could look at seniors and younger people in the same clinic, seeing the same physician staff, experiencing the same system of care, and the seniors are consistently rated higher.

DR. REISCHAUER: It strikes me that this is an important issue to gather information on. It is conceivable that younger people don't get as good service, but it's also conceivable that their view of authority figures is different. And so what we're going to see over the next 30 years is more skeptical people coming into Medicare and these ratings going down. And you don't want to get all worked up thinking that something is changing when it isn't changing.

MS. ROSENBLATT: It's also the issue, Bob, I'm hearing from a lot of physicians that the younger patients come in with Internet data and lots of questions and the over-65 population, particularly those over 85, are not doing that.

MR. SMITH: As a close cousin of love Durenberger, hate the Senate, I'd be very careful with 93 percent

satisfaction rates drawing much of a conclusion from that. It's better than 50, but I wouldn't walk out very far on the road with the CAHPS data.

MS. DePARLE: I was just going to say, I know that we did, even three or four years ago, have this kind of ability to compare with some private plan datasets and the phenomenon you're mentioning did seem to be there.

In addition, what I remember was that on at least one of them we had the ability to parse between 65 to 70 and then 80 to 90. And the older you get, the more appreciative -- I'm speculating, but it seemed the happier you were and perhaps the more appreciative you are of what you're getting or, as you put it, respectful of authority figures, whoever said that.

DR. REISCHAUER: Or maybe those that are satisfied get better treatment so they stay alive.

MS. DePARLE: There is some recent data on that actually, that the more satisfied your are the longer you live, the happiness. So hey, I'm there.

MS. BURKE: Two questions. One, are you able to separate out the satisfaction with physicians as compared to nurses?

MS. MILGATE: They actually asked that question together because they ask if you have a personal or nurse, and then they don't -- actually, they probably could because they do say whether they have a doctor or a nurse.

It's a small percentage that say nurse as their primary, but yes, I think we could probably separate that out.

MS. BURKE: And the second question, and that this may only be true of pediatrics and I suspect Nancy-Ann has experienced this, as have I. Routinely now, in the series of questions -- and what struck me was the questions about smoking and habits.

In the series of questions that are now asked of parents with young children is a question of whether there is a gun in the home. And this is something that is increasing being tracked.

I wondered whether -- I mean, it may be an age issue because of the incidence of gunshots in the younger

population, but it's actually seen as a preventive issue and intervention. And I wondered whether that was being tracked with an older population or not. It may not be because it may not matter as dramatically, but it is now present in every interview with every pediatrician that I've had any experience with in the last couple of years.

I didn't know whether this was true for adults, but it may not be.

MS. MILGATE: Not that I know of, but I haven't asked the question.

MS. BURKE: It may not be. I suspect it's more peds.

MS. DePARLE: We would have been afraid to ask that kind of question, for reasons you can imagine. Because I know on OASIS one of the criticisms was -- Carol will remember this -- we asked about -- and I went through every question after all the controversy over this -- whether there was another person in the home, which is relevant, you clinicians will understand that, for whether there's another caregiver around. That makes a difference in their status.

But some people thought we were trying to find --

MS. BURKE: Find out what their personal lives were.

MS. DePARLE: Yes, you have to be careful about that.

DR. NELSON: I think this obviously is an important subject for a chapter. And I think that it ought to include our findings from the administrative database properly qualified.

But I think also it ought to include information, if we're trying to set the stage to draw some conclusions for longitudinal assessment of quality, quality assessment over time, then it should include also the findings from the Joint Commission and what they are determining based on their requirements for accreditation.

And with particular emphasis on whether things are stable, getting better, or getting worse, where the accomplishments are, where there appears to be areas that still represent substantial deviations from expected quality. Then we can consider this in the context of our job in terms of payment recommendations.

But I would think probably NCQA ought to be referenced as well, so that we have a much broader set of data to hang our hat on than just what we've been able to glean from the administrative datasets. And the PROs, obviously the QIOs.

DR. WOLTER: Similarly, I was just going to say, along the same lines, I actually think this is quite excellent. And with the caveats that have been brought up, I think it will be quite a contribution to put this together along with some of the other things you mentioned that will be coming forward, the QIO, JCH, some of those other things, because we're still at the beginning of something here.

And as we look at this data, the obviously occurs, which is people ask questions. And then they ask questions about how to make the data better. And then that leads to how do we create change? So this will be a great contribution, I think, for MedPAC if we put this information together in one place as others outside of health care begin to look at it.

One specific question. Can we cut this by Medicare+Choice fee-for-service and look at those populations separately?

MS. MILGATE: The only one -- we could do the CAHPS that way.

DR. WOLTER: I meant more specifically.

MS. MILGATE: We don't have claims, unfortunately. I guess the comparisons that possibly could be made would be not on these data but looking at some of the fee-for-service rates from the QIO program and some similar measures on HEDIS. So it might be possible to look at those and compare those.

DR. WOLTER: It would be nice to think going forward about how we might try to do that, since if we're going to put any quality incentives in place for plans, we might want to have some way to look at that vis-a-vis the things that are being done in the fee-for-service sectors, so there might be some comparability. That might have to be designed going forward.

MS. ROSENBLATT: On that issue, wouldn't we have inpatient data from PIP-DCG stuff, and we could at least look at those unavoidable admissions things?



MR. GLASS: I don't know if you have complete claims data. It's abbreviated.

MS. THOMAS: We can certainly investigate it. You certainly wouldn't have the time trend over those seven years, but we could certainly explore that data.

MS. ROSENBLATT: Part of it. When did the PIP-DCG go in, Scott?

MS. THOMAS: There was a run up to -- we can explore it.

MR. HACKBARTH: Good idea. We'll see what we can do.

MS. RAPHAEL: I just was curious if you have any hypotheses. I was struck by your last chart on preventive care. We do flu vaccines in our region and actually the rate of flu vaccines for minority populations is in the 30 percent. We've been trying to get that up. But that hasn't moved and the pneumonia vaccine has moved minimally. And yet we saw an increase in admissions for pneumonia.

And I'm wondering if you have any hypothesis about why we have not been able to change that.

MS. MILGATE: I'd digging back into memories with talking to QIOs about how difficult it is to get pneumonia shot rates up. I don't know, Alan might be better than answering that than I. I don't know. The flu vaccine rate has gone up some, although you see these data here, not on the screen currently. But the CAHPS data don't show it going up as much as the QIO data. So that was kind of curious to me.

It may be because beneficiaries are not -- I don't know, you'd think they'd be aware. I don't know. I should just say I don't really know the reason. Alan, do you have any ideas about that?

DR. NELSON: I'd have to ask what's happened to the payment rate and whether the is adequate. I don't know the answer to that. In the past it was said not to be but I don't know how much it's been improved.

MS. MILGATE: And I know that in the QIO program they had issues because their primary focus was on hospitals and then, of course, there's some reticence to give these types of vaccines within the hospital setting but other than that

I don't really know. And I don't know what the payment rates are, either.

DR. NELSON: I think they were -- and I should know, but I've forgotten. Last year it cost the physician money for every flu shot they gave. And you can't make that up in bulk volume. I think, as with so many of these preventive services, if you want to have good counseling you have to pay for good counseling. If you want immunizations and preventive services, you can only rely on good intentions up to a certain point. And if they're losing money with it, it's not going to meet the standard we'd like.

MR. DURENBERGER: This is probably not so much a clarification as for the final chapter, because I came early and got answers to a bunch of my questions. One of them is the question is what else can be measured by administrative data that we may not have already measured and/or this indication it is impossible to measure adverse events that may have been due to medication errors using administrative data.

There's a whole area, it seems -- and I think about the Wall Street Journal article of a week ago as one example. I think about the fact that hospitals get paid to make mistakes and they get paid again several times to correct it, if it takes a couple of times to do it.

There's probably a whole body, both in the area of safety and of quality, that can't be accurately measured on administrative data. And it would be helpful if we would not try to answer the question as much as clarify the potential for problems that could exist in this area because they've been reported anecdotally or they're reported in some other context so that the larger picture is demonstrated.

And then I think my second observation is relative to the way in which we present the CAHPS information because I read it to say that people think they're getting good quality after we've told them it's not all that great, in effect. And so if it's perception, then I think we ought to highlight perception. That people's perception of quality is sort of a relational perception.

I can always see my doctor. I have confidence in my nurse, or in whatever it is. As opposed to something else because it is not the perception that I experience in my work in Minnesota. The folks with whom I work do not find the system that satisfactory.

So it's clarifying why we're using that survey data in this chapter that I think is important.

MR. HACKBARTH: I think there's also evidence to support the fact that people do distinguish between their doctor and the system. They'll say I like my physician, I have a good relationship. But then if you ask them about the system as a whole, they'll say it stinks. I don't think the two are necessarily inconsistent.

Ray, and then we need to move ahead.

DR. STOWERS: I'm just going to make a comment on that QIO. Dale Brassard just wrote some recent articles, too, on the distribution of the vaccines. And he's saying that the percentage out there seems to be consistent with the percentage of the patients that are making it through the physician's offices. So that they're not doing that bad of immunizing.

So they're saying that we need to broaden the distribution system. So whether it be the health departments or the pharmacies or of the grocery stores or whatever, we've just got to get more exposure to the beneficiaries out there as a place that they can get them while they're out there. Home health care, nursing homes, that kind of thing, that maybe we're limiting the sites where they're giving them more than anything.

DR. NELSON: To end up with sort of the good news finding of the meeting. Last meeting, Jack Rowe pointed out it was the marked reduction in admission for stroke, was really the sort of good news surprise.

This one, my good news surprise was the reduction of smoking on the last page where it dropped from 24 to 12 percent in one year of patients surveyed who said that they smoked cigarettes every day, some days, or not at all.

MS. MILGATE: Not to burst your bubble on that being the good news, but in fact those first two years were asked differently than the last, which we discovered just

in the last couple of days. And so that's why it's still in your materials.

But first years they basically said have you smoked in the past? And then the question was asked of those. So that percentage is probably higher because they smoked in the past.

But the last year is of all beneficiaries and the rate is -- I don't know if I could characterize it as low. But it's 12 percent or so. But the doctors advising people to not smoke did go up. That was what I thought you would say the good news was. I thought that was pretty good.

DR. NELSON: That's good news.

MR. HACKBARTH: Okay, thank you very much. Good work.