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ON HEALTH CARE AND COMPETITION LAW AND POLICY

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FEDERAL TRADE COMMISSION

I N D E X

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P R O C E E D I N G S

MR. HYMAN: Good morning and welcome to the Federal Trade Commission and the Department of Justice hearings on Health Care Competition Law and Policy. Today, we are going to continue our discussion of quality and consumer information. The focus today is physicians. This week we have had three separate sessions -- one an overview, the second a focus on quality and consumer information for hospitals, and today, as I said, is quality, consumer information, and physicians.

We have a very distinguished panel with us this morning. Each of them has very distinguished biographies, which we bound into a handsomely appointed document you can pick up outside and keep for posterity. Our rule here is you came to hear them rather than me or me talking about their biographies. So each of them gets a one sentence or so introduction.

As usual, the Power Point presentations that will be shown will be posted on our website reasonably shortly. And a transcript of this session and all prior sessions will be available on the website. There is typically about a one-month delay between actually holding the hearing and getting the transcript up. I am also told those of you who are desperate for entertainment can purchase a video of the events and build a whole library of the hearings.

But, in any event, the order in which we are going to go is more or less the following. Our first speaker of the morning is Chuck Darby, who is the co-project officer on the Consumer Assessment of Health Plans, which no one calls it anymore. Everyone calls it CAHPS, Survey at the Agency for Health Care Research and Quality or AHRQ. Chris Crofton, his colleague, is a social scientist in the Center for Quality Improvement and Patient Safety at AHRQ. They will be followed by Arnie Milstein, who is the medical director for the Pacific Business Group on Health, and has what I have remarked previously the coolest title in the room, National Thought Leader for Mercer. Next will be Stuart Bondurant, professor of medicine dean emeritus of the School of Medicine of the University of North Carolina at Chapel Hill. He is appearing on behalf of the American Association of Medical Colleges. Following Stuart will be Drew Kumpuris, a cardiologist in private practice in Little Rock, Arkansas and a visiting professor in health care policy at Washington and Lee University. Next will be LaMar McGinnis, clinical professor of surgery at Emory University, medical director of the Eberhart Cancer Center of DeKalb Medical Center. And he is here on behalf of the American College of Surgeons. And then

Peggy O'Kane, the president of the National Committee for Quality Assurance or NCQA. And then finally, batting cleanup, Reed Tuckson, senior vice president of consumer health and medical care advancement at United Health Group.

And we will sort of take a break probably two-thirds of the way through. And then we have built in enough time for a moderated panel discussion at the end, assuming everyone keeps more or less to their time restrictions. Cecile Kohrs, over in the corner there, will flash you things that say when you have got a couple of minutes left. And we would certainly appreciate if everyone would respect one another’s property rights in the time allotted.

So with that, let me turn things over to Chuck.

MR. DARBY: Good morning. I am impressed that anyone is here, considering this is the first day of sunshine we have had in about two weeks and it is Friday.

I chose to focus on the consumer's perspective of health care. And I will go through and define what I mean by that; why one bothers to measure it; what we are measuring; evolving strategy for measuring the consumer's perception of health care quality; problems of measuring at the physician level; and also wanted to just address briefly what we see or maybe my personal feelings as to what the role of the federal government is in quality measurement development and use.

Probably no one in this room needs measurement 101 but let me just for the sake of laying out the territory define two types of quality measurement. One the technical aspects of care. And the second, the so-called interpersonal aspects of care. Those things that the patient is in the best position to report on: the social components of the interaction with the individual provider and the patient; and the interaction required to arrange and to receive care.

The original justification for measuring the consumer's perspective was that it was based on other things. Does it affect the outcome? Does it affect the process of care? And there is evidence that satisfied patients are more likely to comply with treatment regiments, satisfied patients are more likely to return for care, and there is correlation with these technical care processes, and even outcomes in some cases.

Other reasons have evolved for measuring it, and we see now that measuring the consumer's perspective is important in its own right. Consumers help define what quality of care is based on -- what they value. For example, patients value having communication with their provider, being able to have things explained to them in a way that they can understand, and that the provider will listen to them and answer the questions that they have. So that by doing that, the consumer has helped define what quality is, a coordination of care. The National Health Care Quality Report, which will be out this year, that the Agency for Health Care Research and Quality is producing, has as one of its components patient-centered care. So there is an acknowledgment there of the importance of it. And that also of course was documented in Crossing the Quality Chasm.

The Centers for Medicare and Medicaid Services used the cap surveys for evaluating medicare beneficiaries' assessment of their health plans and within the next year or so will also be using that to evaluate the quality of care for hospitals. The National Committee for Quality Assurance uses patient assessment measurement in the form of caps to accredit health plans and get the view of the consumer.

The World Health Organization in its system for measuring health systems performance worldwide is measuring something called responsiveness, which is in fact the consumers' perspective on their health care. And recently the National Cancer Institution developed a whole series of quality measures and one of the cornerstone pieces of that were measures of the patient's assessment.

In general, what are the domains that are measured? Communication? Getting care quickly? Getting needed care? Getting care quickly? Respect and dignity? Coordination of care? Being involved in decision-making or autonomy? And also measurement of the quality of amenities? We could talk a lot about what are the key domains but I think most of the research shows that communication probably has the greatest influence on the overall rating of care. Also, coordination of care is important to patients, particularly those who have chronic conditions. And from our work we see that getting care quickly, and particularly outside of normal office hours, is obviously important for those wanting pediatric care.

In the science of survey research there has been an evolving measurement strategy and the CAHPS development drew upon that work that had been done previously, and I think hopefully advanced the science there. The focus had really been on measuring overall satisfaction -- was someone satisfied with their care? And this tended to yield high, very high scores. But research showed that consumers in fact may indicate that they were happy overall with the care that they got but they might be unhappy with certain selected aspects of that.

So it was quite clear that the consumer's assessment of care was multi-dimensional, that it was not a single overall. There is still that overall rating. And we have perception involved in all of this measurement. And so it isn't that it is all objective but at least we know that it is multi-dimensional and that just looking at overall satisfaction is not enough in and of itself. The evolving strategy looks to measure reports of care -- how often did a doctor explain things in a way you could understand? A report of the experience that was obtained by the patient during that visit with the doctor or visit in the hospital, whatever it would be, indicates a more direct measure of quality.

Again, perception is involved, but the idea is not just to look at what is the final satisfaction assessment of that but what was the report of it. And then a rating of that to get an evaluation also. Both components are very important. This addresses the multi-dimensionality because it gets the specific individual behaviors and domains and sub-domains and then it also allows, if we can do it and ask enough questions, to look at quality improvement of the details.

Problems of measuring an individual provider level and CAHPS, as David indicated, we are sort of morphing, we think we should use a symbol that says "formerly known as the Assessment of Health Plans," and that is still a critical area for us. But we are also getting into the measurement of quality of care from the consumer's perspective in hospitals. We have developed a group practice level instrument, which we are in the process of revising, and we will be submitting it for consideration by NCQA. And then moving down to the individual provider level at some point. So we are beginning to address some of these problems now.

Obviously, resistance from those who are being measured, wanting to make sure that what is being done is valid and can be shown to be valid and useful to not only the patients but also to the provider themselves.

Also, a concern about case mix. We think at this level that it is going to be very important to look at what variables are correlated with the assessment of care. We have found at the health plan level that things such as age and overall health status, education, and gender could be important although they don't explain a whole lot of the variance. But at this level there may be other sets of case mix variables we need to look at.

Obviously, the cost to do this. And with that, thinking about ways to creatively collect the data so that you could reduce the cost. Being able to produce an adequate sample. And looking, and of course I think the field is going in the area of trying to measure at three levels at once: the health plan, the group, and the individual provider. Again to reduce the burden of cost and also the burden on those being measured and the burden on those who are providing the answers to the questions.

Also, attribution of accountability. To what element does the patient attribute different aspects of care? For what do they say is the health plan responsible? For what is the group responsible? And for what is the individual provider responsible?

Just to wrap up, the role of the federal government in quality measurement. I will use the CAHPS project as an example. We were addressing the need for a standard survey that would allow valid comparisons across health plans. The project developed questionnaires and reports with consumers' perspective on the quality of care from health plans. And we then evaluated the process and the outcome of that project. The strength of the project was that there was a defined need. There absolutely was a need to come up with a standard measure. We had a quality research team. The initial round of CAHPS included Harvard, Rand, and the Research Triangle Institute. We have that same team back with the exception that we now have an organization called the American Institution for Research.

I think another strength was AHRQ's reputation for applying the science to practical problems. After the project was over, we went to many of the people who had been involved in the project and those who had used the surveys and said, "What were the strengths and weaknesses, what would we do the same, and what we do different?" And it was clear that the industry wanted an agency, such as AHRQ, involved in the science, to put that stamp of approval on the science that was done and also obviously to be able to fund it and get it done, to pay for it.

But also then what we are looking at now is what is the transition from a federal agency doing that work and then how do you turn it over to the industry to carry it out from there. We used the sound methodology, we developed the reports and the questionnaires side by side, which was important, to know when you are going to report this out. It tells you a lot about how to collect it. We used stakeholder input throughout. And the participation of key organizations, such as CMS and NCQA and others, in the process was just absolutely critical.

The outcome was that CAHPS was adopted by NCQA, CMS, the Office of Personnel Management, and the

Department of Defense and others, the Medicaid programs I failed to mention here. We use the number whenever Congress asks us, "Well, what is the impact," 123 million Americans are enrolled in health plans for which CAHPS data are available. It is accepted industry standard, and that was really the goal, to come up with something that would allow you in a comparable way, in a consistent and valid way to compare across health plans. And we are trying to do the same thing with hospitals and other areas.

There has been wide interest, as I indicated, we have one now that has been adopted by NCQA for behavioral and substance abuse. It is a survey called ECHO. It is part of the CAHPS family. We are developing ones for nursing homes, hospitals, and so forth. And we continue to provide technical assistance to end users.

The role of the government I think is to fill the need when there is little motivation on the part of the private sector to do this. There may be little motivation, for example, to actually develop a comparable survey, bring the science to bear, be a facility for getting stakeholder input, have the visibility to get adoption from key stakeholders, and the ability to provide technical assistance throughout.

Here is some contact information for myself and

Chris. And we also have something called the Survey User Network, and you can go on site and look at all the tools that have been developed or are in the process of being developed.

Thank you.

(Applause.)

MS. CROFTON: Good morning, I am Chris Crofton from AHRQ. And I am going to talk a little bit at a bit of a finer grain level about reporting quality information to consumers about physicians and institutions and other entities as well, a little more finer grain than the presentation that Chuck gave.

First of all, let me start off by telling you that in the CAHPS project we developed a number of templates for reporting the information from the survey to consumers and other people who would use it. We have a print version of a template called, "Compare Your Health Plan Choices." We also have an electronic version of that report called, "Decision Helper." And we developed for Medicaid audiences a version of Decision Helper with more cues and prompts in it to help people through the information and show them how to apply it to a decision.

The templates that we will be developing in the next phase of CAHPS are somewhat different. They are going to be for providers, for performance at the group practice level, for care received in hospitals, for people with mobility impairments, and also for people who use facilities for end-stage renal disease.

What I have done here is pull together some of the lessons that we have learned across the past I guess eight or nine years on CAHPS. And throughout I have sprinkled a few quotes from focus groups and other testing situations that we have had to enable us to know what the change is, what is working, and what is not working about the templates. The first lesson that we learned is that people want information about health care quality but they won't use that information unless it is easy to understand and to apply. Now that isn't really a blinding flash of insight for anybody. I think everybody knows that it has got to be simple or people aren't going to use it. But in the focus groups in other types of testing we have done, the fact that the material needs to be easy to grasp really leapt out at us. In many of the focus groups from which I drew quotes for this, people spent up to 25 percent of their annual income on health care costs.

So it is a huge ticket item for them. Nonetheless, if the information that we give them isn't easy to understand and absorb, they said flat out that it is information that they would just ignore. They would just go on their own instincts to pick a health plan.

Something else that I thought was really interesting about these group discussions that we had was that there is a clear difference between knowing something and knowing how to apply that information to a decision. In one of the groups that we ran, one participant looked at the data displays we were giving them as examples and chunks of texts we were giving them as an examples and says, "All this information is great but you should send it to me after I have chosen a health plan because that is when I will really have to time to sit down and look at it."

So it sort of just slid right over the point we wanted to make, which was that the data can help people to select a better health plan or a health plan that is better suited to their needs.

So that was a clear warning to us that we needed to put information in the report, not just about what the numbers were and what they meant, but how to apply those numbers to a decision situation. And that also creates some tension because we wanted to keep the reports as simple and brief as possible, but we knew that we needed to put in some information to tell people how to use the numbers or it just wouldn't serve the purpose that we had in mind for it.

Another piece of information that we learned is that using multiple sources of information to make a decision is a cognitively complex task. When a person is approaching a decision about which health plan to pick, for example, there are a lot of variables they have to keep in their working memory, what kind of plan it is and what that means for the services they will receive, what kind of costs are associated with it, whether those are premiums, out-of-pocket costs, costs for prescriptions or whatever else, some convenience factors, how easy it is to get appointments, what kinds of clinical locations or doctor's offices are close to you or distant from you, whether your provider is in that network, whether the providers in the network are accepting new patients. There is this whole cluster of information that people have to keep right in front of their faces for one, two, five or more health plans before they make that decision. That is cognitively challenging. And research about how we process information tells us that human beings can only really hold about five variables in their mind at once.

So that means that we have to make the materials as easy to use as possible and build in cues that will help people organize the information and retain the important stuff.

Okay, another lesson that we learned was the only way to know if you have created either a questionnaire or a report template that succeeds is if you go out and ask people. You need to take examples of your questions or examples of texts from a report and get people to talk to you about it, about where it works and doesn't work. There were a couple of different tools that we had for getting that information and they fall I guess basically into what we call cognitive testing. That can be concurrent or retrospective interviews or observing how people use the materials. For a concurrent interview, you sit down with the person who represents your target audience, either with a questionnaire or a text example, and ask them to think out loud as they are going through it.

So that helps you pinpoint the moment where they get off track or fail to understand something or understand something in a different way than you intended. You can also do that retrospectively. In other words, the person can sit down with a questionnaire, fill it out, or read the entire report and then tell you about their thought processes as they went through it. That kind of information was invaluable for us as we were putting together both the questionnaires and the reports.

Something that I think of as a special category of cognitive testing is usability testing. And that is really a test of the question, “Did your materials work or not? Did the materials give the person the information they needed to make a decision?” And to do that you need to take the whole product, the entire report itself, and have a person read it and attempt to use it for the purpose that you had in mind. And in the case of CAHPS, it was for selecting a health plan.

When we did usability testing in the early stages of report development in CAHPS One, we learned some really interesting and humility engendering things by doing this kind of testing. In terms of usability testing, through the cognitive testing, we learned that some people were missing the distinction between different types of health plans. We had the ratings clustered as HMO, PPO, fee for service or whatever. And people weren't making the connection that they were divided into categories like that. So one of the changes we made was to emphasize those topic headings to make them bolder and in a bigger typeface than the other material on the page.

But that sort of backfired on us in a way that we really couldn't have anticipated. When we put that version through usability testing, we found that when we asked people what they thought the booklet was for, rather than telling us it was to give us information that will help us choose a health plan, they said it was trying to convince us to join a managed care plan. And we were befuddled by that. But as we did observations of how people were using the booklets, we saw that they didn't go from back to front. And actually people rarely do in a document like that. They sometimes would start at the end and flip backwards or start at some other point in the document and go thru.

So that just maximized the chances that they were missing material in the beginning that told them what the purpose was and how to apply the information to their decision. And if we hadn't done that type of testing I think we would have been just in the dark about that kind of use of material.

I think we have done around 300 cognitive interviews or focus groups on the questionnaires and the campus reporting templates. We learned a lot of things, a lot of things that really helped us improve both those products. And I picked out a few of those lessons here to tell you about today. When we started developing the initial reporting template, we thought it would be a good idea to put in ratings, not just from people with a normal range of health problems but for people who were high users of health care services as well.

So we had a couple of different ratings there. Our thinking was that if you give information about how a plan treats people who are chronically ill, that really puts the plan to the test and can give you some valuable information about how it functions across the board. When we did the testing on that, however, that was not a connection that people automatically made. If you were a health consumer and you looked at these ratings, it wouldn't necessarily be clear why you should be interested in how a plan treats somebody with a chronic disease. So that ultimately led us to pull out that information and just go with information across the board.

Another thing that we learned is that not all people shared the Western or Anglo-American idea of individualism and making your own choices as being a positive thing. There are many cultures in which making choices about health care decisions, for example, is something you do with family members, especially elders in the family. And it isn't necessarily of value that you be pulled in and made a part of the health care decision-making as a partner with your provider. So that, of course, had consequences for the types of questions we asked and for the information that audiences across lots of different cultures, the use that they would have for CAHPS data.

Another lesson, and this was also a surprise for me, is when you are developing texts, shorter isn't always better. We were really motivated to try to go for the headlines and to try to pare down the information we gave back to people as much as possible so that they could absorb it quickly and apply it to their decision.

But we found that that sometimes backfires. In a lot of readability tests you will find that short, choppy texts, like the original text that I have listed in the notes here, will score at a lower reading level. And that could prompt one to include that kind of information in a report. But we found that there were other things besides word length and sentence length that were really affecting comprehension of the materials. And that was the flow of sentences and that how the ideas connected together across sentences makes a difference in the way a person understands it. So we learned that for things like, certainly for titles for data displays and other things, it was sometimes a better approach to use something that was a longer sentence than it was to break it up into several short and choppy phrases.

Okay, usability testing I have talked about.

And another lesson that we have learned, Chuck talked about including stakeholders in our process, is that if you don't include stakeholders in critical points in the process, it dramatically decreases the chances that your product will be adopted and used. And thinking of providers in particular, in the provider instruments that we are developing, we have learned that we need to include both providers and consumers in the development of what content is appropriate for the questionnaire; in the format of the report, and the explanatory information that goes in there; and in the plan for disseminating survey results.

I think that is a pretty commonsense type of notion, that you are going to gain the respect and trust of the organization or person you are evaluating if they are pulled in and given a decision-making role in some of the processes. But it is something that we have tried to be very careful to implement in CAHPS and careful to implement at many different points in the process.

Another thing we have learned that relates to providing information about physicians is that consumers find it easier to talk about what they see as high-quality providers or even high-quality hospitals than they do about health plans. When we have asked people to describe a high-quality health plan as we are putting materials together, they can talk about a plan that gives prevention care and a plan that has materials that are easy to read. But when we ask them to describe a high-quality provider, they can go into much more detail and pull up some very elaborate examples about what they mean. And on the slides after this, I have given you a few examples of that from our cognitive testing. What we are hoping that means, and what we think it means, is that if people see that quality link more easily in evaluating physicians and using that information, we are hoping that that will translate into greater use of the information to select a provider than we have seen for selecting a health plan.

These are some of the characteristics of good providers that we have learned about. Another thing that we have learned about both physicians and providers or hospitals is that if we are using that information to give to consumers so that they can make a better choice of provider or of a health plan, it is very important to the organization or to the person being evaluated that we report how they have improved over time. And really it is the only fair thing to do. If you publicly go out there with a statement that a provider group or a hospital received low scores in X, Y or Z area, then you are obligated to go back and say and this is how they used information from you to improve. I think that is something that could motivate people to complete the forms and give the information, and also motivate organizations and providers to use the information once they know about it.

That is kind of a quick overview of some of the things that we have learned in the past eight years of CAHPS. There are many things, many more things that we have to learn about developing reports. One, I know Judy Hibbard has talked to this group or will talk to this group. One of the pieces of research that she has worked on talks about how to frame a message and emphasize the risk of not using the information versus the benefit of using it. Those kind of framing messages we need to learn a lot more about. We need to learn about how incentives might affect provider behavior in using quality assessments from consumers and changing their practice behaviors. And lots of things about how to communicate things electronically versus in print.

If you want to see how we are doing with these questions in the future, you can check the Survey User Network website because that gives pretty frequent updates about what is going on in the project and where we are headed.

And I will end it there. Thank you.

(Applause.)

MR. HYMAN: Thank you, Chris. Next is Arnie.

DR. MILSTEIN: Good morning. My remarks this morning will address the question, “What features of the physicians services market require a more proactive federal competition policy?” My comments amplify on prior testimony on February 27th and on work which I published in the April 2003 issue of Health Affairs.

The market for physician services exhibits several features that imply, I believe, the need for vigorously pro-competitive public policies. I will briefly outline these features and the proactive competitive policies that might best address them. Since some of these features and remedies are similar in the hospital services market, a few of my remarks will parallel testimony I gave yesterday on hospital competition policy.

First, most physician service use is by seniors and individuals who have not had the benefit of a college education. These populations commonly take advice from peers and, most importantly, their physicians when newly selecting a physician. Physicians have not successfully advocated for the service line specific public physician performance reporting needed to assure that their physician selections on behalf of consumers would optimize consumers' health or financial outcomes. In essence, consumers in need of physician services rely upon physician agents who are not assuring the objective, quantified information flow on the performance of their peers that successful agency would require.

Second, most consumers requiring physician services are either chronically ill or unfamiliar with specialty-specific physician services which they may need. Chronically ill individuals suffer from a much higher incidence of depression that commonly impairs the critical thinking capabilities that careful physician selection requires. Both chronically ill and new consumers of physician services tend to experience health care as stressful. Irving Janus at Yale and other researchers have documented that such health care-induced stress typically creates idealization in the minds of patients of their care-givers and physicians in particular. Idealization of physicians is the antithesis of the critical thinking required for consumers to transform performance information into a physician selection likely to generate the best health outcome or the most affordable financial outcome. This idealization is well-documented in the Hayes research referenced in my Health Affairs article.

Third, as summarized in the Health Affairs review, there are seven to eight other well-documented psychological barriers to accurate consumer perception of quality unreliability at the physician level and also successful navigation to physicians likely to deliver a higher level of performance. Examples of these psychological barriers include what psychologists refer to as the "familiarity heuristic." This, in essence, is consumers' automatic inclination to associate familiarity, such as a physician who they commonly see or hear about in their daily life or have previously used, to associate that with trustworthiness. And, secondly, optimistic bias, especially in health care, and this is well-documented in the psychological research literature. Consumers tend to believe, without any foundation in reality, that their own personal risk of bad outcomes is much lower than average.

The familiarity heuristic warrants careful consideration by the Federal Trade Commission and the Department of Justice. It implies that if a physician is familiar to a consumer, he or she may enjoy market power, especially among sicker consumers who utilize disproportionate levels of physician services that substantially exceeds what is conveyed by a simple calculation of a physician's market share.

In essence, this market features

psychologically-disadvantaged consumers, relying on physician agents, who are largely failing to ground their failures and other aspects of agency for quality for affordability in an evidence base. This central reality and several other unique features of the market for physician services imply the need, especially in more concentrated physician markets, either for aggressive regulation of physician quality and efficiency, or better enabling of the market's invisible hand. Since the market's enablement is the subject of today's hearings and aggressive regulation of physician performance has never succeeded, I will briefly recommend an illustrative list of these enablements.

The first recommendation. Require physicians to publicly disclose and/or allow disclosure by payers of readily comparable measures of quality and efficiency, for specific diagnoses they treat, for categorical service lines, such as a primary care physician that treats both pediatric and adult patients, and for physician performance overall. Granularatory of performance reporting is needed because research to date suggests that no physician excels in treating all conditions. Secondly, aggregate performance reporting is also needed because many consumers enter the physician's office without knowing their diagnoses or likely treatment.

Second recommendation. Required disclosure should be keyed to measures endorsed by the National Quality Forum, the majority of whose board is comprised of consumer organizations and purchasers. It should also be keyed to performance measures requested by aggregations of customers, including health plans, purchasers or consumer organizations who together are fiduciaries for a significant fraction of any physician's patient mix.

Third recommendation. Prohibit physicians or physician organizations from in any way restricting payer efforts to recognize and reward physician excellence by assigning physicians within a multi-physician organization, or, for that matter, service lines or individual treatments by single physicians to different performance tiers, tiers that are made visible to consumers and/or subject to variable consumer out-of-pocket costs. Such performance-based tiering is the essence of how the market's invisible hand can be most feasibly enabled in all American health benefit plans. Freedom to tier physicians should be vigorously protected by the Federal Trade Commission and the Justice Department.

In my testimony on February 27th, I supported several other pro-competitive policies that I continue to recommend for your consideration. As described in my prior testimony, significant efforts by the Leapfrog Group, the Consumer Purchaser Disclosure Project, and other progressive market forces, such as those catalyzed by NCQA, are already promoting such transparency-based market solutions. These efforts would benefit from support by the FTC and Justice Department.

America is spending almost 15 percent of its GDP on health care services, and physicians determine the vast majority of this spending. As clearly stated in the IOM's Reports on American Health Care Quality, the services that Americans are getting back for these internationally unprecedented levels of spending are characterized by serious and widespread quality defects, and significant economic waste. The FTC and Justice Department's competition policies can and should play a critical role in healing America's under-performing health care system.

Thank you.

(Applause.)

MR. HYMAN: Dr. Bondurant, you are next.

DR. BONDURANT: Thank you. Good morning. I am here to represent the Association of American Medical Colleges. And I thought that in these introductory remarks I might address two questions that are included in the list. The first is the extent to which the patients in academic medical center hospitals are informed of the level of training of their care-givers.

Could everyone hear what I was saying before or do I need to start again? I won't go all the way back. Is that better? Is that better now? Good, thank you.

So that I thought I would address two questions in these introductory remarks. The first is the extent to which patients in academic medical center hospitals are informed of the level of training of their care-givers. And the second is the amount of experience of the care-giver who the patient encounters.

Before addressing each of those specifically, there are four or five general observations that I would like to make that bear on the subject. The first is that every teaching hospital that I know of has an informed consent form that includes on it the statement that students and residents will be involved in the care of the patient so that pro forma at least there is a signed, informed consent. I don't mean to make the argument that that is an adequate way to explain the level of training but at least it needs to be in the record that that is done.

Second, most, if not all, teaching hospitals, all of them that I know about at least, do have specific policies that articulate the requirement that the level of training of the individual be clearly identified to the patient during the time of their hospitalization.

Third, different hospitals have differing degrees of participation by learners of different levels so that in putting in policies of this kind they have to be sculpted to fit the individual hospital.

Fourth, as we consider the role of the learners, we need to remember I think that the persons ultimately responsible for the quality of care of the individual patient is the attending physician and not any of the learners. The fact that the learners are involved does not absolve the attending physician of that responsibility in any way.

And the final thing I would say is that a lot of experience suggests that in the vast majority of situations the presence of students and learners interacting with the patients is a presence that is welcomed and appreciated by the patients. The feedback is almost universally positive but not by any means 100 percent positive.

Now to turn to the two specific questions, in the view of AAMC, there certainly is an ongoing need to examine the adequacy of the formal and informal means by which the level of training of learners is identified in encounters in the academic health care settings. And I will have more to say about some of the specific things that are now being done in just a moment.

There also is a longstanding dilemma of how to teach doctors to execute especially procedural interventions, such as suturing. Sooner or later for the first time, they have to do that on a patient, no matter how much prior experience there has been. But there has been a great deal of thought and innovation as well put into that so that the state of the art is advanced now over where it was just a short while ago.

Well, to come back to the question of learners then and how they can be stratified and those stratifications communicated fully, more fully to the patients, the AAMC believes that all medical schools and teaching hospitals should have well-articulated policies and guidelines that require the identification of the level of all kinds. There are a number of things in place now in addition to the policy statements that I mentioned a moment ago. Hospitals do have policy requirements that learners identify the level of their learning.

In addition to that, every teaching hospital that I know of and practically every hospital requires all providers to wear name tags or badges, and every one that we know of requires that there be identification on that badge that this is a student or a resident at all times. Now it has been said that some of the print on some of those badges is so small that the average patient, the average Medicare patient, can't read the print. So it doesn't guarantee just because the badge is there that this is sufficient. I don't mean to make that argument.

The second point is that in every medical school that I know about, that I have encountered, there is a burden placed on the students to introduce themselves, and they are taught how to introduce themselves to each patient as part of the learning for the patient encounter. And a part of that introduction is a description of their role in relation to the patient. And that introduction, that format of the introduction is supposed to obtain consent for the student, the resident, and the attending physician as well. I don't know of studies that measure the compliance with those requirements but they are universal, and I believe are widely followed.

Third, most of the learners work as members of teams. And the attending physician who has the ultimate responsibility for the team quite regularly introduces the members of the team to the patient and explains the role of each member to the patient. In one particular situation that I know of that has caught some attention lately, and that is the matter of students doing pelvic examinations on anesthetized patients, I have checked with two institutions in which in both institutions for many years it has been the practice of the gynecologist in those institutions to sit down with the patients before the surgery and say these are the people who will be on the team in the operating room and these are the things that we would expect each team member to do. I can't say how universal that practice is, but I can say that there are two institutions in which the OB-GYN departments feel very comfortable that it is a traditional practice in those institutions and is now done.

So those are some of the things that are now going on to ensure that patients have a sense of the level of learning of the people. The AAMC is not satisfied that these are really adequate. And it just so happens it had long before, many months ago, scheduled a meeting of the directors of the courses that teach students how to interact with patients. It is scheduled for the third and fourth schedule next week, Tuesday and Wednesday. Course directors from all over the country will be here. And one of their charges is to develop an explicit model policy for all schools to adopt and for all of the organizations to adopt that will spell out guidelines to assure that patients are informed of the level of experience of the learners.

With respect to the second question, and that is the level of experience with procedures and how many procedures individuals have done and how well informed the patients are those observations, the AAMC is aware that most medical schools and most hospitals have begun to take steps to ensure that students and residents have acquired the fundamental capacity to do many of these procedures, if possible, before they do them for the first time on any patient. For example, again in two schools that I know well, students do their first pelvic examination on women and genital urinary examination on men on volunteers, normal subjects who volunteer to participate or are paid, so that the first time the student does a rectal or a pelvic examination on a patient, he or she will have already learned how to do that on a normal volunteer. And the students in these two schools, and I think they are representative but I can't say how universal that is, never do their first pelvic or rectal examination on a subject.

In addition to that, schools are turning more and more toward the use of either panels or patients who are drawn especially to make themselves available for student examination on special occasions. Their only reason for being available is to be examined by the student or professional actors. In many schools, there are now professional actors who are trained to play the role of patients and both of these groups participate in the evaluation of the students so that their feedback counts for the student's grade, how well the student interacts with them.

So that there is little doubt, there has been great progress, I think, in this in one other way that I need to mention. And that is the development of devices that are used to simulate, to simulate everything from cardio-pulmonary resuscitation to breast examination to heart examination, genital and rectal examination, a whole body of puppets that are highly instrumented and are used as simulators. So that with the combination of the simulators and the volunteer subjects, we have made a lot of progress. Nonetheless, there still is a long way to go. There is little doubt in my mind and the AAMC's view is that the time will come soon when students will be required to demonstrate their proficiency with every clinical interaction that they have with a patient and the AAMC supports that development.

Thank you.

(Applause.)

MR. HYMAN: Next is Dr. Kumpuris.

DR. KUMPURIS: Good morning. Perhaps the best way to make a presentation is not to read your remarks, but because of the time constraints I wanted to make sure that I got everything I wanted to say said before I got the 2-minute warning and got yanked off the podium.

First of all, I would like to thank the Federal Trade Commission and the Department of Justice for having me today. I don't know how many practicing physicians they have but it is an honor to be here. Secondly, in reading the questions that were asked about what was up for discussion, it was clear that there were no clear and concise answers, that the questions were provocative and contentious, and that the process of arriving at an answer is going to be arduous indeed. And for that reason I appreciate the opportunity to come.

First of all, let me just say that the efforts to improve health care quality are not only needed, but long overdue. In 2001, the Institute of Medicine published, "Crossing the Quality Chasm," which found that the United States health care system does not uniformly and consistently deliver high quality care to all patients. A diverse literature addresses this variation in health quality and the difficulties in measuring those differences. Although the conclusion of this landmark IOM report are seldom disputed, the reasons are far from agreed upon.

The first point I would like to make actually goes beyond the borders of what the limits of this discussion are about. But that is just to bring up the point of the interrelationship between health care quality and the access to care. To address one and ignore the other is not only mis-directed, but it represents a lack of appreciation of the day-to-day realities of delivering health care.

In geographic areas, access to health care is a major issue. The standards of quality care delivery may vary. Any agreed upon quality standard would need to take into account issues of access to a delivery system capable of fulfilling those standards. In many areas in this country it is the lack of adequate access to acceptable care, rather than inadequate quality of care, that determines poor outcomes. It should go without saying that problems of access are not simply due to geographic reasons, but things like financial considerations, transportation, cultural and many other reasons. Issues of access as they pertain to quality, are not only not mentioned by this committee, but I would be remiss if I did not mention them at this time.

Now to move on to what the committee wants to discuss. The evolution of the methodologies to measure, or at least understand, the determinants of physician quality of care, make up an interesting history of well-intended false starts. The importance of quality measurement and documentation goes without saying. However, for complex reasons, the results of most prior systems have been sub-optimal. Initially, retrospective efforts to identify bad doctors through chart reviews have been tried. This model attempted to identify and modify out layers, but did little to address the overall performance of most good doctors with the goal of making them even better. Because of its marginal success this model has been mostly abandoned and replaced by other approaches.

Most health service researchers have organized health quality into somewhat arbitrary components. These would include structure, such as qualifications and board certification, process or the appropriateness and timeliness of delivered care, and outcomes or subsequent results of care. From a purely theoretical standpoint, outcomes afford the best assessment of quality. But there are major difficulties in accounting for measuring outcomes. And these include varying inputs, such as disease severities, co-morbidities, and patient compliance. For these reasons, there is now a general consensus that objective measures of process of care provide a superior methodology to assess quality of care.

Explicit review has several obvious advantages. First, it can be primarily disease specific. Did a patient who had a myocardial infarction receive an aspirin? Second, it can be standardized across large delivery systems and regions. Third, data acquisition is not terribly labor-intensive. Fourth, data development is sustainable and ongoing for an individual physician. Fifth, it can be applied to all physicians. And, lastly, results of intervention to improve care can be measured and monitored in real time.

Most of the research to measure quality of care has occurred in the health services arena. However, it needs to be remembered that there is a parallel course in clinical medicine. Patient care guidelines for best practices have been developed in the clinical arena. These guidelines are evidence-based and therefore represent best practice guidelines and are currently available to all practicing physicians. Very rapidly these evidence-based guidelines are becoming the standard methodology of assessing clinical decisions, documenting quality, and determining appropriateness of care.

Of interest, it is not health care researchers who are the drivers of the application of these guidelines in clinical practice. Rather, it is those who are financially responsible to purchasers for using this information. The reasons are obvious. With the rapid and seemingly uncontrolled escalation of health care costs, insurance companies and businesses have a vested financial interest in the quality and appropriateness of care provided to their clients and employees.

Just as measurements of explicit parameters of care has been wed to evidence-based guidelines, now cost-effectiveness is being linked to both. Those paying for health care are increasingly becoming more sensitive to a basic value equation in providing care. More than any other, the cost motive will move quality and cost-effectiveness and their measurements into the marketplace.

The only real question to my mind at this point is who will set the standards, who will control the data, and how will the data be used? Will it be government? Will it be business? Or will it be medicine? The answer will greatly influence how the physician marketplace transforms and responds. In rapid order, it could potentially alter the environment and competition between physicians. Patients who were once uninformed and insulated from the cost of health care will request reliable data on quality and costs before making health care decisions. This process will likely be encouraged by the insurance providers and employers.

Adherence to evidence-based guidelines with documented cost-effectiveness may well be the major driver of market share and competition for doctors, as well as for entire delivery systems. A case in point is Kaiser Permanente, the nation's largest non-profit HMO. Recently, they announced they would publish on their web page all clinical guidelines used by their physicians. In addition, Kaiser agreed to share with the public information on how they pay their doctors including financial incentives. This policy prompted Dr. John Windburg, the health policy scholar at Dartmouth, to say, "This sets a new standard for competition for doctors." Dr. Carol Clancy, who I believe has testified before this group, the acting director of the Agency for Health Care Research and Quality, was quoted as saying, "Kaiser's decision conforms to IOM's recommendation, basing medical practice on evidence and sharing that evidence with the public."

It appears the rapid escalation of health costs coupled with the desire to purchase appropriate, quality, and cost-effective care will be the primary movers in directing health care purchasers and consumers into considering issues of quality and issues of cost. Quality care and cost of care are intertwined into one. And reimbursement will inevitably be tied to providers of best care, best cost.

The rate of adoption of this marketplace approach will vary from locale to locale. Areas with higher health care costs, homogeneous delivery systems, and large employer groups will see the most dramatic and rapid changes.

Currently, some physicians are reluctant to use practice guidelines. Reasons vary but some reasons cited include skepticism of whether guidelines truly improve outcome, cynicism about the efforts to measure quality, challenges to physician autonomy, and inertia and ingrained practice patterns. All of these reasons may rapidly disappear as reimbursement is linked to measures of quality and measures of cost.

And to change gears just a second, this committee, the FTC has posed several intriguing questions as topics and questions for discussion today. To select a few, the first, should physicians disclose to potential patients the existence of volume-quality relationships and how many procedures they have done? Second, should physicians disclose to patients the existence of geographic variation in practice patterns? Thirdly, and I added this one, should physicians disclose to patients any financial relationships that they have that might influence their decision-making? Do they own imaging centers, do they own hospitals?

I have no ready answers to these, but I would like to offer several questions that make the answers even more difficult. If the answer were yes, how would you enforce it? If the answer were yes, who would enforce it? If the answer were yes, would you criminalize the doctors who do not follow it? If the answer were yes, would you make an already litigious environment worse?

In my view, although consumer information and consent are extremely important, the practical aspects of the stated questions make their application to everyday practice of medicine almost impossible. Rather, I would suggest that as reimbursement becomes tied to evidence-based guidelines and cost-effectiveness, these issues and questions will become less important. Quality of care standards will be established using objective data. Cost-effectiveness will be determined using a clinical-value equation. And reimbursement will eventually set standards for both determinants in clinical practice. For physician practices, all else will fade as the market responds to price and quality.

While it is true that many others have predicted this marketplace evolution and as yet it has failed to materialize, the environment is changing. Because of improved informational systems and rising health care costs, many organizations are now rapidly moving towards finding ways to link reimbursement, cost-effectiveness and quality.

The final point I would like to raise also goes somewhat beyond the scope of this organization but once again I am going to use my time to make mention of it. And that is relating to medical errors. In 1999, the Institute of Medicine released a report entitled, "To Err is Human." This report documented that medical errors are a leading cause of mortality in the United States with over 100,000 deaths. At issue is whether these errors represent failure of individuals or failure of systems. The vast majority of physicians are good doctors, motivated to provide quality of care using evidence-based clinical pathways. However, good doctors and bad systems will still result in adverse and undesirable outcomes.

The IOM report called for Congress to provide legal protections with respect to information reported for the purpose of quality improvement and patient safety. Over 50 organizations, both physician, provider, hospital, academic medical center, have endorsed the proposed legislation. A bill has passed the House, but appears to be stymied in the Senate. Until such time as delivery systems can document, discuss, and share information to improve quality of the systems that provide care, absent the threat of legal action, the evolution of quality improvement will be stymied.

I thank you for the time, and I will appreciate discussing this at a later date.

Thank you.

(Applause.)

MR. HYMAN: Thank you, Dr. Kumpuris. If I can be allowed a personal note, I actually met Dr. Kumpuris at Washington and Lee, where he is visiting. And although Dr. Kumpuris is a physician, he is visiting at the law school and you can tell that it has an effect because he didn't like the questions that got asked, and so he added some of his own and chose to answer those.

So with that, Dr. McGinnis?

DR. McGINNIS: Good morning. It has certainly been an enlightening morning already. As a physician, it is my mission to deliver the highest quality of health care for every patient. As a surgeon, I am dedicated to the ethical and competent practice of surgery. The single most important aspect of practice has always been my responsibility to my patients. I speak to you today from my experience of 40 years as a surgeon and on behalf of the American College of Surgeons, an organization founded to raise the standards of surgical practice and to improve the care of the surgical patient.

Quality improvement rests on a composite of factors within the totality of the health care system. In surgery and in specialties, safety relies on the presence of competent and informed surgeons, a safe institution, and a system of good practices within which the surgical care is rendered. Therefore, quality improvement and patient safety are obviously of great importance to the surgical community and certainly have an impact on the bottom line. The College wishes to commend the FTC and the Department of Justice for undertaking these hearings, and we are pleased to have this opportunity to present testimony regarding quality improvement and consumer information.

With more than 64,000 members representing all surgical specialties, our College has been concerned with quality improvement since its founding. In 1918, the College initiated a hospital standardization program in an effort to ensure a safe environment and an effective system for care of surgical and other hospitalized patients. That program ultimately led to the establishment of the Joint Commission on Accreditation of Health Care, JCAHO. And this commitment continues through our College's representation on the JCAHO board, as well as other programs and initiatives conducted by a number of our committees and departments.

Some of these initiatives include the Commission on Cancer which, established in 1922, now sets standards for nearly 15,000 hospitals where 80 percent of the cancer care is administered in this country. It has a significant quality component based on the survey process and the standards that have been established. Our grant from AHRQ, a grant to further validate the Department of Veterans' Affairs National Surgical Quality Improvement Program, is ongoing in 14 hospitals.

I would like to particularly emphasize the importance of the NSQIP program. We presently view this as a potential gold standard for the evaluation of quality in that it embodies careful collection of risk and complexity adjusted data, which is then fed back into the system for a continuous cycle of improvement. We are very dedicated to this program and its evaluation because we believe that it would not only benefit patients, but would evolve data that physicians and surgeons would respect and adhere to.

Clinical trials have been designed to assess comparisons of procedures. There is one going on presently, funded through AHRQ and the VA Cooperative Studies Program, comparing watchful waiting open operation and laporscopic repair of hernias, for instance.

We have established the American College of Surgeons Oncology Group, which presently has 14 ongoing trials comparing a variety of areas of surgery where there are differences of opinion. Our Advance Trauma Life Support Program is now the worldwide standard for training providers who first attend injured patients, and sets up a system of evaluating and approving hospitals.

In short, for the last 90 years, through the programs and initiatives outlined by these and other efforts, the College has consistently emphasized patient safety and quality of care. Surgeons have a responsibility to share as much information as possible with their patients, and that includes information about how many procedures they have performed, whatever data may be available on the outcomes, infection rates, and assessment of the risk and benefits to the individual based on his or her particular situation. The lack of information, and to some degree a lack of agreement on what constitutes high-quality surgical care from both the clinical and patient perspectives creates confusion. We feel it is vital for clinicians and consumers to have an open dialogue to determine the kind of information that can truly be useful in informing consumer health care choices.

The challenge for surgical patients can be particularly difficult because many of them have little opportunity to use such information or exercise choices. So many procedures are performed on an urgent basis that there is simply no time to provide patients with comparative information so that they can actually use this information to make their own assessments and perhaps choose alternatives. Instead, they count on their physicians to help them make informed decisions based on their own unique circumstances. Consequently, an even greater burden is placed on our profession to not only define and measure quality but to develop the systems and practices that can actually elevate the quality of care generally.

The College takes its responsibility to share information with patients very seriously. To that end, the College has produced information that enables patients to protect themselves from unfair, deceptive and fraudulent practices. The College also publishes a wide variety of tools designed to educate consumers about quality and to enable them to make informed decisions about their surgical care.

However, comprehensive and system-wide efforts to measure and ultimately improve health care quality have really just begun. As a result, the availability of truly useful comparative information for consumers remains limited. Nonetheless, quality improvement is a founding principle of the College and will continue to remain an essential part of our initiatives in the future.

It is important to keep in mind that the quality of the information is only as good as the tool, the data that is used to populate it and the context in which it is considered. Administrative data sets are frequently used to populate most quality measures, primarily because of their relatively low cost.

However, we believe these data are unsuitable for use as a proxy for surgical quality because major operations are billed under a 90-day global service period that includes pre-, intra-, post-operative services. All their components are not individually documented and billed. As a result, there is no way to conduct a meaningful assessment by administrative means. Patients vary, as do the steps taken within the service period to solve their problems, and billing codes simply do not capture this information. Further, these data do not give a clear sense of the outcome. They fail to exhibit the cause, effect, and the likely changes that need to be made to improve health care quality. Again, because they are not sensitive to the differences in patients, risk and complexity adjusted.

In addition, surgeons in the systems of which they are a part are hard to separate. This makes it difficult to develop meaningful surgeon-specific quality data. Primary care lends itself more to adherence to public health driven protocols that prevent and ameliorate chronic disease. There are guidelines at work to manage ischemic heart disease, high blood pressure, diabetes, and other conditions.

On the other hand, surgical quality does not lend itself as easily to process measures. We feel strongly that the only appropriate way to measure the quality of surgical care is truly risk-adjusted outcome assessments reported before, during, and after the procedure. Risk adjustment allows both the patient and the health care system to know that the service rendered was appropriate considering the state of the patient and their disease.

Recently, private payers have started offering incentives to improve quality. Bonuses based on measures that are proxies for surgical quality at best are likely to cause system gaming. They provide a perverse incentive for provider groups to take on those procedures and patients at less risk of adverse outcomes. High risk procedures, on the other hand, will be left to a small number of centers, many of which cannot clinically or financially accommodate the demands that this high risk patient mix puts on them.

To summarize, the impact of quality improvement initiatives is increasing. The importance of understanding the distinctions between primary care services and surgery and the impact they have on the way quality can be reported and measured cannot be understated. Without risk adjustment of outcome measures, there is no meaningful way to evaluate surgical care. As payers move forward with incentive-based quality improvement programs, surgeons will continue to be faced with difficult practice management decisions. Surgeons have a legitimate incentive to engage in collective action to increase their bargaining power on quality-related issues.

Clinical integration presents a number of opportunities for surgeons to undertake quality improvement initiatives. I will now detail opportunities for surgeons to come together in a lawful manner to achieve these objectives. The College suggests these following five areas for quality improvement initiatives for clinically-integrated groups. One, surgeon competence. A program administered by the College's Committee on Continuing Education helps surgeons stay abreast of current practice standards. This program, Surgical Education and Self-Assessment Program, SESAP, provides the opportunity to test personal knowledge of the current standards of surgical practice by reproducing the diagnostic and treatment challenges faced in the practice of surgery and to obtain immediate feedback for self-improvement. Furthermore, one often overlooked component of research and its competence is the ability to effectively relate to patients and peers. The College's task on professionalism seeks to comprehensively address this issue across the continuum of professional development. We aim to use contemporary educational principles and state-of-the-art technology to achieve optimal outcomes. The College strives to make a number of tools available for surgeons to incorporate in their practice.

Two, introduction of new surgical technology. In addition to the generic issue of physician competence, an important consequence of the continuing evolution of health care technology is that surgeons are increasingly finding it necessary to acquire new skills after completion of their formal surgical residency program, sometimes many years later. And this is occurring at an accelerated pace. The College was founded initially for the purpose of providing a forum for continuing education for the surgeons of North America and, as a result, we have established multiple programs to accomplish this goal. Our Committee on Emerging Surgical Technology and Education studies the implication of innovations in surgical methods and technology, and develops policies to promote appropriate training for surgeons and to protect the welfare of the surgical patient. The College also sponsors a wide variety of courses and educational activities specifically including those aimed at ensuring the safe and effective dissemination of new technologies. Recently, these have included stereo-tactic biopsy of the breast, diagnostic use of ultrasound, single node biopsy, and management of breast tumors, et cetera.

Number three, best practices for common surgical procedures. It has been repeatedly documented that there are significant geographic and other variations in the way patients are managed, even for ultimately common ailments. In some cases, it is clear that this variation is appropriate. In other cases, however, it is less clear that the variations are warranted. A study sponsored by Health Services Research and Development Service of the VA found that centers with the lowest risk-adjusted post-operative morbidity and mortality rates made greater use of clinical pathways, protocols, guidelines, if you will. In fact, these centers tended to make pathway development a much higher priority than did centers with poor surgical outcomes.

It is important to assess whether the use of these critical pathways or guidelines improves outcome for surgical patients. This could be tested for common procedures performed by each of the major surgical specialties. An obvious step would be to develop a consensus for critical pathway management for such procedures. The College is the obvious vehicle to develop and disseminate best practices, practices which could be utilized and incorporated in their quality improvement initiatives.

Number four, addressing areas of error avoidance in surgery. The College aims to enhance the care of surgical patients, and actively promote quality improvement through leading-edge educational programs and products that effectively address the needs of practicing surgeons, surgical residents, medical students, and surgical patients in the public. We are committed to supporting continuous professional development of individuals, and to this end, the College offers skills-oriented post-graduate courses, didactic post-graduate courses, video-based education sessions, research paper presentations, peer reviewed scientific exhibits and technical exhibits. Furthermore, we intend to comprehensively evaluate the impact of these educational interventions on physicians' learning and behaviors and patient outcomes through a process of continuous quality improvement.

Number five, evidence-based surgery. Most of what surgeons do is based on common practices, published case studies, expert opinion, and is rarely tested in the rigor of a controlled clinical trial. Support of clinical trials in surgery should be strongly encouraged and surgeons must be stimulated to require evidence and to acquire comprehensive knowledge and skills before adopting a technique into their practice.

The College recently established components within its Division of Research in Optimal Patient Care to improve the quality of surgical care by enabling all surgeons to apply the best scientific evidence available in all aspects of their daily practice. Its objectives include the development of practice guidelines, encourage application of practices of proven value, discourage application of practices of no proven value, and applying statistically rigorous validated risk-adjusted measurement of outcomes.

In sum, the College believes that these five areas for quality improvement initiatives can be an important part of clinical integration. Physicians should be able to rely on quality improvement measures as a sign of significant clinical integration to justify a rule of reason analysis when engaging in joint contracting with payers. The College does maintain serious concerns about the factual issues implicit in measuring quality improvement before deciding whether per se or rule of reason treatment is appropriate. These five areas each represent acceptable quality initiatives that surgeons can undertake as a part of clinical integration. Quality improvement is an important aspect of practice that has efficiency enhancing effects, greatly outweighing their anti-competitive effects. The College stresses the importance of practices implementing, tracking, incorporating, and updating data measures or standards of care suggested by their professional societies, formulated in conjunction with patient advocates and consumers at large. We continue to encourage surgeons to include the consumer dimension in their clinical discussions. The give-and-take of that dialogue will help formulate what is best for the patient's care in a truly collaborative way.

We are firmly committed to enhancing quality improvement and patient safety as is evident from our longstanding efforts. We appreciate this opportunity to offer this discussion.

Thank you.

(Applause.)

MR. HYMAN: Thank you, Dr. McGinnis. I think we will take a 10-minute break and then come back for two additional sets of remarks, and then go directly into moderated roundtable.

(A brief recess was taken.)

MR. HYMAN: Let's continue now so we can stay on time. And our next speaker is Peggy O'Kane, from NCQA.

MS. O'KANE: Thank you, David. I appreciate being part of such a distinguished panel, and I appreciate the thoughtful remarks about the complexity of trying to drive a value agenda in health care. I am going to start out, well, first of all, we are a private, nonprofit health care quality oversight organization. We measure and report on health care quality. Our mission is to improve the quality of health care everywhere through information. And you probably have seen the reports we have done on health plan quality in our annual

State of Health Care Quality Report, which is usually picked up very well by local media and so forth.

But I just want to emphasize here the urgency of this agenda. And Dr. Kumpuris talked about the urgency of thinking about access. And I agree with him very much, but I think we really need to understand that access and cost-effectiveness of the system are very related concepts. If the system is out of control, there will be less access because people will have less insurance in the first place and less comprehensive coverage. And we are seeing that very much happening. So we very much need to use whatever tools there are. And I think the tool of the market is a very powerful one that we really haven't seen used to its full potential. We clearly have a system where costs are out of control, where quality is not what it should be, and we have a potential for much greater return, both in terms of improved health and in terms of greater cost-effectiveness for the health care dollars that we are spending.

Why the market needs help, and I learned this in graduate school, but insurance creates a barrier between the patient and the cost that makes it less relevant to them. But I think what we are here to talk about today is getting relevant information on quality out there so that not only consumers can use it to drive their choices but so their intermediaries and the people who have fiduciary responsibility for helping them get good health care can use the information to drive the agenda.

I think the regulatory environment has actually impeded the ability to drive competition in health care and some of the legal environment. But we also appreciate and are very humbled by the complexity of what we are talking about here.

You have probably seen this chart somewhere during these couple of days. This is actually a Mercer survey of employer-sponsored health plan cost increases. And I can tell you as a small employer of 180 employees, our health care costs went up $100,000 last year. That is a lot of money. Our budget is $25 million. And if you think we can keep affording that year over year, we can't. So the attention of the employer community, not just the large employers, who by the way get a better deal because they are big, is riveted on these costs. And we feel great urgency to get the quality agenda aligned with the cost agenda. And that is why we are using the concept of value more and more.

Health insurance is changing. I think we are seeing a lot of talk about consumer-directed plans. They are very different in construct, but the bottom line is there is a whole lot more costs being passed back to the patient. And we know from Rand experiments and so forth, that that will impact their use of services and not necessarily in the way that we would like. So we want to be sure that consumers are focusing on, “How much health am I getting for my health care dollar?,” not, “How much am I spending?,” as the only question.

So the urgent agenda is to promote transparency of quality and cost to redesign benefit structures to drive value. I want to emphasize that. We have heard from Chris very thoughtfully about some of the barriers to expecting consumers voting with their feet to drive a value agenda as effectively as we would like. And we need to learn more about that. But we also need to understand that we have the potential for people to be market-makers, health plans, employers, I will be talking about some of that.

We need to educate the public about this. I think we have been really very behind other countries where they tend to have national health insurance and where the public understands that not everything will be paid for, not everything will be covered. There will be trade-offs made. We have not really educated the public. In fact, I think we have done the opposite in terms of saying it is the insurance industry that is creating this problem. There is a problem for everybody in that we have a lot more potential things that we could pay for than we have the money to do it.

I am -- disgusted I think is too strong a term -- when I see these issues that are really about a common problem that we face being turned into partisan issues. This is an agenda for the American people. We need unification of the parties. We need to forget our ideologies. And we need to be very practical about how we are going to move from the public sector to the private sector. We know quality can be measured. We talked about how this measurement and accountability drive improvement, and consumers do want information. And I think there was a comment about how, as much as we have talked about this, there is really precious little information out there right now for people to use. Currently, the percent of the insured population for which performance data are available at the plan level is 28 percent. So we have got a tow hold I think for accountability for quality, but we have got a long way to go.

It drives improvement. This is just showing you trends among health plans in Beta blocker treatment. I remember Steve Sumerei published a report in 1990 saying only 20 percent of the patients who should get beta blockers after a heart attack in the Medicare program were getting them. When we first started reporting this at the plan level in '96, it was 69 percent. It is now about 90 percent. And we believe this public reporting has played an important role in riveting the attention of plans and providers on getting these numbers up.

Also, those who publicly report do better than those who don't publicly report, although it is kind of maybe about like if you got a good report card, you are more eager to show it to your parents. But there is no question that having the numbers out there, no matter what happens with the consumer end of it, does raise the conversation among providers about why aren't we doing as well as we thought we were.

We get real ROI by improving care in chronic illnesses. I will talk more about that and about some of the creative ways in which employers are trying to share that return on investment with physicians who are doing a good job with these kinds of things.

But I think we focused on under-use, NCQA has, because of looking at managed care plans, but there is a lot of waste in the system that we need to go after as well in terms of overuse and misuse. Some examples, and we have two new HETAS measures that are focused on overuse, overuse of antibiotics. So there are two new measures focusing on appropriate treatment of children with colds who should not be given an antibiotic within the first three days. And children with sore throats, no antibiotic without a strep test. This is an area which has huge public ramifications, as well as cost ramifications. There are plenty of other opportunities, inappropriate use of imaging, unnecessary use of surgery, use of generic drugs when they are available and therapeutically equivalent and so forth.

Misuse I think is much more challenging. How do you go after the costs, let alone the human suffering cost? But there is real money going down the drain because of medical errors, hospital-acquired infections, poorly executed care. The human suffering angle of this, and I move this really to the top of the agenda, but the technical challenges of this are sobering. But we will be really trying to develop an agenda around this as well.

This is basically just to show you about the drop in potential I think that we get when care, the potential of evidence-based medicine, which is not everything that happens in medical practice, up on the left, is when we fail to apply the knowledge that we know improves health, we get one drop. When we fail to execute appropriately or when patients don't comply for whatever reason, we get another drop. So the actual bang for the buck that you see from the evidence-based medicine box up in the left-hand corner is really -- there is a lot lost along the way. By the use of guidelines systems, including information systems and EMRs and patient support, which is another evolving area of knowledge, we can get a much better return from what we know in the investment that we have made in medical research. So I sort of think of NCQA's job as getting more health for the investment that we make.

I wanted to talk a little bit about some of the physician initiatives that we are working on. We have three physician recognition programs. One is currently out and live with 1,800 physicians recognized and that is our diabetes physician recognition program. We partner with the American Diabetes Association there, and it is amazing to me that 1,800 physicians stepped up to the plate with absolutely no incentive to do it. We have a new program coming out together in partnership with the American Heart Association and American Stroke Association focused on patients with ischemic heart disease and focusing on secondary prevention of stroke and heart attacks.

And a third one that really takes a lot of the quality chasms systems, turns that into something that a physician can have in their office, and then allows the physician to self-evaluate. These are all self-evaluation programs with an audit for a sample. And it is kind of where we are.

But I want to say that I think there really needs to be some energy and an engine behind these kinds of initiatives. Doctors are busy people. It takes a lot of extra work to do these things, going in and reviewing your charts, setting up these systems. So benefit design is something that we want to make sure that the FTC is working vigorously to defend as an engine for this.

So let's pay for quality. Where somebody is doing a good job, let's recognize that. Let's enable plans to tier networks and payers to tier networks. Let's incentivize use of high-quality providers and also let's work on the patient to promote their own self care because physicians know that their responsibility only goes so far and their ability to create high quality only goes so far.

This is a program we are very excited about. This was really catalyzed by General Electric. And it includes different employer partners in the three pilot cities of Louisville, Cincinnati, and Boston. We are basically taking these provider recognition programs that I just told you about, and the doctors that get recognized are being recognized in a gain-sharing model where they will get, for example, in the diabetes program, for each diabetic patient that is an employee of the participating employers, the doctor will get an extra $100 a year. That translates to $1,000 to $2,000 for the average solo practitioner. There is one group where there could be up to $100,000 of gain. And it is a gain-sharing model that was developed by Hewitt, the actuaries at Hewitt. They basically looked at the return on investment in terms of prevented hospital days, prevented emergency room visits, actually prevented primary care visits that would be avoided by this better adherence to the guidelines, and they estimate the cost at $350 per patient per year.

And GE is now turning around, taking $175 of that money, giving $100 to the doctor, and $75 to the patient that will go to a recognized physician and that will also self-manage on a web-based tool their own health indicators. So it is a very thoughtfully crafted program that recognizes that these gains could be appropriately shared and that may be a way to drive the agenda forward in a real win, win, win for the employer, the physician, and the patient.

I won't go into -- I think Chris raised a lot of the issues. We do report to consumers in a way -- we have done a lot of focus group work with consumers and they told us, “We don't want to hear about these HETAS measures. We didn't get a Ph.D., but we are interested in hearing about how this plan helps me stay healthy, how well they take care of people with chronic illness and so forth.”

So what do we need to do? We need to create and drive a value agenda. I think we need to identify value providers and drive market share to them. We need to educate the consumers. They need to understand what we are talking about and why this is in their interest. And we need to create a regulatory framework that permits value-based competition. And it is very hard I think in the quality world to find examples where we really get alignment, but I think it behooves all of us that play in this world to get our act together and to work together to drive this agenda and not neutralize each other.

So the government, as payers and regulators, has a huge leveraging role and enabling role here. Private payers, include health plans and self-insured employers, really they should not be thought of as separate. I think there is a common agenda. And consumer organizations who I think have really not been mobilized as they need to be in understanding their interest in driving this agenda. So I think we are talking about a tall order here and a lot of emotional intelligence, but I am confident that this is so important that we are going to have some real progress here.

Thank you very much.

(Applause.)

MR. HYMAN: Okay, finally is Dr. Tuckson.

DR. TUCKSON: I liked that last part, the emotional intelligence part, that was very good.

First of all, who we are, just so you get a sense. We view these issues as a very large and complex health and wellness company of which we are, I guess, right now the largest traditional what you would call a health care plan, United Healthcare. Our Uniprize company provides health care services to corporations, the large Fortune 200 and 300 and 100 companies. We also are a company providing health care to seniors. We are heavily associated with the AARP and those kinds of things and health care to nursing homes and frail elderly persons. Specialized Care Services is a variety of companies that do everything from vision and dental, chiropractic alternative medicine and a variety of such things. Then finally we are a very large data and information company. So we view these issues from the point of view of an organization that touches more than 40 million lives, coordinating care for 17 million people. We are involved in a daily way with 400,000 physicians and 4,000 health care institutions. So we do appreciate this issue.

We view this very much as others have, from the point of view of the quality chasm. And I appreciate Peggy's comment on the urgency. Change has to occur. The system needs to fundamentally change, as the IOM has called for. These three reports we see are key. We, and I am particularly pleased to be leading the Crossing the Quality Chasm Summit process, which will start its work officially on Monday. And so we are excited by the IOM recommendations and view them.

I think this point about the relationship between quality and access is absolutely fundamental. This $1.4 trillion system that is growing at $100 billion a year in contra-relationship with the fact that there is 41 million people without health insurance absolutely means that we have got to provide information for everyone to be able to make intelligent, cost-effective decisions. Squandering resources is absolutely the death knell to access. And these two pressures, the pressures on employers around the increasing costs that is lifting them off of the bottom line and the fact that we waste resources so terribly, leading to more and more people not getting access to anything, is an absolutely defining paradigm in our mind.

We know this agenda is moving forward. We have already heard about the ARS Human Report which is getting people's attention. But also we see again even in excellent institutions, wonderful places like the hospital down South that had trouble with the transplant recently, even in the best of institutions, people see that there are issues and that is causing great attention.

In the marketplace, employers or the people that are paying for care are very, very clear, “What are we paying for? What is the value equation?” They see the variation. They see the quality and safety issues. And they are saying to people, to companies like ours, health plans, we need your help because we also are worried who is going to pay the bill for what is increasingly becoming more expensive. And, as we have heard already, the shifting of cost and payment to employees means that they have to have information around how to make those kinds of choices.

We believe that the strategy for quality was correctly laid out in the IOM Quality Chasm Report. I won't take time to read all of them, but clearly the six aims for improvement are the right ones. The 10 rules to guide the redesign of care, I would emphasize the point of not only continuous healing relationships and evidence-based decisions, but the patient as a source of control, shared knowledge, and we have heard this important word, "transparency" I think is key. The key to all of this they describe, and what has to occur, is investing in information technology, which will allow us to have the information, share that information in an actionable way to lead us to improving quality.

This information is I think best described as the IOM observation that physicians, hospitals, and health care organizations operate as silos, providing care without the benefit of complete information. A company like ours is able to take massive amounts of information, prescription drug, laboratory, all of our claims data, almost seven terra bytes now of information that is housed in a data warehouse, which then is augmented by a variety of other information that is in a daily interaction between consumers/patients and other interactions that gives us even more, and then applying a set of analytic components, regression models, analytic issues, interpretive analysis leading to applications that allow us to be able to provide this information in actionable ways.

The observation, though, and one of the key things is that health care now is operated in silos. We do not have the ability to share information effectively across systems. And so if there was one thing that I would urge attentiveness to or the coming bills or the coming initiatives around sharing information freely and easily, we have got to break down these silos so that every component of the system can have access to the necessary information that allows quality to then result. If we keep this siloization and these barriers, we are not going to reach the health care system that we want. And so it is always amazing that you can go to the ATM machine, regardless of your bank, and pull out your money but you go to try to do this across the health care system and you can't. It doesn't make sense why this would work for your money but not for something more important than money called your life.

The third observation that the IOM report makes is that the system falls short in translating knowledge into practice. And the care depends upon the clinical decision-making capacity of autonomous individual practitioners for problems often beyond unaided human cognition. Doctors are very smart. It is though unfortunately very difficult for them to keep up individually with everything that is happening. The 20,000 new journals -- 20,000 journals are now available in the system, 17,000 new books a year, 6,000,000 references, 400,000 new entries, you have the new genetics now bound to new diagnostics for genetics, the new drugs, the new imaging stuff, and now you can swallow a pill and do a radiological procedure. It goes on and on in terms of the amount of information.

Jack Windburg in his work though shows us that as all of this information pours into the system, the variation in care is very great. This is not just some variation around surgical procedures. You can pick whatever area you want. But at the end of the day we see enormous variation. I respect the point from Dr. McGinnis he makes in terms that some of this variation is appropriate. But we also are aware that so much of it is not appropriate. And what is even more important in today's environment is that this reality of inappropriate variation is known. It is not a secret. It is shared widely.

And so we think that what is essential is to provide information to clinicians that is evidence-based, the best evidence. And we are particularly pleased about being able to provide to almost every practicing clinician in America twice a year a copy of the definitive guide of what works and what doesn't work based on the best evidence available in the world to physicians. And we do make that available along with workshops and putting this information at the point of care delivery.

The challenge is taking that information that is in books or taking information that is in paper or in charts and making that available for the cognitive decisions of physicians in real time. And so that means the Internet is going to be particularly important. We are urging that anything that can be done to improve and increase the use of the Internet by clinicians is going to be essential. We now make most of our business transactions on the Internet. And we have 300,000 physicians, we are encouraged to report, who are now registered for our Internet portal, and a 30,000,000 transaction per year run rate. This is just over the last two years of having introduced this new technology and device.

What is now our key is to translate and integrate all of that with data. And so now we have on-site best treatments, which is an Internet version of the clinical evidence work from the BMJ, providing again actionable information from the best possible sources, and we also provide this same instrument to patients on our consumer website so that physicians and patients together will have access to the best information. We are encouraged by the letters we get from physicians who thank us for providing clinical evidence to them because they share it with their patients to try to disabuse them of some of the overuse that Peggy O'Kane talked about, particularly in the area of antibiotics and viral illness.

So now what we move towards then is providing online, and I talked about those data assets, combining the information around how clinicians are actually practicing by organizing medical pharmacy and laboratory data into performance profiles and matching those against nationally-accepted physician-derived, evidence-based best practices. For us, as a company, we believe that any analysis of physician performance must be led and informed by the profession itself, that there is no one qualified to tell physicians how to practice other than physicians. And so we now put online that performance profile on a series of important metrics of clinical behavior and we will have given an individual physician that information. So we are able to take this information that we have from our databases, provide rules that are defined by professional societies and evidence-based information, putting certain priorities on them, such as safety and so forth, and then reporting those back.

Here is the challenge. The challenge is that we are in this wonderful moment where a lot of attention is being directed towards this. So CMS is about to come out with their physician performance measures. The Bridges to Excellence we just heard about. The IOM has its guidance. NCQA has been leading this for years now. NQF has its performance measures that it is moving forward with. The Leapfrog Group is moving from hospitals to performance measurement. And at the base of all of this for us is the essential organization, the AMA's Physician Consortium for Performance Improvement. Lots of people are in the drama.

The concern we have now is how do we get to an industry standard so that physicians don't get whip-sawed by multiple competing measures of what they do. This will lead to waste, confusion, and frustration for the practicing clinician. And so what we are calling for, and will hope that we can help facilitate, is to get us to the right set of measures that everybody can buy in on that then will give physicians a coherent and logical way of proceeding. And that is what we hope.

We heard that in fact we can see improvement when you do this. Physicians want to do the right thing.

And we have learned that if you give them the right information, they will do that. We now have taken on a new addition to giving physicians’ performance, and that is to provide them opportunities for continuing medical education credits for interacting with this data and for doing this kind of work. Giving a real tangible incentive for doing the right thing and interacting with their actual clinical performance. And so we have moved forward to make that available as well.

We do think the Bridges to Excellence Program is an excellent way of going forward. And we participate in this Bridges to Excellence Program. We did not enjoy the way the Wall Street Journal reported this initiative, "A New Way to Get Doctors to Take Better Care of Patients, Bribe Them." That is just wrong-headed. And I put that there because it is wrong-headed. We think that there ought to be a way to look at learning around aligning incentives. And we are going to study with the leaders of this effort carefully how do you do this and how do you do it right because we think this in fact may have great promise.

The other thing that we think is also essential about having online information is you get a new article out about breaking information, let's say in terms of the effect of low-dose warfarin anti-coagulation therapy, that may be very important for some patients and physicians. How many physicians actually know how many of their patients are actually on these drugs? It is very difficult for many physicians in their offices to be able to pull that up. We can make that available instantly to them and give them a record and say, "Dear Physician, here are the people that we know in your practice that are on these drugs. You may want to consider this new information as you make your clinical decisions."

The safety issues we think are important have been alluded to. Unless your hospital is in the U.S. News & World Reports, this is not science and this is not great. And it is just basically nonsense. We have to give much better than that. We think that the Leapfrog effort is important, and we are big supporters of the Leapfrog effort as it goes forward. As it goes forward, it has got to get even better. Volume, for example, one of the criteria for Leapfrog isn't always a useful measure. There is one major hospital that has been in the news -- system that has been in the news lately. They did real great on volume. They referred lots of people for surgery except the problem was that hardly any of them needed the surgery. So we know volume is going to be important.

And so this point that has been alluded to around centers of excellence and tiering is essential. You have got to be able, and it would be a tragedy if anybody was to slow down the movement of identifying centers of excellence and then being able to basically on really good criteria and increasing intensity of centers of excellence, you want to have broad networks. People want to be able to go to the hospital in their community. So you need to have that. But for specialized things, where you are not doing that many of them, you want to have better criteria. And for really rare things, transplants or congenital heart surgery or doing Whipple procedures for certain kinds of cancer of the pancreas, you really want to have the really best places and you want to have criteria that make sense. And then you want to be able to reward those hospitals that are the best at being able to do those things.

Even when we disagree with folks in the health care marketplace, we are able to work together. We have worked with VHA around patient safety to send to every hospital administrator in this country a copy of clinical evidence, and to explain to them what and how they could create a culture of evidence-based clinical practice that promoted safety and evidence-based decision-making in their hospitals. And the reaction to that has been just tremendous.

The last point I wanted to make is this idea of then making all this available for patient's decision-making. People who have chronic illness need a lot of different services. And most people with chronic illness have more than one chronic illness now. And they require not only medical intervention but non-medical intervention, whether it is Meals on Wheels or a home health aide to transfer you from bed to chair, mobile vans to get you to your clinic visit and those sorts of things. And so how we are able to coordinate care for people who need multiple interventions is exceedingly important. And, again, evidence and data that allows trained people to predict who is at need and at high risk, getting them to the right care arrangements, and coordinating their care is going to be extremely important. This is also important, to provide consumers and patients with information so they can make good decisions.

Everybody wants everything. The circle there is the budgets for each of the largest and most marketed consumer prescription drugs, every one of those is bigger than the advertising budgets for companies like Dell, Campbell Soup, Nike tennis shoes. It is an enormous amount of effort that goes in to trying to convince people to do things. And so what we have been able to do, and think it is important, is to provide information that is integrated.

I really like the point that Christine and others from AHRQ made about how important it is to integrate this data so that if a person goes on to our site, consumer site, for their transaction information, what they also will be able to do is to go in and learn a great deal about their disease from evidence-based information, about the cost of treating their disease, down to five digits of their six-digit zip code. So in their city what does it cost to get such and such a thing done, to provide information about the hospitals that do this work, how do you in terms of picking the best hospital for what they want and increasingly and soon we will be providing information around physicians. It will probably be from our perspective on this information around patient satisfaction criteria, along the line that we heard earlier. We don't think this field is good enough yet to provide information about the quality of the individual physician. That information is probably not yet ready or not appropriate, but we are going to be continuing to watch carefully what happens out of the AMA and its consortium as it moves its field forward, and we will see where we go there. But, clearly, transparency of information is the key and we’ve got to keep working at getting that done.

And, finally, at the end of the day, even after patients and consumers will look at this information, they are still going to need help. Many people are going to have trouble trying to interpret all of this. And so we are able to provide 24 hours a day, seven days a week people on the phone or on the computer who are able to have a chat, to be able to say let's go through this information with you and help you to actionable decision-making based on the best information, the best science, based on the interpretation of the data and also with things to do with performance assessment.

So at the end of the day, we think that one of the things that the marketplace is doing well, and has to have the ability to continue to do, is to have access to this data that allows you to have seamless care coordination across settings, connecting multiple physicians, having them have access to the best evidence at the point of care, having supportive care to provide better safe care in hospital environments, connecting patients across hospitals, nursing homes, physician offices, and community and social support settings, and then finally sharing knowledge of information to patients for actionable decision-making. And I think that we are moving forward on that, and we would urge whatever can be done to not put barriers in the way of the continuing evolution of these movements.

Thank you.

(Applause.)

MR. HYMAN: Thank you, Dr. Tuckson. I would now like to ask all the speakers to come up and have a seat at the table, and we can have a moderated roundtable on these subjects.

Okay, well, I sort of carefully laid out the order of the panel so we had the government perspective first, followed by the provider perspective and payers at the back-end. And so a slight exaggeration. Peggy is not really a payer.

MS. O'KANE: I am not a payer.

MR. HYMAN: Fair enough. And our usual practice is to ask the people who went at the outset whether they had reactions or responses that they would like to make to subsequent speakers because the later speakers always have the advantage when they make their remarks of having heard what has gone first. So I will just start with that and then depending on where that goes, I have a number of other questions that I wanted to have people to discuss. Unfortunately, both Dr. Milstein and Dr. Kumpuris had to leave, but I am sure that won't interfere with our ability to have a great roundtable. So let me start with Chuck. Do you have anything you would like to add?

MR. DARBY: I guess I was encouraged by the fact that the patient was brought up a number of times, patient-centered care is at the core of this. The measurement aspect was mostly about clinical kinds of measures, and I think that in some ways I think we are further along in measuring the patient's assessment of their care than we are in some of the clinical measures. But I find it encouraging that we keep coming back to the patient as at the center of this. And not only as the client but also as someone who can bring about change.

MR. HYMAN: Chris?

MS. CROFTON: I was impressed by the fact that there are these common themes through all the remarks that people made, certainly about patient-centered care. And I think also about involving all of the players at critical points in the process of change. I think that the only way we can move forward is together, and there is clear evidence that we really need to, as somebody's slide said, not just try harder but change things, change the system.

MR. HYMAN: Dr. Bondurant?

DR. BONDURANT: I was going to make the same point about involving all of the players in this consideration. And I was especially interested in the involvement of the patient's perspective in some of those evaluations. But it seems to me that one of the things that continues to bug the quality assessment is the capacity to estimate risk accurately and to stratify for risks, as Dr. McGinnis was pointing out in his comments. The technology of risk stratification, to my knowledge at least, hasn't yet reached the point that allows as precise an estimate of the meaning of outcome differences as one would like to have in order to use outcome estimates most efficiently. And I would be interested in more discussion of that point.

MR. HYMAN: Dr. McGinnis?

DR. McGINNIS: It is good to see the continued emphasis, and I see it everywhere, on patient-centering. And I think as long as we keep the patient at the center, we rarely go wrong. But we do deviate from time to time because of individual group interests.

Another thing that came through to me, and I have been concerned about this for some time, is there is so much silo activity. There is a lot going on in quality and a lot of different silos, but how do we interrelate this?

The other thing that I think we all need to be concerned about is when we talk about quality, the driver must be quality data. How do we get quality data? The College had a meeting a few weeks ago, we are an umbrella of all the surgical specialties, we brought all the groups together and we had a great discussion from many quarters about the quality issue, a lot of input.

But the thing that kept ringing in my mind after that meeting is Janet Kerrigan from IOM who, in response to a question about data, used the analogy of post-World War II when the government evolved the National Highway system that is a model for the world. Is it time now, possibly with the government as the leader, to evolve a national real-time electronic data collection system so we don't have to keep getting these pieces here and there. She made the statement and then Barbara Paul from CMS backed it up, that this is where we need to be going. I would certainly be supportive of that sort of a movement. We need good data that everyone can respond to as accurate data and not tear apart.

MS. O'KANE: I don't really have anything to add at the moment.

DR. TUCKSON: I just would applaud this work of not only the physician performance assessment I talked about, but what the College of Surgeons is doing, that risk adjustment stuff. And I would just sort of say to you that I have seen that pretty carefully, and I have had a chance to study it. It is impressive. And I think what we have to do is to find ways of helping them to move that faster because, while at the same time that they recognize, and they are very good at pointing out, the challenges that their data bring us, the world can't stop and wait. And it is not going to stop and wait.

And so that what you have got to do is to try to help provide the resources for these good people to do their professional job in a way they are doing it. And I think that is really where the issue is.

MR. HYMAN: Okay, consistent with I think all of those remarks, let me start with what seems to me in some ways chicken and egg problems. That is to say, who you identify as the provider? The level at which you are going to aggregate to collect data is going to influence what data you collect and the extent to which anyone, and who those "anyones" will be, will be interested in the data and the use they will be able to make of it. And, conversely, who you identify as the recipient of the information is going to influence how you collect the data, who you are interested in getting the data from, and what that data is going to look like So let me just be very concrete here -- if you think the focus is individual patients, the data collection is going to look rather different than if you think the focus is CMS or individual employers or employer coalitions. And flipping it over on the other side, if you are interested in collecting data at the level of physician groups, you follow a different strategy than individual physicians or state-wide or hospital referral regions, depending on the level of aggregation. So, “Who is the patient?,” or, “Who is the customer?,” and, “Who is the provider?,” I think is the starting place for this question.

MS. O'KANE: I think what you want is a strategy that informs multiple audiences. I think we shouldn't set up a false choice between the things that might be top of mind for patients and the things that if you actually explain to them what the implications of the information are. In our focus groups, patients really respect the need for experts to look at whether the right thing is happening and is it happening the right way. So they see that. I am a consumer of airlines. I don't want to know how they maintain their safety systems, but I do want to know that they are really doing it and the experts agree that it is happening the right way. So I think that one is a lot easier.

And I think there the challenge is to take the patient-centered information, the technical information, and other things that patients need to know about and translate that into something that means something to them or to use it in a way that makes them safe. I don't discount the use of this information for regulatory purposes either.

So I think we just need to be very strategic about making sure we are collecting no more information than we need, but we should definitely not be setting up these false choices. I think there really is common interest in having the right thing happen and having it happen in a patient-centered way.

MR. HYMAN: I wasn't, just so we are clear, trying to set up a choice, let alone a false choice. But to suggest the range of possibilities and what you target influences what you get. So Dr. Tuckson?

DR. TUCKSON: I just think that Peggy is right on track here. And I think that the challenge then becomes -- because, first of all, all of these things are integrated. If you think about the data that you need regarding a center of excellence or a tier, in terms of the best kinds of facilities for a particular condition, that will be interrelated with, in some ways, what the individual clinicians do at that level. So you will have some individual clinician issues. You will have a facility issue and so forth.

And so I think one of the real things that we have to focus on is, as Peggy just expanded on, she said, “Make sure we don't collect too much. Collect the right things.” And the other thing is let's collect it once. Let's have all of the data that we need, so let's find a way to have all these things line up because the last thing you want to do is, let's say, have a physician have to collect stuff at the office level, then you go to the hospital, they have got to collect something and it is different and so forth and so on. You waste a lot of time and energy. So I think if we can start to put that together.

Finally, the real thing is you have got to start somewhere. And we are having enough trouble, but I think encouragingly we are getting somewhere today with the caveats we have heard. But now you start thinking about that comprehensively ill person who requires multiple interventions across clinicians, across health settings. The unit of measurement that is going to be relevant for that person will be very individual compared to another person in the system. And so the unit of measure may include a physical therapy, occupational therapy, home health aide experience along with an in-patient ICU and so forth. And you can just make up such multiple permutations for many other patients.

And so at the end of the day you are going to need to eventually get there. We are a long way from that now, but I think of this idea of a common data highway and collecting intelligently and getting to some kind of metrics that allow us to build what we want for the future, then we can sort of address those as we get more mature and sophisticated.

MS. CROFTON: I think that is a really important area and a very sticky set of problems because the kinds of data you might want for one purpose aren't necessarily the kinds of data you might use for another. An example from the CAHPS project is when we started developing the surveys, we had the clear focus in mind of using the information for consumer choice. This is information we would give back to consumers so they could use it to select a health plan and as we have gone down the road to select a provider, a hospital or whatever else.

But if you want to collect information that will allow a person to compare across a lot of different health plans, hospitals, or whatever, the questions have to be somewhat general. That isn't the case if you want to use the information for quality improvement. The information you get from people has to be a lot more fine grain to tell you where the problem is, what specifically is going on, and what you need to do about it.

So given that there is this dilemma of these competing needs and how it affects the questions you ask and the information that you put out, I think we need to have some kind of grand conversation with representatives from all the groups that might want to use the information, to talk about what we are collecting when. And I think also to develop good lines of logic for why we are doing that because I think that people are more likely to complete a longer survey or to be surveyed about what they see as the same topic if they understand that it is not just sloppy management but that there is a real reason for going after different pieces of data in different ways at different times.

So I think, again, we need to pull the stakeholders together and have a conversation about that and see what we all agree is the most effective way to go about it and the most efficient way to go about it in terms of cost and burden.

MR. HYMAN: Chuck?

MR. DARBY: Related to that, there are major challenges in doing surveys of patients and this idea of what level you are going to do it at. And I talked a little bit about it on my slide, being able to collect data about health plans, about groups, and about individual providers. If you could possibly do that at the same time rather than with duplicative surveys, you have reduced burden and you have reduced cost. But it is a challenge because in each market in the United States there is a little bit different structure in terms of groups and how they relate to plans. The simple issue of drawing a sample of patients -- do you draw it at the individual provider level and then roll the data up to groups and plans or do you draw a sample of plans and then try to break it down to the various providers? That differs depending on what part of the country that you are in.

DR. McGINNIS: I have another shot at this data issue because I think it is so important. We keep trying to fix the system based on the history of the way we have been collecting data. And most of our data has been collected retrospectively or we collect it piecemeal or we collect it for certain purposes, payers, insurers, all interested in different pieces of the data. But what I am trying to get us to think about is a new vision, an over-arching vision of the importance of data in health care. And if we could -- we are the marvel -- this nation is revered the world over because of the way we handle data electronically. If we could move to this where, in treating patients, that data was collected on a real time basis electronically, we would have the capacity to analyze this for use by all of the different groups. Everybody has a different need for the data.

But I think we do need to put this think tank together. But to think in a global visionary manner. The opportunity is here, and I hate to see us continue to go down the pathways that we have in the past. We spend a lot of money on data collection, but does it serve us well?

MS. O'KANE: I just wanted to go to the second part of your question, which is, “What is the right level to be looking on the provider side?” And I think, in my mind ideally, you would have an accountable clinical entity of some kind. On the hospital side, it seems to me, it should be the hospital. On the outpatient side, it could be a medical group, but we know there aren't that many medical groups out there. It is not a good approach for the whole country.

But I think that there would be, this would take some work and some heavy lifting policy-wise, but physicians could be asked to affiliate with an entity like this, and using IT you can create the connections that allow for the kind of communication and coordination that we know is absolutely crucial. I mean the questions about, I forgot whose slide it was, “Who is accountable when there are five doctors involved?” Well, nobody really is.

So I think that there are some different ways of thinking about what is the entity because we are not going to get the kind of coordination or efficiency that we really could get until we have this kind of aggregation.

But that is a longer term agenda. And I think too often in the world of policy we get hung up on the longer term questions, and we don't move forward on the shorter term questions, which actually help us think about the longer ones better. So I would just like us to think about moving forward rapidly on things that we know we can do that aren't going to do harm, but also keeping the other one on a parallel track.

DR. TUCKSON: And as regards to the second point, clearly, we do need to be able to report about the behavior of individual clinicians, just as we report about individual facilities and hospitals and renal dialysis centers and nursing homes and so forth. The issue is how sophisticated can you be today? I think we all are clear, and we have at least resisted the need, or the desire, or the call, to put individual performance data that we now have available on our consumer website for patients to see. As I said in my remarks, I don't think it is ready for that. We don't think it is statistically valid and so forth.

However, there have to be some intermediary steps. And I think, for example, the Bridges to Excellence idea and the NCQA certification for diabetes and the new measures that they will have coming forward in terms of certifying that a clinician has kept faith with a process, with the guidelines that have been recommended by their colleagues. I think CME credits, the new move towards continuing certification on the part of the boards, these are all positive things which I think can be used. So I would say if your question was designed to see whether or not there is movement, and interest, and a push, for some level of individual clinician measurement and also performance satisfaction that we heard from AHRQ, if there is a move to make that available, there absolutely is and has to be going forward, even as we get to the level of actually being able to talk about specific clinical issues.

What I would finally say is that what we are not excited by are the report cards, the grades, the five star doctor based on malpractice data and those sort of things, those we don't think are very useful.

DR. BONDURANT: I was just going to do the theme that Reed just touched on, and that is to point out the power of the kinds of information systems that we are now describing in the educational system at all levels. And Reed mentioned the re-certification. But in terms of even enhancing the adaptability of the systems so that when new kinds of information or new kinds of problems come along, the system can respond more efficiently and effectively. Bio-terrorism is a quick and simple current example of that. But I think it applies to all of medical education, not just for physicians but for all providers throughout the system. And that is part of the great vision that LaMar was referring to I think.

MR. DARBY: I think it was Dr. Tuckson's slide that showed that we are sort of collecting data in silos and we sort of think of health care in these silos. And when you think of a patient who has a chronic condition or some episode of illness, they see more than one doctor and go to specialists and go to the hospital or go from the transition of a hospital to a nursing home. And I think a challenge that we need to face in measurement is how we look at the coordination of care because it is absolutely critical to those patients when they have that kind of situation.

DR. McGINNIS: If we are going to continue on this data area a little bit longer, in reference to Reed's comment about what we do -- and Margaret's comment about what we do now until we get to this vision of the future, let me just talk a little more about the NSQIP program because I think it is important to think about that. It is interesting to look at the history of the way this evolved. In the late 80's, some really dramatic incidents came out of the VA system of error and poor quality. And it caused Congress to give a direction to the VA, study this, act on it, and report out. And over the years, this National Surgery Quality Improvement Program evolved. And so it began in '94 and it has been extended through the 112 VA hospitals. It now has data on almost a million patients. And they have successfully been able to lower morbidity by 47 percent and mortality by 27 percent -- now those are big numbers to me -- in this system.

And so it went through an alpha trial at three hospitals, Emery was one. And now it is out in 12 hospitals for beta tests. It still looks good. Chukra Khuri, who is the PI of this out of Harvard, feels that it is adaptable across the board. It is not just surgically confined. And the thing is, the value is the risk adjustment and that is what really causes physicians to pay attention to it because they know there are enormous differences in patients. And particularly with the aging of American and our ability now that cancer has moved into the consideration of chronic disease, we have a whole new range of what we look at as a chronic disease. And so we have got to be able to look at the complexity of patients and collect data in that regard.

MR. HYMAN: Let me sort of push this in a slightly different direction but based on what we have already talked about. Obviously, how you rate care is going to turn out to be multi-dimensional. So the data that you are going to gather is going to vary tremendously based on what it is that you are interested in. And I will just give a couple of things that we have some formal framework. Process versus outcome is one obvious cut, subjective versus objective, global measures versus disease-specific measures versus treatment-specific measures. Okay, so we have a sort of range of possibilities here.

But that is a completely different inquiry from who puts demands on providers to collect and either just turn over or collate, aggregate, analyze the data and what the list of data collection is. We have heard some discussion about a meeting where we would all come up and meet together and decide what we all wanted. And I think Dr. McGinnis' point about the path dependence problems with our current use of measures, we came up with them for reasons that don't necessarily have anything to do with our interest in quality. So that suggests maybe it is time to step back and think about new data measures.

But a common -- and then I will get to the question, a common complaint of providers is the burden of having to collect multiple measures for multiple entities, some of which account for a big chunk of their practice, some of which are a very small chunk of their practice, and all of them are different. That is a very commonly heard provider complaint. So what is at stake here is, “Are we going to do this top down or bottom up? And how do we end up making sure that it is worth the effort?” That is probably the basic question I want to put on the table now.

MS. O'KANE: First, I am going to kind of rain on your parade, I guess, because NCQA actually when it was launched as an independent organization, our mission was to try to get standardization of performance measures. Our original grant to RWJ in 1990 was about that. And I think we have achieved some -- at least as far as health plans go, there has been some standardization around HEDIS. The National Quality Forum was then established to do the same thing.

There is an insatiable desire to control the agenda by the different parties. And I think it is really our common problem.

MR. HYMAN: I am shocked, shocked.

(Laughter.)

MS. O'KANE: I think there are certain things that need to be done by a group that has multiple stakeholders and that is not beholden to any single stakeholder. Guidelines, for example. We have a horrible story of what happened to what was then AHCPR and now AHRQ in terms of the ability of one individual and one organization to sandbag something that was an essential public good that is crucial to the future of performance measurement and improvement. We really need a constituency that represents the public interest here. And there are certain things that have to be delegated to that constituency. We do not have that. At NQF, I think there is a lot of goodwill around that table but there is still plenty of ability to go off the reservation and it has happened.

So there is a political challenge that is sitting here that is not to be ignored or underestimated.

MR. HYMAN: Hence, my question.

DR. TUCKSON: First of all, I think it is a very good question. There is a dynamic here, I think, that while I can understand physicians and hospitals being concerned about the leadership of the employer community, the insatiable push as they try to figure out how they are going to stay in business everyday and as those constituencies go forward, there is this push now that they are having. It is an uncomfortable push I am sure but I think it is one that is leading us to change. And I think that is a healthy movement.

Similarly, I think that the ability for and the leadership that we are seeing by organized medicine, whether it is the physician performance consortium or specific colleges like the ACS, is encouraging because they are moving forward. Now the dilemma is how fast and how well will organized medicine be able to address the need for change. They have a resource problem and they have a membership problem. What is great about the leaders of organized medicine is that they are committed. Their members don't often like what they are committed to because they see threat there.

And so the issue is, “how do you have the right political mix?” And I think Peggy is right in saying this is a political issue, how do you have the right mix between the push from outside and the speed and pace of change from within? And you sort of need a spur there. I think that that becomes key.

Finally, the place in which this occurs, I think there was a very important moment, I think in the history of this, when CMS announces that it is going to measure physician performance. That was a very important moment. What is even more important I think is that they went to the AMA consortium and said you should be the place to develop the measures. Now it didn't work out perfectly but I think at least we know, at least from what I understand, there is some relationship there, that they are working together.

I think that it is also clear, that it is on the public record that a number of the health plans, several, have come forward and said that they would be willing to participate in a synergistic effort that uses those same measures as the core. And that they are willing to change their behavior. I do know in fact, and I can say that we are one so that this is not theoretical. So I think what you are starting to see are folks lining up. Now the National Quality Forum I think is really going to be a critical place that ultimately brings a lot of this together, and we would have to say that we are encouraged by the potential there. And I think that Peggy's cautions are appropriate and we have to help find ways to make sure that that is the place.

So I guess the long and short of it is that this may be an uncomfortable moment but the marketplace is working. People are pushing. Things are happening. And that there still will need to be some attentiveness to the pace and speed of change. It will be uncomfortable but the terrible thing to do would be to create any environment that thwarted the movement that is already now moving forward.

MS. O'KANE: Can I ask you a question? I don't know if this came up yesterday but there has been consolidation of providers in many markets that really make it impossible to make this agenda work. I am talking about in the hospital sector. I suppose it could happen in the physician sector. But I know that the FTC did try to raise concerns about this and that these issues kind of fell apart in the courts. And I have heard some discussion about the current leadership of the FTC being concerned about this issue. I don't know if you are able to speak for this but I think it would be an incomplete discussion if we didn't talk about some of the factors that, even if you have good transparency, it is hard to know what the mode of action is?

MR. HYMAN: Yes, good law professor question. Let me respond to the question with a question.

MS. O'KANE: I am not a lawyer.

MR. HYMAN: But I am. Let me for the members of the audience who were not here yesterday or aware of the Federal Trade Commission's record in enforcement issues. The Commission has brought a series of cases and taken consent judgments in cases involving physicians who essentially organize themselves in ways that are not consistent with the antitrust laws. And there have been five or six of those cases within the last year. The Commission has also challenged a variety of hospital mergers, alleging that they are anti-competitive and along with the Department of Justice says failed rather miserably in those challenges since the mid-1990s for reasons that we actually held a full day of hearings devoted to. I guess it was a half a day.

But the chairman of the Federal Trade Commission announced last year that he would start a merger retrospective to look at consummated mergers and see whether the predicted adverse consequences had actually materialized and has also announced that depending upon the results and if he can see a viable remedy, they will pursue those cases administratively.

But that takes us to the question, which is sort of the level at which there is push back, okay. There has been remarkable unanimity around the table and at all of the speakers about the benefits of information, the importance of collecting it, aggregating it, using it to drive the marketplace. To which the obvious question is, “Who is not in the choir and what are they doing to sandbag what is going on here?” So without pointing fingers at individually identifiable individuals, what is the pockets of resistance? And is it that hospitals are essentially unwilling to accept additional data gathering responsibilities without additional compensation? Are there legal or regulatory barriers that complicate the process? If everybody is in agreement this is a good idea, why haven't we done it already?

MS. O'KANE: I think it is wrong to think everybody is in agreement about this. I think there is tremendous resistance to this. I think sometimes the resistance is appropriate caution. Oftentimes it is just what you expect. There have been other examples outside of health care of industries that didn't want to be particularly accountable for things and so on. So I think it is a reality. I think it really would be unwise to underestimate the power of the forces because there are reasons why we don't have some information that we should have today. It is not an individual, it is a common behavior of industries I think. And part of the reason the FTC has its role is because if you own a market, you are in a position to dictate prices. And that works in health care even in a more insidious way because in health care we are able to create our own demand. So if we create more supply, there will be more demand.

MR. HYMAN: Fair enough, but there is a

difference between inertia and anti-competitive behavior. The antitrust laws are appropriately concerned with the latter. And the former we depend on markets to sort of motivate people which is why miles per gallon go up relative to what they were in 1970. Law professors are very fond of automobile metaphors for those of you who haven't heard that one.

Does anybody else want to be heard on that particular issue?

DR. TUCKSON: I am not going to be able to give you the level of detail, I am not a lawyer. And there is some lawyer stuff in there, your question somewhere, so I am going to be careful. But I think that there is no question that we have experienced dominant players in the marketplace who basically can say to us, and who say to employers as well on whose behalf we operate, “We don't have to play this quality game because (A) we have got the market; or (B) we are the only game in town. And either way we can thumb our nose at this thing and we will continue to do what we are doing and provide lip service to the people who come here saying we are going to give you some information about quality.” And so that is a concern. There is no question about it. And that could frustrate this movement.

And I think the other area in terms of these

FTC or Justice Department issues, again, would be anything that would impede the free flow of information, that allow us to break down these silos for whatever kinds of reasons. We have had enough experience with state attorneys general who may want to interpret some legitimate concerns around privacy and those issues in a way that would stop the flow of information for health and safety purposes. And so I think we have to be concerned there.

But there is no question that there are many markets where we see this occurring, where we don't need you. And if you want to try to play an incentive game by providing information in a way around quality, differentiation of quality will drive patients into the system. If we don't need any more patients, we don't have to play this game.

DR. McGINNIS: As Reed said, the leadership of medicine is committed to what we are talking about. But when you look out at practicing physicians, physicians still are practicing in small groups. There are very few individual practitioners but they practice mainly in small groups. They have been through a sea change over the last 10 or 15 years. They are trying to survive. They are busy. They get up early and go to bed late. And get called during the night and work on weekends.

They have a presumption of quality. So for them to accept the notion of making changes relative to quality, they have to receive quality data from institutions that they respect. But, as Reed also said earlier, physicians will respond to information. They want to do the right thing.

And so I think to get their attention we have to supply the data that indicates more heavily than the IOM reports, and they are monumental, that there is a problem in quality. I know physicians that have taken the time to look at the IOM reports do note very rapidly that despite the impressive membership, there is virtually not a practicing physician on the IOM. And that does have some bearing on how much attention they pay to that report. But the report is having a resounding effect, unquestionably.

MS. O'KANE: Can I make a comment?

MR. HYMAN: Sure.

MS. O'KANE: I think that this is a moment that is a real opportunity for physician leadership. And I think that -- I don't underestimate the challenge that it presents for organizations like the College. I think physicians feel very beleaguered, and appropriately so. They have all these different regulatory things that make no sense to them. They have different plans coming in with different formulary forms and there is just a lot of stuff that makes their lives full of, it feels like, non-value added activity. I believe that, I say this, stick my neck out, I think that if the physicians could come forward with sort of a proposition for plans and for others, that in return for some standardization on their side and in return for some relief of non-value added regulatory stuff the physicians face, and in return for some rationalization of the malpractice system, they would be willing to have certain things that they would do, like have systems, follow guidelines.

DR. McGINNIS: Now you are talking.

MS. O'KANE: I think that there is a moment where a new bargain could be struck between physicians and society. And physicians are in the driver's seat in many ways. They are the stewards. And they don't make all the money for all the tests that they order and so forth. But physicians I think, I hear physicians from many of the specialty societies that we talk to saying that they understand that the system is going to crash and burn if it doesn't start working more effectively.

So I would encourage the college or others to sort of come together and really listen and be in the dialogue. I think part of the problem is that each of our sectors wants to come and inflict our strategy on the other. And I think it really is important to get a dialogue going to recognize that there are appropriate concerns being expressed by each sector and that maybe there is a collaborative solution that would work.

MS. CROFTON: I wish I had an answer to this question or some kind of resolution, but I just wanted to comment on what you said about having so many choir members here. And I think there were a lot of common things in what we were talking about and acknowledgment of common problems, but I don't think in terms of collecting and disseminating quality data that we have a group of people who are linking hands singing Kumbaya. We are just not in that place. And I think the reasons that we are not vary from user to user, user of quality data to user of quality data. But something that I think is encouraging to me is that that there are processes for that that can bring about alliances over time that will make these things happen.

And I am thinking particularly of the early days in our project, in CAHPS, when we were working on the health plan questionnaire. NCQ had a questionnaire that they were using for the same purpose that was a giant leap forward from what had been done in the past through a long, collaborative, sometimes contentious process through which we all collected a whole lot of data and reported on it to each other. Over a process of years we came to agreement about what that questionnaire should be. And I think part of the reason that we did was because we realized what we all had to lose if we didn't have that common measurement tool. And I think that is what really clinched the deal.

But I didn't want to let this moment pass without some acknowledgment of the facts that those are long, time-consuming processes and they are well worth it in the end if you get to that point of common agreement. And I think that we have got more than one demonstration of the fact that it is possible.

DR. TUCKSON: And I would just underscore that even though you are right, we may have -- this is not perfect yet and we are not singing Kumbaya but let's take the example that both Peggy and I used in our presentations, which is the Bridges of Excellence. Here you have a disease that is important to talk about, whether it is global or disease specific. This is a good one, that is a good disease, epidemiologically important. You got a good set of measures that include process and outcome. The measures were developed in part by the AMA performance consortium, so physicians were at the table around the diabetes measures, along with multiple other stakeholders. And everybody agreed, through a consensus process of evidence-based criteria, so there is no argument around the measures, it aligns incentives, it connects the marketplace of payers, plans, and physicians and aligns incentives around behavior. And then makes it transparent for patients.

So there are examples. And this is a new thing. How long did it take for that to get done? It didn't take years and years and years. This was done in a pretty expedited way. From soup to nuts, in a year.

MS. O'KANE: Not to be negative, but it built on like 10 years of back and forth and squabbling. We had to work it with the DQIP project, which was started by the American Diabetes Association and CMS and so on. But I think your point is really well taken. And I think we can sort of -- there is a way of expediting, sort of looking at past history and saying why did that take so long and how do we get to yes faster.

MR. HYMAN: Well, let me see if I can get some disagreement on a specific issue, then. The first issue I want to just put on the table is public dissemination of measures as opposed to private use for quality improvement. What I heard from NCQA is it is very important to have public reporting so I wrote this down to rivet provider attention on the issue. Get them to focus on it. And I don't think we will have time but it is an interesting question, how you go about doing that. Is it simply the publicity? Is it money that will flow from it directly or volume that will flow from it? An interesting set of questions.

But I also heard from Wellpoint that some of the measures are ready for public dissemination and others are not. And that is a particular decision that -- I am sorry, United Health Group, excuse me -- that they are not going to use all of them. And I heard from the American College of Surgeons that it is important to have data for private, internal CQI usage. And I didn't hear any particular mention of public dissemination of the results. And I don't want to speak for everybody else because I didn't hear anything explicit on that. So public dissemination, everything? Some things? Nothing?

MS. O'KANE: Not everything. I think it is very important in areas where we are very clear about the science base, we are clear that the data are reliable and so forth. In our provider recognition program, it is a different model. You have to reach a target in order to get the recognition. And it is set very high. It is set way above the national average for health plans. So we don't report, for example, on how Dr. Jones in Minneapolis did on his diabetes measures. He made it over the bar and that is what we report. We do report on an aggregate basis and we have seen improvements over time among the 1,800 doctors that are in the program. But I think that one needs to be sort of practical about this in that certainly if you want to have public reporting of problems, I think it becomes very difficult because there is a real incentive to hide problems.

So I think you have got to realize this is more complicated. I am sorry we don't have any easy answers to any of your polar questions.

DR. TUCKSON: Let me be very clear in terms of how we view this. We brought together the leaders of the American Board of Medical Specialty Societies, the Council of Medical Specialty Societies, the AMA, the Performance Measurement Consortium, the ACGME that credits graduate training programs, and commissioned the best paper, the best thought we could get on this field. And they made it very clear that at this point in time it would be inappropriate, and basically we would also drive physicians underground almost essentially if we were to release the data, just raw data around performance, around specific diseases. This is just not appropriate at this time to do it.

So there are fall back positions. And I think those fall back positions are actually pretty good. They are not bad. There are other things like the NCQA recognition program that says, “Did your physician actually comply with the guidance that they were supposed to do? Did they do the things they were supposed to do consistent with agreed upon standards? And we will certify that in fact this has occurred for this particular disease.” And that is an important thing. Without presenting all the raw numbers and the data, it simply says that they have met a standard. And we will put that on our provider directory and say to the patients, “this person has done this thing.” And that is a kind of a reasonably intermediate.

In our company what we think we will do in addition is to say, “Did your physician review and study and interact with their actual clinical data? Did they learn from it? Did they read the literature associated with this particular disease? Did they comment to us about their performance and talk to us about whether they are going to continue to do what they are doing or have they changed and why? Have they read literature and showed those things?” Then we will be able designate as part of continuing medical education, or as Dr. McGinnis more aptly named it, continuing professional development, and be able to indicate in the provider directory this clinician has actually worked with this information, showed signs that they know it, have gotten continuing professional development credits for it and you can designate that.

So I think that there are things that are reasonable and legitimate to do without frustrating clinicians in their desire to improve performance and still let patients know information that is actionable for them in terms of making their decisions. And we could take this into greater depth but we don't have time now.

MR. HYMAN: Feel free to correct my characterization of the ACS position.

DR. McGINNIS: I was going to say if I said what you said, I mis-spoke because we do not have organizationally or philosophically opposition to transparency. But it is the kind of information that is reflected. We want it to be accurate.

Let me give you some specific examples. The College, through our Commission on Cancer and in a collaboration with the American Cancer Society, in trying to give information to the public, we have on both the College's website and the Cancer Society website information about hospitals, facility information, what they have available, specialists, technology. We have a level of information regarding experience, that is the numbers of breast cancers treated, the numbers of colon cancers, that is available. The third area we wanted to have was outcome information but since the outcome information in the National Cancer Database is not risk adjusted, hospitals are obviously reluctant to have that sort of information released. So we have not done that.

Relative to guidelines and giving public direction to guidelines, we have begun to recognize from the Cancer Society's standpoint that the National Comprehensive Network has these guidelines for the care of cancer patients that we believe are gold standards because they are evidence-based and updated annually. And so we have promulgated those to the professional community, and we have translated those to lay language. And further translated them into Spanish and are doing this into Chinese and making these available so that they can be available to the patient. When they go talk with their doctor, they can sit down and understand what the doctor is saying. So we want to have this openness but it has to be properly based.

DR. TUCKSON: Now you did want to try to get a little bit of -- I will provoke just a little bit in the sense of saying, “By the way the scenario I described will only hold up for another 12 months.” It is not going to hold up much longer. And I will tell you, just in terms of the real world out there, we get smashed by purchasers who are very frustrated with the answer I just gave and are essentially saying, “Why are you not giving our employees this information?” And they are only going to buy off another 12 months, 18 months on waiting for all this stuff to get moving a little bit faster. And so we will be back here, if you hold this meeting a year from now and you come back and say where are we now, you are probably going to see a lot more tension or we will have seen a lot more movement.

The other thing is that, and I think Peggy's point, I don't want it to get lost, is essential and that is the tort system. If the tort system is not addressed, this stuff goes down the toilet quick because you can't release this information in the litigious environment that we have today and not expect doctors to get the heck sued out of them.

DR. McGINNIS: Amen.

DR. TUCKSON: So we just have got to get it done.

DR. McGINNIS: And that is particularly -- well, it is pertinent to all of this but when you get down to errors, if the reporting of errors is not protected, it is just not going to happen. And that is so hurtful to a system of correcting errors.

MR. HYMAN: Let me just mention something that

I think has not really been mentioned yet, which is the issue of privacy, HIPPA, the extent to which that interacts with the ability to get data and to disseminate data. And if anyone wants to say whether it is a real problem -- well, I won't give you a false choice. Tell me whether it is a problem.

MS. O'KANE: They teach you to think like that in law school I think.

I think there have been a lot of problems with HIPPA. We know a lot of the people who are involved, we and the joint commission co-convened meetings on privacy when these issues were being debated, and we believe very, very strongly that there are real serious issues related to privacy, that they are huge concern to patients and that they ought to be.

But I think there was a sort of separate community of the privacy advocates that really wasn't in dialogue with anybody in health care. So the goal of maintaining privacy became the paramount goal. And the way HIPPA was originally written and the way it is interpreted I think by many is that privacy should overwhelm other concerns like accountability and coordination of care and so forth. We have written numerous white papers talking about conflicts between what HIPPA was proposing and what were other regulatory goals and CMS goals for Medicare and so forth. But I think that there are still -- and I think that there are people out there on the provider side who are using privacy as a shield against accountability.

So it is a cautionary tale about the conflict between various important goals and the need to reconcile them and to have sort of -- it is very difficult when you have different agencies implementing different things. But, again, it is very important. It is a concern, and it continues to be a concern.

DR. TUCKSON: Just only, again as a company that provides and coordinates health care benefits for people in 35 of our states, so many of our customers are regional customers. To try to be able to move information in a way that benefits them across states even is tough, with the individual state mandates, state kind of rules and regs. But at the end of the day, as I tried to show in my slides, you cannot possibly coordinate care for people, particularly again with the range of things that a person needs who is ill today. It is extremely important to make sure that you can connect the information systems around Meals on Wheels, home health aid, mobile vans, with the endocrinologist, the cardiologist, and the physical therapists. If those folks can't all work together, this poor patient falls through the cracks. And what falling through the cracks means is 14 different people providing different medications, some of whom are not compatible with each other and interact poorly with each other, missed appointments or too many appointments, waste in the system.

It would be a tragedy if we were to take a legitimate interest in privacy and confidentiality. And of course you have to. We are all, as physicians trained in that from day one, about the importance of that as an ethical issue. But to misuse that provision in a way that caused death, misery and suffering would be just horrible.

MR. DARBY: From the standpoint of doing research and collecting data, I think there is chaos at the moment. And it created an industry. I get at least three e-mails a week inviting me to a seminar to explain it to me. I don't know whether all three of them would explain it in the same way. I suspect not. But I think it has set us back some. I think long-term though the issue of privacy was critical and hopefully it will be sorted out.

MR. HYMAN: Let me just give each of the panelists a very brief opportunity if they wish to make any closing remarks and let me go in reverse order. So

Dr. Tuckson?

DR. TUCKSON: I have said too much already.

MR. HYMAN: We accept waivers.

MS. O'KANE: I just appreciate the opportunity and the intelligence of the questions that you have posed. And I also learned a lot from my fellow panelists.

DR. McGINNIS: To comment just a little bit further on HIPPA, I think the question is out largely. It is a great hassle. It was very important but it is another example of excess that comes out of Washington. So in correcting something good, they have the potential for causing real harm and particularly as it relates to the research but to patient services and many other areas.

It has been a pleasure to be here. Thank you.

MR. HYMAN: Mr. Bondurant?

DR. BONDURANT: It has been a pleasure to be here and thank you and the FTC for holding the hearings. And I would like to identify myself with Dr. McGinnis' remarks about HIPPA.

MS. CROFTON: We appreciate the opportunity to be here to speak and also to learn from people on the panel. I think if somebody asked me what was the big take-home message here, the one recommendation I would like to see carried away, it is about the power and importance of evidence in straightening some of these dilemmas, and particularly in the task of getting people to unlock their grip on the agenda and to make it a shared agenda across the board. I think evidence is really going to be the key to that.

MR. DARBY: I just echo the thank you and it was a great opportunity. I learned a lot also. One thing, just to come back again to patients, I get frustrated because there doesn't seem to be a way to really hear what patients have to say. Organizations, various stakeholders, they spend a lot of time together and we can hear them very clearly. But even though there are some great consumer organizations out there, there doesn't seem to be any that speak for all of them in some way. And until we have that ground swell from consumers to say this has got to happen, it is going to be very hard to make it happen.

DR. TUCKSON: I actually would like to get my last comment. And that is just to commend the FTC for its attentiveness to this issue of anti-competitive practices. I think at the end of the day it is tough out there. It is a tough marketplace. It is a tough battleground and health care is different than other environments. And how you exercise your responsibility in public accountability in this regard will say an awful lot about whether or not this movement is frustrated or whether it will go forward. But this is hard ball. It is tough times out there. And we urge you to continue to be attentive.

MR. HYMAN: I would like to thank the panel, and I would ask the audience to join me in applauding their efforts here.

(Applause.)

(Whereupon, a lunch recess was taken.)

AFTERNOON SESSION

MR. HYMAN: Good afternoon. Thank you all for coming to this afternoon's session of the hearings on Health Care and Competition Law and Policy, jointly sponsored by the Federal Trade Commission and the Department of Justice. We have a very distinguished panel, which I will introduce momentarily, but first, Commissioner Thomas B. Leary of the Federal Trade Commission, one of five commissioners that serve on the Commission, will make some brief opening remarks. Commissioner Leary has extensive experience in antitrust and has been speaking more recently in writing as well about issues relating to the application of competition law to health care.

Commissioner Leary?

COMMISSIONER LEARY: I am pleased to be here, and I want to thank you for your patience in listening to me because the fact is that probably everybody in this room knows a great deal more about the subject of health care and competition than I do. And that is exactly the point. That is why we have these hearings. The Federal Trade Commission, as you probably know, is not a sector-specific agency, unlike the Federal Communications Commission or the Federal Energy Regulatory Commission which focuses on specific sectors of the economy. We are supposed to be experts on competition and consumer protection across the entire economy. And, as a result, we do not develop an embedded expertise in any single sector to the degree that a sector-specific agency would.

And at the same time we have responsibility for policy development in those areas. We are not just prosecutors. We weren't just created to be prosecutors by Congress in 1914. We were supposed to be policy-makers and we were supposed to listen to people in various affected communities. And we were then supposed to kind of apply our own expertise in general and then make policy on what is sensible competition law or consumer protection law. And that is what we are about. And this is sort of the input part of it and that is why these things are so important.

So my basic message to you is I want to thank you. I want to thank you all for the time and the effort that you put into helping us to sort out these problems.

As you know, the current hearings on consumer information are part of an extended series of hearings on health care, which we had starting I guess last fall and which will continue into the future. I don't know how many more we are going to have. This is just one segment of the problem and it is a very, very -- it is a piece of a very large problem. As I view this from afar, it seems to me that there are some over-arching, extremely difficult issues in the whole area of health care that make these markets different. And they are all familiar to you. The first one that always occurs to me is the third-party payer situation. We were taught our economic models, the things we deal with basically are by a buyer and a seller.

And you all learn what happens in the equilibrium that a market arrives at with a buyer and a seller. And here we have at least three key players. You have the people who pay for the services and the goods; and you have the people who provide the services and the goods; and then you have the people who get them. And the outcome of that equation is not something that we are used to dealing with. And it leads to, as you all know, pressures for more and more and more services. And pressures for more and more expenditures on health care.

And yet at the same time, it seems to me, as you get into more and more affluent society, and not withstanding momentary dips, the trend is upward all the time, the real dollar income of the average person in the United States today is four times what it was when I was a boy. And so that is the trend. And, as you might expect, in an evermore affluent society a greater and greater percentage of the overall pie being devoted to health care and a smaller percentage being devoted say to food or various other essentials of life.

So it is kind of hard to know how much increase is good or bad. It is hard to measure performance in this business. We are trained as antitrust lawyers to look out for various actions that reduce output and increase price. That is kind of the hallmark of an antitrust problem, something that reduces output and increases price, either by a monopolist or by some kind of a conspiracy. And what does it mean to reduce output and increase price in the area that we are talking about here. It depends I guess on what you consider output. As a provision of procedures, is that an output or an input? It might be a good thing to reduce output if you consider it as an output. And it might be a good thing to substitute high-price procedures that are useful for low-price procedures that are not. It might be a good thing to spend a lot more money up-front on preventive care. And if you do that, why obviously you are going to have price increases, immediate price increases but hope that it will save money in the long run or that people will live longer. The longer we live, the more we spend on medical care.

And so all I am saying to you is that for us, in the position I am in as an antitrust lawyer for over

40 years, the problems in this area are quite difficult.

And finally, specifically what we are talking about here, your piece of it I understand for these days is consumer information. And we come from a -- it is kind of an article of faith with us, that markets work best when you have more and more and more accurate information going to consumers. And they work less well when you have inaccurate information going to consumers. And one of the problems that I see as a kind of an outside observer of this kind of a marketplace is that because of what the Supreme Court called in California Dental case, "information asymmetries," a great imbalance in knowledge between the people who are, say, providing the care and the people who are getting the care. How do you provide more and more information to consumers so that they can make more intelligent choices on their own and at the same time avoid misleading them because they don't have available to them the same critical facility that most of us have as consumers.

But that is not a problem unique to health care. There are all kinds of very, very complicated products that we buy in our own lives, apart from medical products and services, where there is the same information asymmetry. So that is not a unique problem, but it is one that characterizes this business.

I guess my ultimate belief is that more consumer involvement in their own health care decisions is a great deal better than less. And that one way or the other that is the direction that we should be staggering toward. And I also believe that very firmly that ultimately we ought to be trying very hard to work out a reward system in the medical care field that rewards outcomes to a greater degree than inputs, as it does today. And I realize that these are not easy issues but it seems to me directionally that as personally where I think we have to go.

And having said that, I just want to leave you here. I am unfortunately under water on a lot of other stuff, but I promise you I will read the reports and transcripts of these hearings. I always do. And I wish you well, and I want to thank you again.

(Applause.)

MR. HYMAN: Thank you, Commissioner Leary. As you can see, nobody is seated up at the table. That is because there is going to be lots of Power Point shown, and it is very unpleasant to sit in these seats and try and twirl yourself around to look at it. But the panel is no less distinguished from sitting in the audience than sitting up front.

I am going to introduce them in the order they are going to speak. And our rule here is very brief introductions because you are here to hear from them, not from me. We have prepared this bound set of bios, which is available outside on the table, along with some of the hand-outs from individual speakers as well as some hand-outs from this morning.

The basic plan is we are going to have a series of presentations. And then at the end of those we will take a short break and then we will use the time remaining to have a moderated roundtable discussion among the panel participants. The focus of this afternoon's hearings, as with this morning, is quality consumer information, focusing on physicians.

So I am going to introduce the entire panel and they will sort of come up in order. The first speaker is Glen Mays, who is a health researcher at Mathematica Policy Research. He is speaking here today on behalf of the Center for Studying Health Systems Change. Following him will be Dr. Wendy Levinson, who is a professor of medicine and vice chair of the Department of Medicine at the University of Toronto. Then Dr. Joanne Lynn, who is director of the Washington Home Center for Palliative Care Studies. The next speaker will be Shoshana Sofaer, who is the Robert P. Luciano Professor of Health Care Policy at the School of Public Affairs of Baruch College at the City Universities of New York. And then Dr. Nancy Nielsen, who is an internist from Buffalo and vice speaker of the House of Delegates of the American Medical Association will speak.

You will notice there are two additional name tags up here. Dr. Clair Callan is the vice president of Science Quality in Public Health at the American Medical Association. She will be participating in the roundtable and assisting Dr. Nielsen with technical questions. And Bob Berenson, Dr. Robert Berenson is an independent consultant, although it says here Academy Health, that is one of many things that he does with his time. He clearly never sleeps. He has a very extensive career in health policy in Washington. Everywhere I go I meet people who know Bob.

So without further ado, why don't we get Mr. Mays up and we can start his Power Point presentation.

MR. MAYS: Thank you very much. I am pleased to be here on behalf of the Center for Studying Health System Change to talk with you a bit about the role that health plans are playing across the country in the production of information about quality in health care and the use of that information in creating incentives for quality in health care. And so I will be presenting findings from our most recent round of work in the community tracking study, which I will talk with you about in just a few minutes.

Just first by way of background, I wanted to talk a little bit about what the interests are from the health plan perspective in producing information and using information around quality in health care and in using that information specifically to create incentives for physicians in health care delivery. Clearly, a key reason is in creating incentives based on quality is to encourage quality improvement and perhaps foster quality-based competition among health care providers.

Additionally, there are clearly interests in the health plan sector of the economy in using that information to reduce unnecessary utilization in health care and thereby reduce costs. However, there is also recognition that by creating incentives linked to quality in health care, there may also be a selection effect in that they may be effective in attracting higher quality providers to a health plan network. And in that regard, these incentives could potentially be used as a mechanism for health plans to compete themselves, compete among health plans on the basis of quality in health care and the quality of their provider network.

More generally these incentives potentially can be used to align the financial interests of providers in health plans, purchasers, and consumers, the key stakeholders here, aligning their incentives, their financial incentives toward achieving improvements in health care delivery and improvements in health outcomes.

And then, finally, using incentives toward providers based on quality potentially can get health plans away from the business of having to monitor directly delivery of health care services. Monitoring those prospectively through prior authorization requirements and a lot of the tools of managed care that consumers and providers have really objected to in recent years. So it can get health plans out of the business of having to manage -- trying to manage care prospectively or concurrently by creating incentives that allow outcomes to be achieved without having to use those administrative tools of managed care.

The potential disincentives, again from a health plan perspective, of using incentives tied to quality. First of all, health plans may have to attach higher payments, to use higher payments along with those incentives in order to attract risk adverse providers and get them to agree to enter into these arrangements, particularly if you are putting a portion of payment at risk based on quality. For risk adverse providers faced with uncertainty about the outcomes of health care, you may need to introduce higher payments in order to achieve agreement with providers.

Additionally, quality incentives have the potential to distort the health care service mix or the mix of services that it delivered away from some types of services and procedures that may not be attached to these incentives. So if you introduce incentives for some types of health care and not for others, that may create distortions in the mix of services that are delivered by providers that may not always be desirable.

Additionally, the incentives potentially can encourage providers to -- create incentives for providers to engage in preferential selection of patients who are likely to -- particularly incentives that are based on outcomes, encourage providers to select patients and agree to serve patients that are more likely to achieve those better outcomes. And, conversely, they can create incentives for providers to shy away from serving higher risk patients or other kinds of patients that may be less likely to achieve those outcomes.

And then, finally, these kind of incentives can be very difficult and potentially costly to administer from a health plan perspective. Acquiring reliable measures of quality, collecting them, doing risk adjustment and other types of processing that may be required in order to use these measures for incentive purposes can be quite costly from a health plan perspective. So the question that many plans have, and continue to have in looking at these arrangements is: do the outcomes justify the costs in these arrangements.

I am just going to profile for you some of the major findings that we have had, again looking nationally over the past two years, developments across the health plan marketplace. And what we are seeing with regard to health plan use of quality information and use of quality incentives. One key thing that we have seen is more activity regarding profiling providers and providing feedback to providers using measures of health care quality. Certainly, an up-tick over two years ago.

Additionally, we have seen some plans begin to experiment with public dissemination of information on quality, again as a way to begin to encourage consumers to use this information in their decision-making about health seeking behavior.

We have also seen some additional experimentation with financial incentives. Health plans are tying financial incentives to quality measures as a way to encourage providers to improve quality and potentially trigger some quality-based competition among providers. And then finally we have seen a very modest amount of experimentation with using quality information in developing provider networks, specifically in developing and differentiating groups of providers based on quality, sorting them into different tiers of networks. This again serves as a way to create incentives for providers to improve quality and as for consumers to seek out higher quality providers.

We have also seen the use of quality information incentives migrate from HMO products, which is where we have perhaps historically seen more activity in the use of quality information incentives, migrating these types of activities now to PPO products and other types of more loosely managed products that are becoming more prevalent in the health insurance marketplace now.

And, finally, health plans are experiencing continued challenges in the use of quality information incentives, both the cost and the complexity of creating that information and setting up those incentives and the ability to get provider buy-in and acceptance of these measures. And so I will go into detail on these findings more in just a second.

I want to give you just a quick sketch of the study that has produced this information for us and the methodology we have used. This is information that is coming from the most recent round of work from the community-tracking study. This is a national, longitudinal study funded by the Robert Wood Johnson Foundation and conducted by the Center for Studying Health System Change here in Washington, D.C. It is designed to produce information about how local health care systems across the country are changing and what the implications are for health care delivery and practice. There is a survey component and a site visit component. And I will be talking specifically about findings from our most recent wave of site visits, which we have just completed over the last couple of weeks.

There are a series of 12 markets, communities across the country that were randomly selected to be nationally representative of local health care markets. We visit these markets longitudinally, on a two year rolling basis. So every two years we go into these markets. We conduct interviews with a wide range of health care stakeholders in these markets, including health plans, physician organizations, hospitals, employers, others in the insurance industry, brokers and benefits consultants, as well as policy makers at state and local levels to get a broad and balanced perspective on changes that are underway in the markets. It also allows us to triangulate results across different types of respondents.

I will be talking primarily about findings that we have learned from our interviews with health plans. In each of these 12 markets, we interview -- each of these 12 markets we interview three to six health plans in the market that basically cover the largest commercial health plans in the market, but we also make sure to capture health plans that are involved in serving Medicaid and Medicare populations. We interview the largest Blue Cross/Blue Shield health plan in each market, as well as the largest commercial, national commercial health plans and also locally-based health plans in each market to get a broad perspective.

And the round four visits that I will be focusing on were conducted between September 2002 and May 2003. This just gives you a sense of where the 12 markets are located. Again, these were randomly selected to be nationally representative. And we have a good mix of communities across the different geographic regions.

I wanted to start by talking about some of our findings related to why health plans are interested in using quality information and incentives tied to quality for their providers. Over the past four to five years, we have seen a decline in the use of many of the tools that managed care health plans have traditionally used to control cost and manage health care utilization. We have seen a pretty marked decline in the use of risk contracting arrangements with health care providers in many of our markets as a result of providers no longer being willing to engage in these arrangements because they are not profitable for them. But in some cases also health plans not finding these arrangements work very well.

Additionally, we have seen a loosening of many of the utilization management tools that managed care plans have traditionally used, particularly the use of prior authorization requirements for visits to specialists or for procedures on an in-patient or an out-patient basis, a movement away from primary care gatekeeping as a tool for managing utilization. Additionally, we have seen a migration in many of our markets, a migration away from the most tightly managed products, the HMO products, toward more loosely managed health insurance products, PPO products, that allow a broader array of providers for consumers to choose from, and allow the option for consumers to receive health care from providers that are not included in the health plan's network.

And along with that we have seen continued movement to larger, more inclusive provider networks, really across all product types. Even the HMO products have moved increasingly to larger, less restrictive networks of physicians in hospitals. And what these trends have done really is they have weakened the ability of health plans to use contracting and administrative mechanisms to manage health care delivery. Particularly this movement to the larger provider networks has really shifted the focus of quality measurement and quality improvement from the health plan level to the provider level because now in many of our markets the health plans really have comparable physician and hospital networks. They are all using the same basic networks of physicians and hospitals.

So there is very little differentiation across plans in the provider network. Plans are no longer able to use selective contracting as a way to try to limit their networks to the most efficient providers or perhaps the highest quality providers. So with this movement to these less restrictive products, there has been a growing focus on looking at ways to monitor quality at the physician level and stimulate quality improvement at the physician level.

Along with that, we see continued pressure on health plans to constrain medical costs over the past two years. In most of our markets we have seen -- this has been the third or fourth year of double digit increases in health insurance premiums. And in many markets, health plans are concerned about the continued affordability of their products and are looking for ways to respond to the demands for employers for constraining the growth in medical cost and for introducing lower cost products.

Additionally, we have seen in some of our markets actually demand -- from organized purchasing groups and from large employers demand to introduce quality incentives or incentives for physicians tied to quality and demand for health plans to begin to become more active in the production of information about quality and the distribution of that information to consumers to help inform their decision-making.

And we have also seen growing pressures from purchasers for health plans to stabilize their provider networks and improve their relationships with providers. Over the past four years, we have seen in many of the markets some turbulent relationships between the provider community and the health plan community with a number of very contentious and public contracting disputes, large provider organizations pulling out of the networks of certain health plans and disputes over payment methodologies and rates. And that creating a lot of uncertainty for consumers about continued access to their health care providers.

So over this most recent period of time, health plans have faced growing pressure to find ways of stabilizing their networks so they can assure a constant access to providers, a choice for consumers. So this has created additional pressure for health plans to back away from their aggressive negotiating tactics on health care prices, to back away from some of the rigid administrative tools they have used to contain costs, and to find other ways to encourage physicians to deliver health care in efficient and effective ways.

So what are we finding nationally across these markets in terms of the use of quality information and the use of incentives tied to quality among health plans? This chart just shows you a summary of the prevalence of different types of quality information and quality incentive arrangements that health plans are using across these markets. By far the most prevalent type of activity related to quality going on in the health plan market relates to the profiling of physicians, so collecting a standard set of measures on health care quality, provider-specific measures, passing those back to providers, comparing providers to other providers in the network on the basis of quality measures. We have seen that activity, an increase in that activity. And again, using measures of quality here as opposed to pure measures of cost or utilization, we have seen this activity now in all 12 of our markets and more than half of the health plans interviewed in this round of the study.

In terms of health plans actually releasing that information, provider-specific information on quality, to consumers and to purchasers and others who are making health care decisions, those activities remain much less prevalent today. We saw the health plan activities around public dissemination of information on quality in only three of our markets and in only five of the health plans interviewed.

In terms of health plan activities related to creating financial incentives for positions tied to measures of quality, again there has been a fair amount of activity over this most recent two year period of time. We are seeing that in more than half of our markets and about 15 health plans that were included in this round of the study.

And then some additional experimentation with ways of creating non-financial incentives to providers that are tied to quality. One example of a health plan using quality measures to establish different tiers of provider networks within their health plan and some other health plans using quality measures to extend exemptions to traditional utilization management requirements or physicians, again as a way to create some non-financial incentives for providers to begin to improve performance on the basis of quality measures.

So I am going to go into a little detail on each of these types of mechanisms. First, the most prevalent mechanism that health plans are using now involves collecting standardized information on quality, provider-specific information, providing this information back to providers, comparing them to their peers based on quality measures in order to both identify poor performers and then to try to encourage those providers to improve their performance.

So the kinds of developments that we have seen over the past two years are health plans adding quality measures to their existing profiling systems that historically have been based mainly on measures of cost and utilization. We have seen in a number of markets again health plans taking their profiling systems that traditionally have been used only in the tightly managed HMO products, and introducing them into PPO products, particularly as these products have grown much more popular over the past three to four years.

And we have also seen health plans introducing a number of new arrangements for providing consultation and assistance to their low-performing health care providers, the providers that score -- that appear to be outliers in terms of the quality measures they are using.

And in terms of the quality measures that are being used in health plans, we are seeing a wide range of health care measures being used that target underuse, overuse or misuse of health care services. Probably the most prevalent type of measure being used by health plans are measured that are included in the HEDIS measurement set that originally were developed for profiling performance among health plans. But now health plans again using these measures, collecting them on a provider specific basis.

Other types of measures being used, there is a fair amount of activity in developing quality measures in the area of prescribing and prescription drug delivery; a number of health plans are tying quality measures to their disease management programs and looking at physician adherence to clinical practices and guidelines that are established for disease management for specific chronic conditions. Health plans are also using measures related to patient satisfaction and self-reported complaints. And, additionally, health plans in several markets are beginning to create measures around the patient safety measures identified in the Leapfrog initiative that has been undertaken.

And in terms of health plans engagement in actually disseminating information on quality to consumers and purchasers, clearly the rationale that health plans give for developing these arrangements is their efforts to enable consumers to begin to migrate from lower quality to higher quality providers based on the measures they are delivering and to begin to stimulate some level of competition among providers on the basis of these quality measures.

We have seen more activity in this area on the hospital side than on the physician side, but we have seen some, in at least two of our markets, we have seen health plans engage in disseminating physician-specific or medical group-specific information on quality to consumers. And health plans have been interested in not only disseminating this information to consumers to help inform their decision-making but also in providing this information to employers and other health care purchasers in an effort to inform the purchaser choice of provider network or the purchaser choice of specific health insurance products that may be offered.

In terms of the use of financial incentives related to health care quality, clearly the rationale that health plans report in using these arrangements is an interest in stimulating quality improvement at the provider level. In terms of physician incentives, we have seen a variety of arrangements take shape over the past two years, primarily focused on what health plans call upside risk arrangements. So they are not placing any current physician payments at risk under these arrangements but they are creating bonuses or additional payments that would be available to physicians who meet the established criteria related to quality measures.

So we are seeing bonus arrangements, as well as shared savings arrangements in some cases where health plans will say any savings that we generate from improved prescribing practice, for example, and limiting the inappropriate prescription of antibiotics, any savings generated from that activity will be shared with the providers.

In general, the incentive amounts, we see a fair amount of variation among plans in terms of how much payment is being tied to these measures of quality. But generally it seems to be fairly modest amounts, ranging from 2 to 10 percent of the total physician payments in most of the health plans using these arrangements. And in general, most of these arrangements are still viewed as pilot programs or demonstrations that health plans have introduced for specific segments of their provider networks rather than ruling them out across the provider network. So health plans may be using them with a specific type of provider, very frequently primary care physicians, pediatricians for some of the incentives tied to delivery of well childcare, for example. So health plans are really just still experimenting with these incentives.

And then, finally, in a few markets we have seen health plans look at ways to create non-financial incentives for physicians, again tied to quality measures. So the goal is still the same, to encourage quality improvement at the provider level, but finding other ways of incentivizing those improvements beyond directly financial mechanisms. So one strategy that has been used by several health plans is to offer physicians exemption from the health plan's standard prior authorization requirements if they meet established targets on their quality measures. So, for example, a physician who exceeds an established threshold on delivery of services or accurate prescribing patterns may get an exemption from the need to seek prior authorization for the health plan when prescribing certain drugs or when referring patients to specialists.

Additionally, in one plan we have seen the use of quality measures to establish tiered networks, tiered provider networks, basically taking their provider networks, sorting them into two different tiers, based in part on quality measures. So you would have a preferred provider network that would be established for the health plan. Typically, it would offer -- consumers would receive lower co-payments, lower out-of-pocket payments if they access care from this preferred network of providers. And the way that providers receive entry into that preferred network is in part based on some of these quality measures. So we have at least one plan experimenting with that and several other plans developing similar arrangements.

Just to summarize some of the continuing challenges and issues that health plans are facing in rolling out some of these arrangements around information incentives: data issues are really paramount here. The availability of data, the quality of data, again at the provider level continues to be a problem for many providers, particularly many health plans, particularly those that rely on contracts with individual physicians. It can be very difficult to develop valid and reliable measures of quality at the individual physician level.

And there are also issues in risk adjustment. Continued issues around provider acceptance, although this appears to be more difficult on the hospital side of the network than in the physician side in terms of getting providers to agree to contracts that include quality incentives.

The cost of implementing and maintaining these incentive systems continues to be an issue and a lot of uncertainty about whether health plans can realize a return on investment in terms of lower health care costs overall through introducing these information and incentive arrangements.

And then finally, health plans continue to be challenged with ways of making consumers aware of the information and encouraging consumers to begin to use information on quality in their health care decision-making, in selecting providers and perhaps as well in considering treatment alternatives.

So just in conclusion, I think in looking over this most recent round of data from the community tracking study, we clearly have seen an up-tick in the use of information and incentives related to quality in health care among health plans. But plans are still early in their experimentation with these methodologies and still have a lot of uncertainties about whether they will take hold in the marketplace, whether consumers will begin to use them, whether providers will accept them, and whether they will be effective in encouraging quality.

There is a fair amount of optimism about the potential rewards in terms of cost savings and quality improvement. And the plans we have talked about, many of them are making substantial investments in information systems and in other mechanisms to support these arrangements. So they are clearly optimistic about the rewards here. But they also recognize the risks in terms of creating new administrative costs and added complexity, both for providers and consumers in this market.

So I will stop there.

(Applause.)

MR. HYMAN: The next speaker is Dr. Wendy Levinson, who once her Power Point loads, will be able to talk.

DR. LEVINSON: Well, I appreciate the opportunity to be here today. And I actually want to start by saying that even though it says University of Toronto, I have actually spent most of my career in the U.S. I am a practicing general internist who has practiced mainly in Portland, Oregon and then in Chicago for many years. And my perspective on this really comes from both my own practice and my research related to communication between doctors and patients. And I have focused a lot of my work on issues that are relevant to these hearings relating to malpractice, informed decision-making, and conflict of interest in the doctor/patient relationship. Most of my work is actually being funded by the Agency for Health Care Research and Quality and also by NIH. So that is the perspective I share these comments with you today.

So I actually want to start by taking a minute to talk about this diagram because I see the physician/patient relationship and what goes on in our daily work as practicing doctors as embedded in the health care environment and influenced strongly by things of interest to these hearings. The interaction between doctors and patients is situated in the context of the environment. And policy issues really have a direct impact on what happens between doctors and patients in daily interactions. Patients are concerned, as we have heard about, with things in this outer box, quality, cost, information, the legal environment. And many of these things influence both the patient and the physician. In turn, they shape the expectations and the trust that both doctors and patients have before they walk into a health care encounter.

Then there is communication that occurs between the doctor and the patient, and I am going to tell you that that is a lot of where patients actually do get informed about health care, before they enter the exam room. And, lastly, what occurs in the encounter between the doctor and patient strongly influences the outcomes that you see in that right-hand box of trust, satisfaction, adherence to treatment, biologic outcomes, malpractice and enrollment or dis-enrollment from health plans.

So take, for example, a patient seeking hip replacement surgery. They are going to have heard about who in their health plan performs this well. They might have read the quality data we heard about in the last presentation. They are concerned about what is covered in their health plan. And they may even be concerned about how their doctor is paid and whether their primary care doctor is going to refer them to an orthopedic surgeon if they have certain conditions. And they enter the exam room with this information they have heard about in the environment. The doctor too enters the exam room with his or her own concerns. For example, if they are practicing in certain parts of this country, they are very worried about being sued. And that influences how the doctor comes in to the encounter.

Then these lead, as I am going to share with you, with what really transpires between doctors and patients and the communication that they have together. And about why the communication really matters. And a little bit of the science about this because there is a very large body of literature that shows that what transpires between doctors and patients in the communication between them affects all of these outcomes. It certainly affects the trust at the end of the visit. Any of you who have been a patient know this, that you leave the exam room, go home and tell your family member about what the doctor said, and whether you believe the doctor based on something that transpired between you. It certainly has a big impact on patient satisfaction.

There are health plans around the country that have been offering communication skills training to their doctors to enhance patient satisfaction because they know it affects the bottom line, which is dis-enrollment. If patients are not happy with what happened with the doctor, if they feel that that provider didn't listen, was hurried, rushed, didn't give them enough information, they are much more likely to dis-enroll from that health plan. And in this market that you are well aware of, the incentive is strong to keep patients enrolled in your plan and enhancing patient satisfaction is one of the ways to do that.

There is a body of literature that demonstrates the relationship between adherence and communication. In a very clever study, they collected the contents of garbage cans outside of emergency rooms and counted up the prescriptions. Lo and behold, about 50 percent of the prescriptions were in the garbage can. I can assure you 50 percent of the patients did not say to the doctor, "I don't plan to fill this prescription." But they were thinking that. So breakdowns in communication lead to problems with following doctors' recommendations.

And there is a really interesting small body of literature about the relationship of communication to biologic outcomes. This literature shows that patients who are actively involved as partners in their health care, participating and making decisions with their doctors, have better outcomes in chronic disease. So in diabetes and hypertension, rheumatologic illness, patients that are active participants in their care may actually do better. So this is what doctors mean by informed and active participation in care.

And, lastly, I have done a fair amount of work myself on the relationship of communication and malpractice. And though I won't talk about it a lot, I can assure you that there is just no question, based on the literature, that it is not just bad things that happen in care, it is breakdowns in communication that lead patients to feel that they are going to go to a lawyer to sue them. It is when patients feel their doctor didn't listen, wasn't caring and concerned, and then a bad outcome occurs, that they turn to litigation. And they forgive actually many outcomes that they could litigate if they feel like the doctor was compassionate and caring. So the communication matters to a lot of outcomes to patients and physicians.

So the implication of this is that policy decisions have a direct affect on that environment I showed you and that in turn these affect the actual interactions between doctors and patients. And true informed decisions depend not only what happens before a patient enters the health care experience but also what happens between doctors and patients. And I am going to share with you two specific examples of research briefly to give you a flavor for some of this.

So I would start by saying that there has been an increasing drive to inform patients in health care. The Institute of Medicine has stated in its "Crossing the Quality Chasm," that "Health care that ensures that decisions respect patients' needs and preferences and solicits patients' input on the support and education they need to make decisions is what we should be striving for." This is often referred to as "patient-centered care." And the Institute of Medicine, along with ethical reasons and certainly legal reasons, would push the profession to try to develop ways to enhance patient-centered care. And there are quite a number of efforts underway to enhance this kind of collaboration, where providers are able to solicit what do patients really want and to try to work with patients to achieve those goals.

We did a study where, this is the kind of work I do, I audio taped 1,300 encounters in the community with practicing primary care doctors and surgeons. And we tried to listen to those audio tapes to see how informed consent really happened. And we used these criteria. We looked at whether there was any discussion about a patient's role in decision-making, whether doctors talked about the clinical issue, and the nature of the decision. So if you are going to have hip replacement surgery, what does that surgery entail, and a discussion of alternatives. If you are not going to have the hip replacement, then what can you do for the pain you are having in your hip. And that might be using medications. Did doctors discuss the pros and cons of the different alternatives or the risks and benefits? The assessment of patient's understanding, like after all this stuff the doctor tells you, did the patient get it or did they misunderstand because we tend to use a lot of jargon that can be easily misunderstood. Was there any discussion of uncertainties associated with the decision? And, lastly, did the physician explore what the patient's true preferences were. And these were based on both ethical and legal standards of what we considered good, informed decision-making in the encounter to be.

What we found is that in complicated, and I am only showing complicated decisions like you would be considering whether to have a hip replacement, that physicians told the patient that they had a role, like we are going to make this decision together or this decision is really up to you about 18 percent of the time. They were very good at talking about the nature of the decision. So if you listen to a surgeon, you will know what the hip replacement is going to be about and how long you will be in the hospital and what the procedure entails. They talked about alternatives about 30 percent of the time. The pros and cons about 25 percent of the time. Uncertainties, some but not a lot. They assessed patients' understanding very, very rarely. And they solicit the patient's preferences about 27 percent of the time.

So what this really says is that true informed decision-making happens a lot when the doctor and patient get together. That is when the patient does hear what the choices are about the pain their hip and whether to consider hip replacement. And I think doctors and patients value the discussion that they have that truly shapes decisions and patient satisfaction. But what this data would say is that really these informed decision-making conversations fall quite a bit below what ethical and legal standards would be for this.

I think this has significant malpractice implications. If you have a conversation and then go on to have a bad outcome and reflect back on whether you were well-informed about the risks and the benefits and the alternatives, you may look back and say, "Gee, I didn't know that this bad outcome could happen" and then it makes you more angry that you had the bad outcome that you didn't expect or anticipate was a possibility.

It certainly has implications for training of physicians, and I would tell you that there is a lot of interest in the physician community in educating physicians to do a better job of communication. This is driven by data like this. For example, the American Academy of Orthopedic Surgery, based on this and some other work, has a huge national campaign to improve orthopedic surgeons' ability to communicate, particularly on informed decision-making.

In addition, the American College of Graduate Medical Education, the standard setter for residency training, has put out new competencies and interpersonal and communication skills as one of the seven key competencies for the ACGME. And the American Board of Medical Specialties is training physicians so they realize its importance. And so there is a recognition that these skills matter to the outcomes that doctors and patients both care about, the ones I mentioned to you earlier.

And, lastly, I would say that it does have a very important implication for time during visits. I think one of the things that many of you have heard about through this is physicians have been frustrated over the years by the bureaucratic nature of administering a medical practice now, the insurance control, the preauthorization, the things we are trying to get away from. But one of the reasons doctors have been unhappy with that is that they value time with patients and patients value time with doctors. And you can't adequately inform patients about important or complicated decisions in two minutes. If we don't protect time in that encounter, I think we will have patients who feel ill-informed, no matter what they were told before they entered the exam room because this is, like I said, critical minutes for truly understanding the nature of complicated decisions.

So I share that with you a little bit to help you understand what the implications of the policy issues are on how patients actually make decisions in the course of a day with their providing physician.

And I want to shift for a minute and talk a little bit about another issue, a policy issue, which is the financial incentives and conflict of interest in the doctor/patient relationship. This is also an area that has been of interest to me, and I think of interest to you. You are certainly aware that there are many state and federal regulations requiring disclosure of initial physicians' financial incentives. So Medicare and Medicaid organizations participating in that, health care organizations, are required by law to disclose, often in fine print, how physicians are paid. Certainly managed care has heightened the consumer's worries that perhaps physician financial incentives might actually not be in their best interest but be undermining quality of care. And in the days of more managed care incentives around constraining costs, this had been a big concern to patients.

And, in fact, some patients directly raised this issue with their physicians. In fact, I recall a patient who kind of looked at me one day, mis-trustingly, and asked whether I was not referring her to a neurosurgeon because I was paid more if I didn't refer her. And I was shocked to hear her say this. It wasn't at all on my mind but I realized that if she was thinking this, a lot more people were thinking it and weren't brave enough to say it to me. So I think that some of the regulations and the public is worried about whether physicians are being paid in ways that might not be incentivizing quality, like we heard of before, but actually might be not in their best interest.

So we did a study funded by AHRQ to look at what the patient preferences were for disclosure about this kind of information and most importantly to ask the question can you disclose physician's financial incentives without undermining patient trust, which is so key to the doctor/patient encounter. We did that through a major national survey conducted every couple of years called the General Social Survey. This is a two-hour face-to-face interview conducted by the National Opinion Research Center. And we had about 3,000 participants. And for those people we defined financial incentives as "some doctors or groups may be paid more if they limit the use of expensive tests or to use a specialist, such arrangements are known as financial incentives." And then we randomized patients to hear different ways that the doctor could talk about this issue. The patient actually asked for a MRI for headaches. And the doctor had to tell them that they didn't need the MRI and raised the issue of financial incentives. And we had six different strategies to communicate that information. And we measured the effects on satisfaction and trust to put your interests above costs, whether you would agree with the doctor's decision not to order the MRI and whether you might switch doctors or health plans.

So, interestingly, we found that 50 percent of the public had heard of financial incentives, physician financial incentives of any kind. That certain groups, blacks, Hispanics, and less educated patients, actually people who are less healthy, were less likely to know about financial incentives that could impact their care. Almost everyone wants to be told that financial incentives to physicians exist, if they do. And they prefer to be told by both the health plan representative when they sign up but they also want doctors to tell them. The vast majority of patients did not want just the health plan alone. They felt doctors should be involved in talking about money. And I can assure you doctors are not experienced in talking about money with patients, and certainly not talking about their own financial incentives in any shape or form. It has not been part of what we have talked about.

So we tested six strategies, and I just want to give you a flavor for this because it is interesting. This is what we call the common enemy strategy. “It used to be that physicians were able to provide tests to patients just to set their mind at ease. Unfortunately, your health plan won't allow me to do. Even though I would like to order it, your plan is not going to pay for it.” Now I can assure you this is a common strategy. This is what doctors told us in focus groups that they frequently do to tell patients about incentives.

And here is another one, this is dealing with emotions. “I can understand that you are worried about whether everything is okay. It also sounds like you are worried that I am not ordering the test because it is too expensive. These days with managed care lots of people share your worries. I want to set your mind at rest because I truly do not think that the test is needed at this point.” So this was clearly a different way of communicating similar information. And then we were able by the randomized design to assess the outcomes. And this is just a bit of a flavor for it.

As you can see, the common enemy, the people were much less likely to agree with the doctor's decision not to order the MRI than the emotion-handling strategy. They were less likely to trust the doctor. They did, by the way, believe the doctor when they used the common enemy strategy. They thought it was real. And they were more likely to switch doctors or switch health plans than if you used an emotion-handling strategy to address discussing this kind of financial incentive.

So the implications of this work really is that, as you know, federal and state requirements require disclosure. Health plans, and more importantly I believe, doctors are going to need to talk about these kinds of things with patients, not something we are used to. And that there are some ways to disclose, which will decrease trust and others which may maintain or at least not damage trust too much. It is not going to be the fine print in a brochure that patients or a web location that patients want to hear about it. They want to hear about this in person if it affects their health.

And so what I would say in closing is that patients who are truly informed are going to be informed not only through the kinds of information that we have heard about in other settings but also through effective communication with providers. And in turn, as I mentioned in the earlier diagram, effective communication is going to have a positive effect on many outcomes, biologic outcomes and satisfaction, trust, perhaps malpractice prevention. The policy decisions made in these kinds of settings will directly and indirectly affect the interaction that occurs between doctors and patients. If physicians are really apprehensive about malpractice and the crisis occurring, that will affect their interaction with patients. And if patients are worried that financial incentives are not aligned in their best interest, they will be mistrustful when they enter the exam room. That does affect how the doctor and patient work together. And I think disclosure of financial incentives will affect the outcomes of care through the interaction between doctors and patients.

So I am open and eager to participate afterwards in the discussion. Thank you.

(Applause.)

MR. HYMAN: Thank you, Dr. Levinson. Our next presenter is Dr. Joanne Lynn.

DR. LYNN: Hi, delighted to be among you. I am feeling a little out of my league. It is not entirely clear how I helpfully address the issues before the Federal Trade Commission. But I tried putting a few of our issues and ideas together. My background is as a physician. I also work in ethics and health services research. And work mainly with people who are very sick.

So it is a bad prognostic sign to be among my scope of interest. I am interested in people who are very sick and never again going to really be well and are going to die of their condition. Interestingly though, for most of us that condition now lasts a few years at the end of life. It is no longer the case that people sort of get terribly sick and die all in one sentence and all in one week. Mostly we get very sick, live with it for a very long time. And then gradually find a way to die. So some of the issues that arise are a little different. I am going to start with a few ideas about how to think about this field and then I will try to lay out some of the ways in which I think it would be helpful to the FTC.

First thing to recognize is how people come to the end of life is enormously different than it was even a very short time ago. This is a comparison of 100 years ago. And you will see that -- if any of you don't have the handout, hold up your hand and one of my team will bring it around to you. There has been an enormous shift. Most people, just 100 years ago, died at what we would now say is very young. Only a very small number of people, about one in 10 of the people who now make it to 80 would have made it to 80 100 years ago. The causes of death were relatively abrupt. Women who made it to adulthood died of childbirth. Men who made it to adulthood died of work. And only the very rare person who was lucky and had good genes and never smoked and never worked in a dangerous facility managed to make it to old age. And therefore, costs at the end of life were very inexpensive.

One of our biggest problems in taking care of people at the end of life is that Americans simply don't recognize that it is plausible that life should end. This is the Wizard of I, and the serf comes and asks, "Do you have anything that stops aging?" And the wizard answers, "Sure. Which disease would you like?" It is a fundamental recognition that most Americans have managed to avoid -- we managed to put out all sorts of things that will save life and rescue you from dying and prevent death. And I am here to tell you that there is nothing that prevents death. At best we trade off causes and make it a little later. But it sure sounds different if you said, "New gizmo for heart disease." Instead of saying that it promises to save a half a million lives next year, than if you said it promises to delay death by a few years and give you the opportunity to die of strokes and dementia.

We are down to a very small number of ways to die. About 83 percent of us now die covered by Medicare. Nine out of 10 people who die covered by Medicare die of heart disease, lung disease, cancer, stroke, or dementia. That is five. That is it. If you wipe out one, you will substantially increase the others. A fundamental fact, which is not part of our public consciousness at all, certainly not part of our advertising, it is all prevent this and something truly wonderful will happen. And while it is a good thing to live a little longer, it is also the case that the longer you live, the more likely you are to die with dementia, functional deficit, and frailty. And it is not entirely clear that the public would buy that trade- off.

So the fundamental truths are that the dysfunctions in the care system arise from the enormous change in the demographics. We find it very easy to blame doctors and to say it is their venality, stupidity, and inability to communicate. Whereas in fact in a world in which we have not a single evening soap opera kind of character on television and almost no movies that characterize how people live near the end of life for anything other than young women dying of cancer, then -- young to me is anything under 80, incidentally -- it is not at all surprising that doctors and patients all have a very hard time talking about how people come to the end of life with heart disease, dementia, frailty, because we have no language, no stories, no cultural myths. So the language categories and assumptions are all fouled up.

There is a claim that the big problem is that doctors ignore what patients have to say, and that is not at all clearly to be the case. It seems much more likely that doctors now do follow the preferences and clear statements of patients. But the clear statements and preferences of patients are exceedingly rarely laid out. There are very few patients who walk in with a badge saying: "I am quite clear that here is the way I want treated, here is what I want, here is what I don't want." If a patient has that and has it clearly thought it, there is pretty good evidence that it is followed. There is also pretty good evidence that that almost never happens; patients instead arrive scared, ambiguous, uncertain, and doctors and patients tough it through. So it isn't at all clear that patients clear preferences are being trumped. It is much more likely that they have never been helped to generate clear preferences.

And quality comparisons that we have out there, if you go to any of them, any of the national ones, any of the state-based ones, the ones Last Acts put out for end of life care, they really don't address quality comparisons among possible ways of being served at the end of life. So you don't have a way of going to the web and figuring out whether Kaiser or Aetna or just fee for service is going to be better for you as you face your end of life with frailty at 94. The information you need has never been collected, is not catalogued there. If anything, it is almost adverse to that information because instead it is all about how you could successfully manage to get through one or another surgery or procedure. What you really want to know is things like continuity, symptom management, family support, bankruptcy, the kinds of things that weigh on your mind as you are facing living with a bad disease. And those are not only not catalogued, they aren't even collected. We barely know how to address them.

One of our myths is that we know who is dying. This is actual data from the Support Project. This is what we call the Hebrew Analysis. The right-hand side of the graph is the zero and you work backwards, right to left. So you are reading right to left. The day ahead of death, the median patient dying of lung cancer still has a 20 percent chance to live two months. A week ahead, the median patient with lung cancer, this metastatic, non-small-cell lung cancer, inoperable and present for more than a month, so this is not sort of anything -- nobody thinks this is a good disease, this is almost a universally fatal illness within six months -- nevertheless, within a week of dying, half the patients looked like they could make it two months.

How could that be? This is our most predictable big-time illness. The reason is because a fair number of people die rather abruptly. They get an infection. They get a stroke. They get a complication. They get a seizure, and they actually die fairly quickly. This is 20 to 30 percent of people with lung cancer.

When you look at heart failure, look what the median does. The median on the day ahead of death is still 60 percent chance to live two months. And just a week ahead, it is 80 percent. Now if you take the Y axis and shift it to six month prognosis, lung cancer goes right to the bottom, because almost nobody makes it six months. What happens to heart failure is that it slides down 10 percent. So the median person on the day ahead of death with heart failure had a 50/50 chance to live six months. Now it takes a while for us to get our brains around a sentence that complicated. It is as if you had a weather reporting system -- weather forecasting system in which the best you could do would be 50/50 chance of rain and every single rainy day followed on a 50/50 chance. So you had 100 days with a 50/50 chance. You had exactly 50 rainy days. The model works precisely. But you never have a 90 percent chance of rain in this disease because the usual dying is a sudden death in the context of very fragile health.

So these are the people who are going along barely hanging on and then they get a heart attack, they get a stroke, they get a something, and they are suddenly gone.

But the best you can do is to have an ambiguous prognosis knowing that if you had a large population, you could draw a Kaplan Meyer curve and plot out exactly how many people would be alive six months from now. But you couldn't tell me whether Mr. Smith was going to die early or late. That means you cannot tie good care to the promise to die quickly.

So if we are going to build good care for the end of life, it is going to have to be able to take care of people who live a long time. Some of these people are going to live five years, and every day is a fragile endeavor. And some are going to be gone tomorrow. They are going to have stood downwind of a salt load and they are going to be gone. And you can't tell when that is going to happen. That is a very hard thing for us to believe. We believe that if doctors were just honest with us, we could tell who was going to die. And the idea that three or four weeks ahead of death a doctor cannot tell you who among a group of very sick people will die within a month is contrary to the way we want to think about the end of life or the way we want to think about how to organize care. So we want to think that until doctors say you are dying, you don't have to worry about it.

One way we have been misled is by thinking that, if the Y axis is all treatment and the X axis is time, that we safely can stay in an aggressive mode of treatment for a long time and then we will hit some divide, which is terribly uncomfortable, and after that we are supposed to do hospice care, palliative care, something of the sort. And we know how to do one or the other, but never both. It is like you can use the board to play checkers or chess, but you can't play them simultaneously.

So we don't know how to do one or the other. What we have is most patients actually present needing this sort of care. From diagnosis there are a few things you need to do to help the person live well with a bad disease. So you are going to be treating symptoms from early on and helping provide support and recognizing that this disease may go badly. But you are going to mainly be doing things to modify the disease. As you go along, the proportions shift. But there is never a point in time in which you only do one or the other. Right up to the end of life you might be doing something that would modify the course of the illness. But the proportion that you would be attending to end of life issues and symptoms would be much higher.

That is a very different mental model of what is happening at the end of life. It requires that you be willing to put people in the intensive care unit to unload their central circulation with a do not resuscitate order and support for possible end of life during this hospitalization. It requires that people in hospice might be able to have access to some aggressive treatments. We have been very comfortable in thinking we could only do one or the other and never mix them up. And if we are going to actually serve the population we will all become, we are going to need to think through how to build care systems that can do this instead.

So we have been thinking about how to do that and in a very short synopsis we would say that instead of dividing the world by diagnosis and setting of care, which is how we mostly divided it, we divide it by lung disease, gall bladder and so forth and, on the other hand, hospital home care, nursing home. We instead say there are three kinds of people in the population. There are very healthy people. And what do you need from health care on a day that you are healthy is basically 911 and prevention, you want mammograms and ambulances and nothing else. You don't want your doctor calling you at 3:00 in the afternoon to see how you are doing. When you accumulate some chronic illnesses, you actually want prevention, but now prevention for the disease you have. So you want secondary prevention. But you actually want the same things. You want to prevent the progression of the disease you have and the rescue services.

But all of us get a tour through that last little wedge. That last little wedge is the piece of time when you are living with a very bad disease. And there, what is different, is that the care system has to be more responsive and appropriate or everything that matters to you in life becomes bankrupt. You will not be able to enjoy anything else in life if you are overwhelmed of shortness of breath, by depression, by pain. If your family is overwhelmed by care-giving, if you can't get to food or you can't get to the bathroom.

So at the point at which you need daily help, then the care system has to come to you in a very different way. And we have to probably think about how to organize care very differently. Now here is where we are really stymied because we have no way to innovate, or at least in any large numbers, in order to learn the processes that would serve this population optimally.

There seem to be three general trajectories. It is useful to think in terms of building care systems around this. One is the one that is epitomized by solid tumor cancers, colon cancer, and so forth, when a person goes along, the X axis is time, the Y axis is sort of how well you are doing, and really does pretty well for a long time and then finally has a short period of time where they really lose ground, take to bed, look sickly, and die. This is the model that was in mind when we built hospice.

Many more of us now die with organ system failure, with intermittent exacerbations and a rather sudden dying. This is the one that was characterized by that heart failure slide I showed you earlier. People are terribly sick and rescued. They think they are waiting for cancer. But in fact the disease they have will kill them. It will kill us. It is just a matter of which one, which episode will take our lives.

Already this is a little more common than the cancer trajectory, but by far the most common is the failure trajectory of frailty and dementia. Already more than 40 percent of us die this route. It takes the longest time. Much more of the costs are outside of Medicare. We have much more problem because Medicare and

Medicaid and private wealth all contribute to supporting this phase of life, and we have not built terribly good care systems for it.

But we could build care systems around these three and make it make sense. There are other countries designing their care systems this way. We are still debating whether we can expand hospice 10 percent. And, in fact, the number of people, the number of days that are involved in end of life care is on the order of 1,000 to 10,000 times what hospice now covers. It is not a very small piece of the care system. Indeed, the best estimate is it is something on the order of a third of all health care dollars go into taking care of you with a disease that takes your life. That is not surprising, that is when you are sickest.

But it is a very different way of thinking about end of life care. Instead of thinking of it as this tiny little sliver of the health care system, you say, no, wait a minute, whole lots of people in hospitals, ICUs, doctors' offices, are actually living with the disease that will take their life. And we could probably do better if we thought about how to put that together.

This is the rough proportions, just to show you how they tend to break out. This is all in Medicare population. But 83 percent of us die in Medicare now.

So what is it a good care system should be able to promise? And what is important here is not the specifics but that we should have care systems that are able to promise anything. That when you sit down with a patient who faces a terribly serious illness, what you want as a patient and what the provider would ideally want is to be able to promise the patient that they will get the right treatment, their symptoms will never be overwhelming, there are no gaps in the care. We have thought it through. There will be no surprises. We will plan ahead. We will customize the care to your preferences. We will honor your family and take their role seriously. And, most importantly, we will help you to live the life as fully as possible in the shadow of dying. Now those are reasonable promises. Your grandmother would have told you that if she had thought about it long enough.

What is important is we have no way to make any of those promises for a care system that crosses any boundary, hospital to home care, home care to hospice, hospice to nursing home. We have no way to even measure the performance of care systems across the way we structure the boundaries. So what a patient needs to hear, you are sitting their with emphysema, you need to hear that you will never suffocate. And instead what you hear is all this garbage about how we know how to treat this or that or the other or you might get a free lung. But what the patient wants to hear is that we know what we are doing and we have thought it all through. We don't even have a way to do that. We don't even have a way to sit all the players down and have them think through how to provide care.

So the current shortcomings are just everywhere. We have untreated pain. Forty percent of people in nursing homes have pain when they arrive. Forty percent of them still have it two to six months later. Advanced care planning runs about 20 percent in most studies. Twenty percent of people at the time of dying have an advanced care plan. Almost everybody says they want to live out their end of life wherever they are living, nursing home or home. More than half of us die in hospitals and another 25 percent in nursing homes, after usually relatively short stays.

Here is one particularly stunning example. We just published this last week in Annals. We asked a bunch of hospitalists about an emphysema patient and said if you had a problem like this, would you want terminal sedation to be available rather than having to be on a ventilator. Ninety-eight percent of the hospitals' physicians that we asked in a big meeting, it was 300 people with one of those immediate responder systems, 98 percent of the doctors said that they would want terminal sedation available. One percent said they routinely offer it. You don't usually get a split quite that bad, but that one is memorable, right? Ninety-eight percent of doctors would want to be promised that they could be sedated rather than go back on a ventilator. Only 1 percent routinely offer it to their patients. They don't even know how to raise the question.

So observations on quality, we have this sense that if only doctors would comply, patients all have clear, enduring, important preferences about treatment choices. That is our sense is that we could draw out diagrams and patients could say, oh, yes, I want a ventilator or not or, oh, yes, I want dialysis or not or I want this or that. Shoshana is shaking her head hard. Of course, that is not the case, especially as you are up against dying. Most patients have never been through this before. You get kind of one shot. And so here they have all these ambiguous things. At best their doctor is saying something like you have an "X" percent chance to make it through with this treatment. And they have no idea what the suffering entailed would be like. How fatigue will feel. How shortness of breath will feel.

How it will feel to watch what happens to their family as they go through care-giving. Patients don't come into these situations with off-the-shelf preferences.

So you have to learn them in the process. And very often the things we are willing to ask them about treatment choices aren't what matters. What matters are things like dignity, comfort, looking good in the eyes of their family, having a good memory left in the eyes of those who live on, sometimes even having a legacy to leave to their children. And we are not comfortable in asking patients if that is what they care about.

The best practices, interestingly, are arising in the VA and in staff model managed care. So you are much more likely to have very good end of life care in the Veterans Administration or in Kaiser than you are anywhere else in the care system. And I think we should take that to heart because those are the places in many ways that have the oddest of payment structures, where it is either salaried or salaried with a very distant set of incentives that the doctor doesn't feel very intensely at the time of service. And they are capable of vertical and horizontal integration. So they can really have a population that they look to serve in whatever service they need.

Hospice probably does offer high-quality comprehensive care, although that has never been tested or researched. But even if you believe that they are on the whole providing very good care, you have to come to terms with the fact that only 25 percent of us use them at all and then only for the last three weeks of life. So if the average duration of serious illness at the end of life is now two to three years, and it hits about 90 percent of us, then you have to realize that hospice is a tiny sliver of the service array.

And there is very little innovation or research under way. When the IOM committee asked the Institutes at NIH what they were doing with the bad end of each of their diseases, the fellow from National Heart, Lung and Blood Institute actually managed to answer that that was simply not in their purview. The illness that kills one-third of us is not in the purview of the Institute given the funding to do research on that disease. So they are only interested in cure and prevention. They are not interested in how people live out the end of their life with that illness. That is the kind of approach you get almost everywhere. So even though we are spending now probably a third of our funds on this phase of life, there is almost no research or innovation agenda for this.

So let me tell you a few things I can think of about the markets. The first thing is quality is largely unmeasured. Quality in this arena, we don't ask people how do you feel about your life closure. We don't ask people how is your spiritual life. We don't even generally ask about symptoms, are you comfortable. And surely those are terribly high importance issues. In fact, when we go to measure quality, two out of the three national web sites that try to report on the quality of hospital care report hospital and mortality, which means that in the hospitals being rated they are now beginning to disassemble their palliative care programs, trying very hard not to have death in the hospital, because it adversely affects their mortality rate.

I would say, my God, if somebody is going to die somewhere, have them die in the most appropriate place. Let's not give hospitals a disincentive to keep somebody on board who is going to die within the next 24 hours. It almost never serves them well to bump them out in their last 24 hours.

So our measures, because we think, well, you would always want to avoid mortality, in a world in which most of us make it to 21, have avoided infant death and driving and war, so we have made it to adulthood, almost all of us are going to make it past 80. And the idea that you want to always avoid death becomes kind of silly. Most of my 85-year-old patients have kind of made some sense out of the fact that there is going to be a death in store. They don't want it to be worse than it has to be.

We need the possibility of geographic concentration. While all of us are going to have this experience, any population has only a tiny fraction of people going through it at any one time. If you want to mobilize most services to the home, then you don't want any one nurse in any one service to have to be spending more than half of her time driving around the city or driving around a rural area to get from one place to the other. Instead, you want any one nurse, any one nursing aide, any one doctor to be able to go to Mr. Smith's house, go a block away, go to Mrs. Jones' house, go to the next one, go to the next one. In all of Washington, D.C., the number of people living very seriously ill on this day is something under 3,000 people. Probably that could be served by at most three good programs. You don't want 27 because then everybody has to spend all their time traveling, even in a city as small as this. So geographic concentration has a real advantage as an efficiency issue. How to manage to do that without causing anticompetitive pressures is quite a challenge.

A second is that we need longitudinal

integration, which means that you need to be able to have the same hospice working with the same home care program working with the same doctors working with the same hospitals and nursing homes. And right now Medicare aggressively tries to break that up. So that as a patient goes from hospital to SNF, they must be offered every possible SNF. As they go from SNF to home care, they must be offered every possible home care. As they go from home care to hospice, again every possible hospice. Now that sounds like it would be reasonably good because they make their trade-offs. But it means critically that their home health aide can't follow them. Their doctor can actually overcome some of that.

But these are people that become very dependent upon the person who comes in to give them a bath. And every time you change your funding stream, you have to change your home health aide, which becomes disastrous. So we need ways of integrating longitudinally in order to serve the population optimally.

There is a lot of substitute possible among the services. States that provide almost no home care have very high hospice rates of use. States that provide very heavy home care, like New York state, have almost no hospice use. There is a lot of trade-off among these services. So the fact that we have collected data service by service means we are missing what is happening to this population because we don't know how to describe them as trade-offs among the possibilities. So we simply don't see that piece of our lives as a population. We don't have a metric by which to understand these trade-offs.

A very important component of the service array is the voluntary family care-giving, which probably amounts to half of the hands-on care. That is almost completely unmonitored and unreported. Not only that, it is also unsupported. We are the only country in the western world that does not pay volunteer care-givers, give them respite care, give them training, give them insurance, give them any benefits. So not only are they invisible as a labor pool, they also are unsupported as a labor pool. But it is critically important that we start paying attention to voluntary care-givers because we are going to have twice as many people sick when all the boomers get sick. And half as many children to provide the voluntary care-giving. So the most critical labor pool is actually not registered nurses, and maybe not even front-line, hands-on home health aides. The most critical labor pool may well be daughters and daughters-in-law and we haven't even learned how to tally them.

Measures of quality look better with earlier death, I have already mentioned. That almost every measure of quality in a care system will look better if the very sick die quick. And it is a real problem for measurement. You can reduce the apparent rates of pain, disability, family bankruptcy, almost everything negative if once you are very sick, you don't live very long. It is not at all clear that the public actually wants that to be the force of the measurement.

So we should be very careful about that because by far the easiest way to have a care system look good is to have people either be out of the care system or dead. I guess there are two ways of being out of the care system. You can transfer or you can be gone. But it is a real problem as you get to older populations because you can have a care system look real good on pain because people, once they are in pain, do not live long.

Patients want to have had the good death. That is a terribly important tense. They want to have lived out their life with comfort, dignity, and have a proper life closure. But prospectively they want the next one. Small chances of prolonging life. The doctor keeps saying, "But one more treatment might just work." And so prospectively they want that small odd of an increased life span.

Current payment does not support key elements of chronic care. If you look at the hand-out we gave you from the Western Journal of Medicine and look at the table on the second page, what we have done is to lay out for heart failure how much it would cost for this couple to have had optimal care versus the care that is the usual ordinary schlock care. And you will see that Medicare would have saved money. Medicare would have saved $37.30 on this small little case. Every single provider would have lost money; every single provider, the hospital, the doctor, the ambulance, everybody else because Medicare does not pay for self-care education, 24/7 on-call, mobilizing services to the home, or continuity. Any of the things that matter for this patient are not regularly paid for by Medicare. That is a profound contrary incentive and very hard to move. It is why, of course, Kaiser and VA are doing better than regular care.

There are now six randomized control trials showing better ways of taking care of patients with advanced heart failure. Every single one of those programs has folded at the end of the grant funding because it is not sustainable under Medicare.

Prevention and treatment are always presented as achievable. We always say our new gizmo promises to prevent death. I’m here to tell you there is no preventing of death. At best you can delay it. You can't improve a disease. You almost never can cure it. The curable diseases we cure like this. We don't cure very many things in very old people. We give you a better disease to live with. You live a little longer. The honesty in communication is strikingly absent, including from our federal officials.

I have a whole file of things called "silliness about mortality." It is almost all federal officials talking about the wonders of prevention. Yes, prevention is a really terrific thing. But I can tell you that no matter how good you are at prevention, you still die. And guess what? You get a choice among those Horsemen of the Apocalypse: your heart, your lungs, cancer, stroke, or dementia. You don't get a whole lot of other choices. So fundamentally we are in an era of trade-offs among those alternative ways of dying. And we probably spend now a whole lot of money on these treatments and support. And yet we call it cure and rehabilitation.

So the kind of things the FTC threw out for me to answer, should we be addressing volume-sensitive quality. In my arena, there is no evidence on that. Are academic centers better and trainees worse? Again, there is no evidence. If anything, my anecdotal evidence is that academic centers tend to be the worst places to be when you are very sick and dying. It is much better to be at home in the care of a general practitioner and a good nurse.

Do patients get what they want? Sure, if it is absolutely clear what they want and they have made all their trade-offs. That is a very rare circumstance. Has the Patient Self-Determination Act helped? Not much. The Patient Self-Determination Act did help to provide some clarity on state laws but it did not really help in terms of mobilizing patients to provide real instruction. And the role of competition is just terribly complicated. The usual patient does not want the product, that is good care for the end of life. They don't want to be in the end of life. They don't particularly like the information.

The good and the bad providers are all very busy. They can fill up their schedules no matter how good or bad they are. Patients are too sick and the families are too stressed to shop around very much. Medicare and Medicaid payment presents real barriers.

In our book, "The Handbook for Mortals," we actually tell families that if you go to a doctor, if you have a problem that is likely to lead to shortness of breath, ask a doctor early on about whether they are comfortable in providing terminal sedation and, if not, change doctors. We have gotten all kinds of nasty feedback on that sentence because people say, "Oh, the patients can't handle that." I say, “Well, for heaven's sakes, who can?”

This is the slide you have seen now twice because I keep pushing the wrong button. This is a reminder that we are roughly like the explorers in the 1600s, virtually everything I have told you in this talk I didn't know 10 years ago. We are in an era of exploding insight and great learning. We could greatly increase the rate of learning by investing in exploration. But we are like the explorers in the 1600's, we are proud of having figured out the world is round and still making an awful lot of mistakes on the details.

Thanks.

(Applause.)

MR. HYMAN: I think we will take about a 10-minute break and then we will continue with the two remaining presentations and then go directly into the moderator roundtable so everybody gets a chance to stretch and avoid the health consequences of sitting for too long.

(A brief recess was taken.)

MR. HYMAN: Our next speaker is Dr. Shoshana Sofaer.

MS. SOFAER: This is an ongoing conversation that I had with my friend, Paul Cleary, which is: “What is the revolution?” And for a long time, when I first arrived in Washington in the early '90s, having come from California, where I was an extremely happy patient of a staff model HMO, and coming to a part of the world where HMOs were reviled. But also working within a place that had a staff model HMO, which was GW at that point in time. Everybody said managed care was a revolution, and I never believed it. And now it is not a revolution because basically the managed part of it was never there in the sense of really managing care. It was managing cost except for those places that were genuinely integrated delivery systems organizationally, not just getting a capitated payment. So the real revolution is not managed care.

To some extent it is more, but still not quite the same, the emergence of purchasers, who recognize their clout in the marketplace. This is something that has only emerged. We really did have a much more monopolistic system in health care 20 years ago. And we have verged to some extent on what the economists sometimes call monopsony, which is that the monopoly is on the buyer side rather than on the seller side. But Glen's data about how the provider resistance made people back off tells you that that monopsony isn't working terribly well either. For-profit medicine was another potential villain in the piece. That hasn't really turned out to be much of a revolution, primarily because a "non-profit" facilities in health care often behave so much like for-profit facilities in health care.

What we also feared for a while was the consolidation and integration of ownership of facilities, whether for profit or nonprofit. It is something that the FTC has been, of course, very concerned about. And not -- yet anyway, what many call “evidence-based medicine” -- to me the real revolution is the idea that health care and physicians have to be accountable for the quality and value of their work. And that they have to be accountable, not just like in the "good old days" to each other, not just to those who pay the bills, not just to their individual patients (I have heard many physicians tell me that they are accountable to their individual patients) but to the public and society at large. That is a big, big change. And I think it is a really profound change for medicine and is a very profound change for society. And that in a sense is what we are reckoning with.

What has caused this revolution? The first phrase I put up there is "question authority." I see enough people in this room who probably grew up like I did in the 60's and had this bumper sticker somewhere in their graduate student apartment. But we have become, the Baby Boomers who question authority. And a major authority figure in this society are physicians, and people who manage hospitals. So we are questioning their authority. And that questioning has to some extent led to an undermining of that authority, although that is not the only thing. Maybe because the answers we have gotten haven't been terribly satisfying.

In addition to that, from a more database perspective, the quality variations in this country are significant. And it may be the case that not only is the floor too low but the ceiling is too low. And I could only point you back to what Dr. Lynn was saying just a few minutes ago to tell you that perhaps even the very best of care at the end of life is far from what it could and should be. And particularly if try to think about patient-centered care, patient care that takes psycho, social, and environmental issues into consideration, as well as biomedical, both the floor and the ceiling are way too low. We spend more than anybody else per capita as a society, and in a lot of ways we are getting only very mediocre results and again results that vary very much depending on where you are, what kind of insurance you have, what your education level is, et cetera, et cetera.

In addition to that, we know a lot more than we used to about how define and measure quality. When I first started graduate school in 1975, there were big arguments about whether or not it was at all possible to measure quality. These are in the days when -- was somebody who was really a revolutionary in his own right. We have come a long way. Are we there? Not by a long shot. But we now have the sense that it is a feasible, doable thing to define and measure the quality of health care.

So let's talk a little bit about what the response of physicians has been to this, and I speak both as somebody who is a patient, somebody who lives with a physician, some of my best friends are physicians, I work with physicians, and I have an enormous amount of respect for the vast majority of physicians with whom I interact in my day to day life. But what I have seen is that shaped by their perception of lost autonomy, lost public influence, lost prestige, and lost income, and I think all of these are losses that have been sustained by the people in this profession, they are angry, they are resistant, and they are, in many cases, in denial.

We just recently finished a set of focus groups with physicians in group practices in Massachusetts, as well as practice leaders, et cetera. And we were talking to them about the possibility of disseminating publicly information based on patient reports of their experiences with physicians. And they were appalled by the idea that this might happen. Convinced that the reason it was happening was so that their pay could be adjusted. And they were not thinking of it, as Glen put it, in terms of that they were going to be upside incentives. They were convinced that this was being done to reduce their income further, to make their life even more full of hassles. And what I think they really personally experience is disrespect. That is sort of the emotional climate that we are dealing with. There is an unwillingness to accept lay definitions of quality or patient reports on their experience. And there are concerns, sometimes often grounded, about the validity of the measures that are being used and the cost of the measurement process to the system as a whole and to them.

But on the flip side, I also see physicians coming to this issue from the perspective of their continuing desire to heal, to cure, to help, and to, I put it in quotes, "be scientific." Physicians are as a profession and they take pride in the fact that they are a science-based profession.

So what does that get you? Distress at their current situation, especially in the decline in the quality of their relationships with patients. Somebody was speaking about the time that you spend with patients. Well, very interesting indications that everybody feels like they are getting less time with their patients even though in fact they are getting more. So it must be something about that quality of that time that is changing and is making them feel like they are being pushed to do an awful lot more in a lot less time.

Now what you also have to take note of is that there are a lot of physicians at this panel. And there are a lot of physicians who have sort of made it their business to try to improve the measurement process, find better measures to replace worse measures. And, in addition, many, many physicians who are making a commitment to quality measurement and to quality improvement; a much smaller percentage of them are then making the commitment to disclosure of the comparative quality information. But I think that that is because they are really afraid of malpractice and afraid of looking bad. Humiliation, public humiliation, how many of us really enjoy that experience? Not a whole lot. So

I think we should be aware of these things.

So then in this context why should the quality and performance of physicians be measured and publicly disclosed? First of all, I think we have got to recognize that people believe that it is physicians who control quality. When I have asked people in focus groups about health plan indicators, they will tell you health plans don't have anything to do with quality. It is the physician that has to do with quality. It doesn't matter what health plan I am in, it matters what physician I have.

People also actually have more control over choosing their physician than they do over choosing their plan or choosing their hospital. It is the case that over 50 percent of the insured people in the United States are only offered one health plan. So plans is not where they are exercising choice so that they can be effective in the marketplace. It isn't even really hospitals because how do you get to a hospital most of the time? Your physician refers you because that is the place she or he has their staffing privileges unless you live in a place like Los Angeles, where everybody has to have privileges at a least 10 hospitals in order to be able to make a living because the hospitals are so small because of the lack of density in the city.

So then I have heard the ultimate consumer, my nephew's wife, who wanted to be able to have a vaginal birth after a Caesarean on her first. She actually went to the trouble of calling the two hospitals that her OB practiced at, getting information on their VBAC rates and how they handled VBACs, visiting and talking to the nurses, and finding out that one was completely different from the other; she went to the one that supported the VBAC experience. How often does that happen? Probably more rarely than the patient that Joanne was talking about who actually comes in with a very clear set of advance directives to their physician.

So in addition to that, physicians are living with the heritage, the history, and the tradition that they have embraced over the last 100 years. That is, their own self definition that they are the captain of the team. So if you are the captain of the team, especially in our individualistic society, you are responsible. You are the one with the authority.

So now I am going to turn around and say, well why not physicians? And there are some good reasons why we shouldn't focus on physicians or certainly shouldn't focus just on physicians. First of all, in today's medicine, physicians have only partial control over quality. The whole message of the quality chasm report was it is the system, stupid. And it is the system, stupid.

But physicians are a part of the system. Physicians have leadership roles in that system. And physicians are going to have to recognize that they have got the responsibility to make that system work for themselves and for their patients. And they must get engaged in a different kind of way than many of them have been, i.e., where they have basically said let somebody else do that, I am going to stick to the "practice of medicine and see my patients." It doesn't work that way anymore.

In addition, besides the system, there is also the fact that outcomes in particular are very, very influenced by individual behavior and by society as a whole, not just policies. But where you live, how you live, who you live with, and do you have social support influence your care. All of those different things have a profound effect on the quality of the care that you get and on the outcomes of your care.

Another thing that has intrigued me is how do we know that a patient and a physician belong to each other? What is our definition of that? I have been going around asking physicians that I know, "How do you know that somebody is your patient?" And this is especially problematic in a context where a person may have to change providers every year as their employer changes their insurer and their insurer changes their provider network or doesn't or whatever.

So how do we make that meaningful link between a physician and a patient because the real question is not who is your patient but who are the people whose care you are willing to be accountable for? That is the really meaningful question here. My friend Barbara Sebohar is here from the surgery side. It is a whole lot easier in that context because it is a procedure by and large that has a beginning and a middle and an end. If we are dealing with the medicine side of things, it gets way more complicated and the continuity issues become more important.

There are a raft of technical reasons why this is going to be tough. Reliable sampling is a nightmare, either in terms of identifying the people and linking them with a patient, and getting enough numbers, privacy concerns. Last night I was talking about this with a friend of mine who said, "How can you find out given HIPAA what patient is attached to what physician?" He is a psychiatrist so he doesn't want anybody to know who his patients are. He is an analyst, he only has 27, right, at any given point in time. He doesn't have 5,000 patients. We can't do a sampling of his patient population. We have serious skills, challenges of risk adjustment for any quality measure. The data collection costs are serious. The cost of really effective reporting and dissemination of quality information is also substantial. And we have not even begun to scratch the surface of how much it is going to take to do that really well. Underlying all this is that we don't have an efficient information infrastructure to actually generate this data without super, super hassles. So this is what we are balancing.

However, in spite of these problems, more and more people believe that physician quality can and should be measured and disclosed. More and more institutions are committing resources to that end, all different kinds of institutions. We heard about plans from Glen today but I am going to tell you about the Central Florida Health Care Coalition in Orlando, Florida. And they are going to start rating physicians as either platinum, gold or silver based on data that includes technical quality information, utilization information, and patient experience information. They are going to wrap it up and give people their Good Housekeeping Seal of Approval. And they are going to make that available initially to the purchasers and the providers and then eventually to the consumers. So this is going to happen. The question is not whether, but rather when and how well and at what price. So this is not one you want to fight.

Now, I mentioned our little gang of 15. We are called the Consumer Health Care Quality Group. And we created ourselves and have no funding. We sort of talk to each other on the phone periodically, and we talk through issues that are of concern to us. We are a mix of advocates, academics, people who work for various kinds of trade associations. We have membership from NCQA, from the Foundation for Accountability, and we have a good time. Every so often we get a foundation person to talk for us. And we don't have any government folks by decision on our part, we don't have government folks involved, okay.

We actually managed to write an article that actually got published in Health Affairs in March of this year and it is a call to action that identifies essential elements that are going to be necessary in order to drive quality improvement through public disclosure of comparative quality measures. And these are the seven things that we said we were going to have to do. First, we were going to have to convince people that quality problems were real and that quality could in fact be better. When I talk to advocates for low-income people, they say, "Why should we look at quality information unless we know that somebody is actually going to do something with this quality information to make our lives better?" And I think that is a really good question.

Quality reporting must be standardized and universal, okay. We didn't use the word "mandated" but we were about a hair's breath away from it. This is not going to work if somebody has to be a knight in shining armor to be the first person to come up and say, "I will agree to have that javelin thrown at me." That way lays a certain degree of madness. What we report is going to have to be relevant and valued by the people we think should act upon it. Why haven't consumers used the quality information that they have had so far? Because they don't think it means anything to them because it is about health plans and that is not where they think quality is.

So now we are going to have to try to figure out, quite really, if we are going to provide quality information, that can't be our excuse anymore. We are going to have to measure the things that matter to them. And those things are probably going to be very different from the things that matter to clinicians and even then the things that matter to purchasers. So there is going to be some way that multiple stakeholders are going to have to get together in a constructive environment to figure out what is the test to which we want the health care system to teach, so we don't do what Joanne was talking about and have measures that encourage, prematurely early death. Maybe we can say it that. Okay, so this is another important one.

The reports have to be easy to understand and use. I am aware of one of the health plan reports that compare all their groups that you were probably talking about Glen. It is God awful. From any perspective of human communication and communication with lay people, I would never want to use it myself. It makes your eyes boggle, not to mention your mind. We have to do this a whole lot better, and we really are beginning to learn how. In addition, it is not just enough to have a report somewhere. You have got to figure out how to get it to people when they need it, through a channel that they trust, and how to help them actually use it. So that is another issue.

And, again, providers are going to have to reward two things, quality improvement. And this I think is even more important, reward not just providing quality care but reward providing care to the people that are the bad risks. And Bob Berenson will tell me what the likelihood is of that without some really significant shifts. Because right now the deck is stacked all in the opposite direction.

I think about when the Top Docs came out in Washingtonian Magazine the year after I got to GW that announced that GW was the best place to go if you happened to have HIV/AIDS. And the death knells that were rung throughout that facility because no good deed goes unpunished. And this is an example of that. And it isn't just a matter of sort of risk adjustment. I don't think that is the whole thing here. We really have got to be very careful about how we reward quality improvements and care for the sickest. And providers are going to have to create both the informational and the organizational infrastructure for improvement. They are going to have to learn how to do quality improvement.

It is easy to do all of this stuff badly. So that is why it is really important to stress doing it is not enough. You have got to do it really well. And that is frightening to me because most of the time most people don't do things really, really well. So this really makes my heart shiver.

The price is going to be very high if we do this badly. No one is actually going to use the information, either to make better choices or to improve quality. People are going to lose even more trust in health care. We are going to continue to waste a lot of money. And those with the greatest needs are going to continue to be avoided unless they can pay their own way in some way, shape or form. So is that sounding a little grim? Those are some grim outcomes but those are the ones that we have to avoid.

So what do we want to measure and report? I am going to talk about three categories, patient experiences, technical quality and not really cost, economic issues. These are a list that you should have seen many elements of. Clearly, these are the things that patients are in the best position to report on because it is their experience. Patients, and in some cases, family members of patients: their access to care; their communication and interactions with physicians and with others, such as the medical staff, the office staff. They can tell us: I have left physicians because I couldn't stand anymore the way that I was treated, not in the examining room but in the front office. Those are things that are real.

Responsiveness and understanding of issues that are not purely biomedical. When people walk into a doctor's office they remain human beings with multi-faceted aspects to them. And I don't really believe that it is possible to heal them or help them, let alone cure them, which we will put that on a side, care for them if that wholeness as a human being is not going to be taken into consideration. And so people are going to want you to show compassion, to show caring, and to also understand that you want this particular medication because it is going to improve, not your chances of survival from a mortality perspective, but your quality of life, which is of great importance. Your ability to interact with your family. Don't give a diabetic a diet to follow if you don't also tell that diabetic how are they going to negotiate the new eating pattern with their family, okay? People are not in a vacuum. So those issues and we are not asking about those issues very much in our quality measures, just so you are clear about that.

And whether or not people have actually received certain kind of services that a large number of the population need to get, screenings, immunization, services that are evidence-based.

Let's talk a little bit about technical quality. We can talk about structure, process and outcome. There is a lot of structural variables that are in fact going to be important. There probably are very few uncertified neurosurgeons around, but I sure wouldn't want to go to any of them. So certification I think, affiliation, staffing is important. Language that is spoken is very important. When are your office hours open?

Processes that are known to have significant effects on outcomes, outcomes including cure, chronic condition management, functional status, and psycho-social. Those are broad areas. And if you are going to tell people about technical quality, you can't use jargon. You have to tell people in English. And you especially have to tell people why these measures are important.

So another issue that we need to deal with is which patients do you report on. Do you report on everybody? Do you report on the high users, which I actually would prefer because those are the people that have the most experience of the system. Those who have used services recently and actually remember what happened to them? So these are technical issues but I think they have significant implications, not only for the accuracy of the data but for how compelling and meaningful the data are to others.

In terms of economic issues, I want to just signal that we have forgotten about the one thing that you are talking is quality; we don't have comparative information on costs in health care and price. We don't have that information. That hasn't been important up to now because people have had insurance coverage. So they have needed to understand their benefit structure but not necessarily what the doctor is getting paid as a fee. But if you go to a consumer-driven health plan world, then cost is going to become important. And they are especially important for the procedure-driven specialities.

One statement I want to make about financial incentives. I think that we are in murky territory here because we only assume, and I think have very little evidence to demonstrate, the effect of financial incentives on physician behaviors. We assume theoretically that these financial incentives have these effects. But I have to tell you that when patients tell you that 95 percent of them say that they want the information, what they really want is they want to know that bad things are not being hidden from them, which is, I think, a little bit different. But if you gave them the information, they wouldn't know what to do with it and they wouldn't know what to make of it unless they had some really heavy duty translation.

So cruising to the end here, here are my implications for you folks. And this is belief, I am not going to claim evidence on this, this is sort of like belief, Kantian. The public, on both an individual and societal level, have I believe a right to valid, reliable, relevant, and useful comparative information about quality and cost; which is to say the value of physicians. This can help make individuals make choices for themselves that can in turn help them achieve better health outcomes in a personal sense. And we hope that public disclosure can also create external incentives or push for quality and value improvements in the market as a whole.

However, I do not believe that we can leave the fate of consumers strictly in the hands of the market. There is too much at stake. Your commissioner said earlier that health care is not like other markets and I completely agree. Market solutions alone are not going to work. People, and especially the most vulnerable, need protection as well as information. They need regulation and advocacy as well as market-based interventions. Patients are still the least powerful stakeholder in health care. And we are sitting here today saying we haven't been able to improve quality in health care, "we" being the physicians, the purchasers, the hospitals, and the federal government. So you know what “we” are going to do is we are going to let patients be the ones that bear the burden and the onus because they are going to be able to do it where we have never been able to do it. I don't think so. This is going to take everybody participating.

Final thought, which I think is going to echo some of Wendy's earlier statements. To me the heart of medicine is the relationship between the physician and the patient. That is where it lives, breathes, and dies. This relationship needs to be one of trust, respect, and integrity. One that embodies the ideals of what we call professionalism. My desire, hope is that we disclose comparative quality information publicly. But that we do it in a manner which reinvigorates that relationship between the physician and the patient and does not require either party to give up their autonomy. In other words, I am not saying going back to the days of a paternalistic kind of physician/patient relationship. I am saying we need to reinvigorate that as a much more relationship of equal and mutually respected and respectful partners.

Thank you.

(Applause.)

MR. HYMAN: Finally, Dr. Nielsen, from the American Medical Association.

DR. NIELSEN: Nothing like being the last speaker on a Friday afternoon when it is sunny out, and I am the only thing standing between you and getting out there or a strong drink or whatever you are looking for.

This is not a time to use Power Point. This is a time for us to think about some of the very important things heard this afternoon. How many of you were here this morning? Good, a fair number of you were. This has been an extraordinary day and you have heard a wide variety of opinions on a variety of things. And as I am about to weigh in you have a right to know who I am and what I represent and who I represent. I am an internist. I live in Buffalo. I have had a big practice for 23 years. I am also vice speaker of the American Medical Association's House of Delegates and that is why I was asked to come here today. But I wear a couple of hats that you need to know about because you can, depending on your point of view, decide that I have a personal commitment to this quality issue or you can consider it very serious conflict of interest, depending on your point of view.

So let me tell you about them. First of all, I am on the board of directors of the National Patient Safety Foundation. That is an organization that the AMA started in 1997, two years before the IOM's, "To Err is Human." And that organization is very committed to systems change, the kinds of things that several of the speakers this afternoon have talked about. I also am senior associate dean of the medical school at the University of Buffalo. And then finally, if I don't have enough conflicts of interest already, I am associate medical director for quality at a large HMO in Buffalo. I do that part time. So I know full well about the profiling. I have seen that. We do some of that. Fascinating discussion, by the way. Thank you very much. You taught me some things and taught me some things to do and not to do when we go back. So those are where I am coming from.

I am here actually on behalf of the American Medical Association. And I think the way the last speaker left it at the end is the way I want to start. And that is there are no villains in this piece. There are no villains. We are all in this together. We have a mess of a health care system in some ways, do we not? We have over 41 million people in this country who do not have health insurance. That is a moral issue and there is not right now the political will to change that. We cannot avoid that particular problem. But we are all in it together. And, yes, it is true that physicians do feel a loss of autonomy. The ones I deal with aren't quite as angry as you heard about -- I don't know who you know but you have got to meet some of our friends too.

But in Buffalo they are not quite so angry but they do feel the loss of autonomy, there is no question about it. They feel helpless. And they do feel the enormous burden of regulation. So it is quite true what the speaker said, that the impact of federal regulation is enormous and it invades the doctor/patient relationship right there in that examining room. There is no doubt about it.

Well, that is the bad news. And I am also here to tell you that this is the best profession in the world simply because of that doctor/patient relationship. We are committed deeply to caring for our patients. And because of that we have for a long time been a player in this quality arena, before it became the de rigueur thing to talk about. Our commitment goes back a long time, back in the early 90's, along with AHRQ and with the American Association Health Plans. Now they are strange bed fellows for you, the AMA and the AAHP. Think about that one.

We were the early sponsors, the original sponsors of the National Guidelines Clearinghouse. And those guidelines are on the web. And they are there for consumers, for physicians. They are easily accessed. You don't have to be a member of the AMA to get it. Any consumer can go to the web, as many do, and look at the guidelines that have been posted there to help physicians in their decision-making and patients in their choices.

And even before we developed the Clearinghouse along with those other organizations, we have been bringing together state medical societies and the national specialty societies together to try to deal with the issues of quality. That includes practice guidelines, partnership, and the clinical quality improvement forum. These have been ongoing for years and so our commitment is there.

And every once in a while when there are very important gaps between what we know in terms of our medical knowledge and what is happening in the workplace in terms of physician practices, the AMA and the appropriate medical societies have collaborated on such alerts as quality care alerts. Now this morning you heard about beta blockers. That was one of the things that we did issue a quality care alert on. And we were also partners in changing the statistics on the number of patients who received beta blockers after MI. So we are all partners in this morass, and we all have a vested interest in doing it right. Not a vested self-interest nearly as much as the interest in getting it right. Because all of us, physicians alike, are also going to be patients and are patients.

Well, let's talk about our newest initiative and this is our most vigorous one. This was referred to by Dr. Tuckson this morning. This is the Physician Consortium for Performance Improvement. We have brought together clinical experts from over 60 specialty and state societies, along with AHRQ and CMS, and we are working together with them to develop the clinical measures that result in improved patient care.

What is the difference between guidelines and the performance measures? There is a difference. If you think about the guidelines as a road map, then you can think about the performance measures as the most critical markers along the way that are associated with good patient outcomes. But remember what presents as a patient in the office is not an abstraction. Each patient is unique in their own risk factors and underlying diseases and that obviously impacts on the outcomes. And that is what we are calling the risk adjustment. And that is not the only factor but clearly risk adjustment is very important. Those of you who were here this morning heard Dr. McGinnis talk about that quite eloquently. If you don't case mix adjust, you will inadvertently stigmatize a physician who may be caring for a high number of high risk patients. And obviously nobody wants to do that. You want to get it right. And so we are in this together in terms of trying to get it right and seeing what the actual measures should be. But remember that you should case mix adjust first.

Let me give you an example of where that was done in my home state of New York. Many of you know that in New York for a number of years, over 10 years, there has been public disclosure of the cardio bypass surgery mortality data. It used to be hospital-specific, it is now physician-specific and it is made public. And that has had some interesting consequences. Some of them have been very good. Physicians who may have been operating on patients without taking the appropriate care to assess what their risk factors were have stopped doing that. But let me caution you about an unintended consequence. And those are the things that we need to all think out together. The unintended consequence is this. Cardiac surgeons in New York are reluctant to operate on high risk patients. In Buffalo, you will find that the high-risk patients are not operated on in New York. They go to the Cleveland Clinic. And that is because of physician reluctance. Why? Because their statistics are publicly available. I think that is not the outcome that we want. We want accountability. There is no question about it. But we do have to think through those things and try to figure out how we are going to avoid those kinds of unintended consequences.

There was a recent study from Massachusetts called Physician Clinical Performance Assessment, the state of the art. And that study places in perspective the assessment of physician clinical performance. The study concluded that the use for external reporting carries with it a number of analytic challenges. That doesn't mean it shouldn't be done. Just be aware of the challenges that are presented. For example, sample size. You wouldn't want to report on a physician's care of a diabetic patient if he only had three, would you? The sample size is just not big enough to make any meaningful conclusions.

There could be a number of other impediments to outcomes that you might not so easily understand if you were even case mix adjusting. For example, what if you have a patient who has poor health literacy, doesn't understand the instructions even though they nod and appear to understand? I remember a situation in my practice, I had known a patient for two years before I realized he couldn't read. He always brought his girlfriend with him. His girlfriend signed everything. She didn't come in the examining room. He was very bright but he couldn't read. I had no idea.

I finally found that out after we had a long encounter and after a long talk and I changed a whole lot of ways I dealt with him after that. But he did not offer that and I wouldn't have known it. You couldn't tell on the surface.

What about patients that have economic barriers in following through, what if they can't afford the drugs that you are proscribing? They may or may not volunteer that. There may be an insurance barrier in terms of coverage for accepting the recommendations, the therapeutic recommendations that a doctor is giving. So there are a lot of things that enter into this that we have to consider, which does not mean that any of us should not be accountable. Indeed, we should and we want to be.

All right, let's look at a couple of the issues we were asked to consider. One was volume. Well, you have heard already from some of the speakers this afternoon that volume indicators are not so simple. We at the AMA recommend that volume indicators should only be applied when it has clearly been shown by valid statistical means that the outcomes are influenced by frequency of performance. You might wonder why that is. You might say, gee, it is just intuitively obvious, isn't it, that if a physician does something often, they are going to do it better. But not so. Not necessarily so at all. In fact, one of the humorous comments that was made this morning was you remember the situation out in California where there was a lot of cardiac surgeries, a lot of angios going on but not very many of them that apparently were truly indicated. Nobody would support that sort of approach. And if that was true, that was fraud and hopefully that will be prosecuted to the fullest extent.

It is absolutely true that a patient should feel free in that room with the doctor to ask questions, not only about quality but about volume. And the physician must answer honestly. But the physician also has the right to say, wait a minute, this is a new treatment. We don't know yet. There aren't that many that have been done. Let's talk about it. There is no exact relationship to volume if that is true. But it has to be discussed openly and honestly and physicians cannot be defensive about that.

The imbalance -- Commissioner Leary spoke this afternoon about the imbalance in knowledge between physicians and patients. Let me raise another one that I haven't heard anybody speak of, this morning or this afternoon. There is one source of knowledge that physicians find difficult to deal with. And that is, let me describe it to you. It is the patient leaping through the ragweed field without the allergy symptoms. You recall that TV ad. The direct consumer advertising is an important force that has become a bit of a problem. The drug industry maintains that that educates consumers. I maintain that there is a little of that. But there is a whole lot of marketing going on. And so whenever anybody gets information, whether it is from the Internet or from a TV commercial or from their doctor, they have a right to ask what are the perverse incentives, what are the incentives that are operating here?

Well, what about geographic variation? There are a number of articles that have been written about the variations in particular practices or procedures. This occurs much more often when there is not a clearly defined single path to treat a condition or when beliefs about the risks and benefits of a particular kind of treatment do vary. In the situation where there is agreement or relative agreement, for example, hip fracture repair, you don't see geographic variation. So we at the AMA believe that the way to address the geographic variation is pretty simple. Take a look at the evidence. Let's find out what the science is. Strip the science away from past practices, which may have been based on honest belief but are not based on science.

And, finally, related to consumer information in the academic setting, which was one of the questions we were asked to address, and I haven't heard anybody else talk about patients who receive care at teaching hospitals, such as the ones I work at, and who may indeed be treated by physicians in training, medical students. Those students must be supervised. Residents must be supervised. That is absolutely mandated. And the AMA Code of Medical Ethics states very clearly that patients must be informed of the identity and the training status of individuals involved in their care. And patients have a right to refuse to be cared for by medical students if they choose. All health care professionals have to properly identify themselves. And we teach our medical students in the first year that they in clear and unambiguous terms tell patients that they are a medical student, no euphemisms, no young Dr. Jones. Young Dr. Jones is a medical student in one year and you say it that way. And if they don't, we deal with their lack of professionalism and take care of that in different ways.

I know it is late. I am going to stop now. I simply want to thank the FTC and the Justice Department for the opportunity to come here to tell you that physicians are very interested in this whole issue of determining better quality for all of us. We are in it with all of you and we are thrilled to be here. And we look forward to a hopefully brief discussion, because it is a nice afternoon. Thank you.

(Applause.)

MR. HYMAN: I just ask all the panelists to come up and sit where their names are. I committed a sin of omission in introducing people. I explained that Dr. Berenson was a long-time Washington participant in the area of health care policy. But I neglected to explain that I had invited him to be a sort of a free-lance commentator, mostly because I couldn't persuade him to do his own formal presentation. So I took him on the terms that I could get him. And so I would like to ask Bob to make whatever remarks he wants and then we can open it up for broader discussion.

DR. BERENSON: I will do my best in a few minutes. I have got at least half an hour worth of comments but I will try to keep it to seven minutes. Just to pick up on Dr. Nielsen's last point, when I was a second year, just about to enter third year medical student, I was rounding with one of the attendings on the private side of the hospital that didn't have any house staff of any kind. And the patient turned to me when my attending said, "Why don't you draw blood on this patient," said, "You are not an intern, are you?" And I said with full disclosure, "No, I am not."

Let me just go through the presentations very briefly and just make a few points. It could all go on forever. They were terrific and I think you got a lot of useful information. On Glen's sort of review of what plans are doing, using incentives on quality, just I want to refer to -- he didn't emphasize it much but I have spent a lot of time thinking about the difficulties plans have actually investing in and promoting their work in quality and actually wrote a health affairs article in '98 which has been ignored by most of the world. But basically argued that the structure of markets don't promote this kind of activity very much. When you have got all the docs and all the hospitals and all the plans, you have got first a market share problem where any individual plan doesn't give enough business. And so even if the incentives are two to 10 percent, that ultimately is a 10 percent market share plan for any given provider, the marginal part at risk might be under one percent. So that is a problem. There is first a free rider problems. When one plan invests in all the other plans' benefit. There is absolutely the issue of adverse selection that Shoshana was referring to; i.e.; that if a plan really gets a reputation in a certain area, they may get adversely selected, they are not then first mover advantaged. So I actually recommended that within the antitrust enforcement strictures, and this is why I think it is relevant, is that plans should actually do more collaboration in this area.

Clearly, there is a practical issue also, which we found out on a site visit. I go on site visits, is that hospitals and doctors have a real problem complying with 10 different sets of requirements. And so at least in a few markets there has been some good work to standardize data, standardize measurements. But for the most part plans then use the information and may have different reward systems or different carrots or sticks. I raised the question in my article whether plans could actually get together to have common carrots and sticks and whether the antitrust laws would permit that. And not being a lawyer, I suggested they might. But I think it is actually an issue for you guys.

The other point I would make on Glen's is that I also picked this up on the site visits is that it is nice to have marginal incentives to do good. But it is the base incentives that drive the market. So I remember an interview with a large cardiology group who is actually getting involved now with putting up cardiac facilities, of which they will be owners. And asking what they were doing for congestive heart failure, disease management type programs. And the answer was basically why would we do anything in disease management for congestive heart failure? What we are doing is catheterization and putting in stints in people. That is where the money is. That is where the Medicare and other payment systems are. So this thing has to be aligned. Payment systems need to be aligned.

Wendy's, just a couple of comments, Shoshana already picked up on one thing I was going to say is that even though docs, and I was once a doc, I consider myself a lapsed physician, are sure that there is less visit time, there is actually as much visit time. But the point I wanted to make was the visit is anachronistic. And the idea that you would have this kind of a discussion, let's say it is about deciding about how the last year or two of life should be, in a visit, it should be over time. It should have lots of different forms of communication. We don't have payment systems yet to really accommodate that. And we have to figure that out.

The other point I would want to make about disclosure of financial incentives, I found it curious that the definition had to do with potential withholding. But I have been impressed by -- especially now in a world where apparently there are so many loopholes in self-referral restrictions that doctors can be owners of facilities or have real incentives to bring ancillaries in house that I think in disclosure on the fee for service side may be equally important and deserve some attention as well.

And then in your discussion about the importance of communication, it really raised for me an issue that applies to the sort of last three, four presentations, which is that we tend to focus on -- we have in recent years focused on outcome measures, some process related to outcome measures. Shoshana sort of mentioned there are structural elements of quality also. But I would refer to it as information that I think at this point, I think the technical barriers to really doing measures of physicians are formidable because there is no good case mix adjustment, because of small numbers, because of a lot of things that I think patients should, in some kind of routine way, want, and should be educated as to why they should want, information about -- language is a good one and not just self-declared "I speak Spanish," but some reason to believe or whatever mechanism the office has for doing interpretation services but the use of an electronic medical record. Or, as Paul Elwood would recommend, a shared electronic medical record or some way of identifying the nature of shared decision-making and does the office commit to it. We could go down the line on any number of things. Does the office use Internet communication as the sort of standard way of communicating evidence-based guidelines. Now there would be big problems here as well in self-declared adherence to these things.

So there would be a standardization issue, a verification issue. But I think we should be thinking, at least in my 30 years of having been a physician, about how medicine is practiced may be fundamentally shifting now in some ways or it should be to sort of provide information to patients about what is the nature of this person's practice. And do that while we are trying to figure out how to do the more complicated outcome measures.

There is not too much I can say about Joanne. I agree with her on most everything and in fact have -- I would only want to add one or two things. Particularly on the issue of geographic concentration and the suggestion that instead of 27, we should have three. Now I guess the antitrust laws don't affect government purchasing, if I understand that. But, interestingly, just for information, the couple of competitive bidding models that Medicare has actually are pro-competitive in my view and actually get you down from 27 to three or in the real case of the demos for DME supplies, from 5,000 vendors to about 20 in a geographic area. The first selection is based on price bids. And once you pass the threshold on price, then there is a review of quality and service. And actually an opportunity for the purchaser, in this case, Medicare, to do a form of negotiation or say if you answer your phone 24 hours when the oxygen goes bad and the patient needs some help, you are in.

In other words, I think you can have competitive bidding models which are pro-competitive and I think would apply to the private sector as well. You have to protect against embedding a certain sort of organization forever but you don't have to have everybody in a competitive system.

And I guess the final point I wanted to make, I have covered most of everything in shorthand here, is that to Shoshana's point about accountability for quality to society and the public, I was a little confused because I thought you were suggesting that it is now happening. And I thought most of your information suggested that it isn't happening. And I have actually been impressed by the lack of impact, despite the IOM report. It is an inside baseball discussion right now. And to me the best evidence of this, at least inside baseball, is that there have now been a few articles, I am oriented to Medicare now so I will use that, a couple of JAMA articles documenting quality problems for the

Medicare population on sort of 23 measures of pretty well accepted process and some outcome measures on quality, which has gotten mostly yawns from the policy-makers.

But the Iowa delegation and some others are going to the mat to get more money for Iowa, even though Weinberg has I think done a pretty good job of suggesting that more spending doesn't necessarily result in better quality. They want their piece of that spending as well. So the concern is really about spending. There is still an assumption that more is better. There is not any real sophistication in this town about quality problems.

And I applaud the efforts of organizations, like the AMA and others, that are doing something. But I still think for most practices and most policy-makers, it is still of marginal importance. And I will end on that.

MR. HYMAN: Does anybody want to respond to any of Dr. Berenson's comments?

Let me throw out two questions and see whether I can get anyone to bite at 4:48 on Friday. And it, of course, creates bad incentives for all of you to have revealed that beforehand. The first is just to ask whether we should think about information, collecting, gathering, disseminating, in terms of utility? Do we want to target the supply side, that is the providers or the demand side. And who do we identify on both of those. Is it employers? Is it insurers? Is it individual patients? What part of the -- if we say the answer is demand side, who is it we are going after?

And the other question I think flows from a number of speakers, all of whom pointed out the difficulty that physicians have in determining the actual preferences of patients. The discussions are hard to have. Sometimes they don't happen at all. What can be done to make that happen more often and happen more effectively? Is it medical school training? Is it collusion at the other end of the spectrum? Or is it something in between?

DR. LEVINSON: I will start with the second question. So I think historically medical education and doctoring has been very biomedical. And the whole way of thinking about medicine that has contributed to the discussion that we are having is doing procedures is good. And curing disease is good. And that that is kind of the culture of medicine. And I think that really the shift towards a different kind of model of care, a more collaborative model of care, a less paternalistic model of care and a different kind of communication that very much is integrated with this discussion about patients being involved in making choices is happening. And it is happening in medical schools. It is going to be in residencies because of a accreditation. And it is happening in certification.

So the American Board of Internal Medicine in their re-certification process now has modules on communication and physicians need to re-certify every 10 years. And instead of it just being a paper and pencil test about right information, which is of course equally important, there is also questions about these kinds of issues, like end of life care and talking about difficult topics like domestic violence and patient preferences.

MS. SOFAER: I actually want to respond first to the first question that you asked, which was about the do we go to the supply side and the demand side. And I don't think there can be an either/or here. One of the things that we have learned is that even though consumers have had very good reason not to make particularly good use of the quality information that is out there, the fact that it is out there and so far has been an incentive for the providers to respond even though the consumers aren't making -- I think that the pathway is a different one. Again, it is sort of that more the fact that it is publicly out there that hospitals or physicians are worse or better than each other, that does seem to have had an impact. And Dr. Hibbard, who was here yesterday, in her recent study in Wisconsin with hospital ratings, in a very well-designed study, it is clear that the people whose information was publicly disclosed, that audience paid attention to the fact that there was another audience that was seeing it. So I think that it is not an either/or kind of situation.

I also want to respond actually to what Bob said earlier, which is I said it was the idea of accountability. I don't think the accountability -- I think that accountability for quality to society and public is far from a reality. But even considering the fact that we should be doing things comparatively speaking is revolutionary in medicine.

I will stop there.

DR. NIELSEN: I want to comment on how we train physicians a little bit differently. I think you are absolutely right, medical education is changing. The example that is being used now is all medical students are taught by standardized patients, you all know what I am talking about. These are patients who are actors, who have a standard script that they learn, they are then in a room. The student goes in, interviews the patient, examines the patient. And then the patient grades the medical student. The patient grades the medical student on those parameters that the patient is best able to assess. Did the student listen to me? Did the student respect my choices? Did the student give me choices? Did the student give me any hope? Did the student do all the talking? Remember that communication is a two-way thing. It is not talking at, it is also listening to. So that is being done in medical schools right now and it certainly is being done because of our RC requirements in the residencies.

I want to propose that we really want, and what I think consumers want to know, see if this one fits, is how to pick a doctor. That is what they want to know. And I want to tell you a story, and I will make it quick because it is late. I had a superintendent of schools come into my office as a new patient. And I asked him how he happened to choose me and he told me the following story. He just moved to town and he said he didn't know how to find a doctor, didn't want to call the Medical Society because they would just tell him geographically who was closest. And he didn't want to ask neighbors because he said the neighbors could have a doctor who is friendly but not very good, how would I know?

So he decided that he would ask which is the best hospital in Buffalo. And after he found that out, he then called the nursing supervisor on the 3:00 to 11:00 shift. And his theory was the following. His theory was that the nursing supervisor on the 3:00 to

11:00 shift, who probably had more time to talk than 7:00 to 3:00 and probably wasn't asleep from 11:00 to 7:00, would know who the doctors were who responded the best in an emergency. Who were the doctors who didn't get mad at 2:00 in the morning when the patient went bad and the nurse called. Who knew who talked to the patients and listened to the patients and dealt with their discharge instructions and dealt with their family. And I will tell you that I think whatever our model is it has got to simulate the nursing supervisor on the 3:00 to 11:00 shift.

DR. LYNN: Congratulations on being the doctor picked that week.

DR. NIELSEN: I was thrilled.

DR. LYNN: A couple of thoughts on your two questions. Trying to figure out how to be helpful to the FTC is certainly not my usual role. I think that, at least in my arena, we desperately need an epidemiology, just a basic description. There is no way to know whether Dallas does better than Denver on end of life care. How many people are bankrupt and how many people are in pain; how many families are driven to distraction; how many patients get their preferences documented; how many of them get it followed. It would not be hard to do. You could do it with just a couple of 100 people sampling in every area. But we just don't do it yet. It is like child abuse. It wasn't really a problem until we started having all ERs report it, and then all of a sudden we started seeing how many there really were. So we need an epidemiology that would allow us to do trends over time and comparisons across regions.

A second thing though about the information gathering and dissemination and sort of where you take it from which part. The degree to which we fail to provide honest information in my arena is just astonishing. I have been doing this sort of ad hoc little collection of all the consent documents from defribillators, those marvelous gizmos, the ER in your chest that Dick Cheney has. I have been told now of one, but I have not yet seen one, that tells patients if they ever want to be deactivated. Here we are putting a device in the chest that stops your one clean exit, which is a cardiac erythema, and we are putting them in old people with bad disease and we are routinely not telling anybody that you might ever want it stopped.

So hospices are having to learn how to slap magnets on to chests because people get sent clear to hospice with no one having thought about stopping the damn device. Surely there is some level of information in which we are all involved in a magnificent collusion to avoid the obvious when we put defribillators into people's chest and don't think about stopping them.

Let me talk a second about the determining preference. It was interesting the way you phrased it. You said that doctors have such trouble determining preference, which is a mental model that implies that it already exists out there. I think we have to find some more creative language, something like helping people come to understand what would serve them best. It is not just sort of now that you are in this situation, tell me what your preferences are because almost nobody has them that way. They have got to live it through, try to devise it.

MS. SOFAER: The preference is not to be in the situation.

DR. LYNN: Well, that is the first one, yes. I think though there are some simple leverage points. I think that for some of these things it would be -- one of the mercies of growing old and dying slow, which is what most of us will get to do, is that we will get a few rehearsals. We will come close to a fire a few times. But why don't we after the first round just nail anybody who hasn't taken an opportunity to deal with that rehearsal. I would propose that the second time a person comes into the same hospital with the same serious chronic illness and they have had no advance care planning, the hospital should get half the DRG. I think it would take us about a week to figure out to start talking to people before they left the first time. We just haven't even started getting serious about this at all. So we don't have any of those sorts of things.

I think we need some kind of a feedback loop so that the doctor at the end, there is no payment for dealing with death certificates. Slap a $50 payment on but the trigger is you have to write three paragraphs about what happened in the last few months and then use the U-pins and send it back to all the doctors who took care of this patient in the last year. And the doctors at the end of the line would start learning to say this patient and family could have had a whole lot better care if... and then collect those and start seeing where our real shortcomings are. Nobody upstream ever knows what happens in hospice. Nobody upstream ever knows what happens in a nursing home. We are all in our own little bailiwicks and we don't talk to each other. So just some feedback loops I think would be very important.

And then finally, I don't want to make it sound maudlin but we have got to find some ways to get some of these issues into popular stories and mythology. Families stand there and look at you and say, "What do I do now?" And I used to think what they wanted was a decision tree and sort of choices. Now I realize what they are saying is I don't know how Tuesday follows Monday in the circumstance in which we now are thrust. I have never heard of this. I don't know anybody who has been in this situation. I don't know how to be a care-giver. I don't know how to live with somebody who is dying. And we have got to actually have to have some more realism in our popular culture that arms people with stories because the stories that come from the Bible and the stories that come from Babe, The Blue Ox and Paul Bunyan were magnificent for the problems of an earlier era but we don't have the stories now to get us through the situations we actually face.

So I think we need -- not that the FTC is likely to be in a position to do that, but I just see red when I pick up Newsweek and see the ad for Airacept that has the wonderful guy looking 58 years old, holding his grandchild and talking about how Airacept gave his life back. That is not my patient. That is not the way we use Airacept. That is just misleading. You feel a little bit better for a little bit of period of time but no one is going to let you go waltzing off with a grandchild if you are bad enough to need Airacept. Let's get real. The degree to which we could start trying to be a little bit more honest about what it is we face as mere mortals, none of us gets to evade that, it seems that we could try for it. I am not sure what the FTC's role in any of that would be. The community kind of has to grow up enough to stomach the fact that you don't get to live forever. And maybe we aren't yet there. But we certainly could stop lying.

DR. BERENSON: Can I do 30 seconds on this one?

MR. HYMAN: Sure. I was going to say anybody who is willing to try and follow Dr. Lynn.

DR. BERENSON: I am going to change the subject.

MR. HYMAN: I now know how Shoshana feels. And I would have laid serious money, "Babe, The Blue Ox" would not have come up today.

DR. BERENSON: I thought a lot about sort of using the words "choosing for quality" in health care and how we contrast that in other markets. People pick quality airlines to fly. And for the most part it has to do with amenities related to scheduling and what used to be food and things like that. But we rely on other mechanisms to assure safety. Call it supply side, with a heavy dose of regulation. And I think we should, going back to health care, there is a whole bunch of stuff under the quality rubric, which is about basic safety in the system and reliability of the system that is not the consumers' and the patients' responsibility. And they at some point all have preferences or should have preferences or we can help them figure out how to think about things that they care about. But they shouldn't be deciding to go to one hospital or the other because of basic safety issues and that is a supply side issue.

DR. LEVINSON: I just need to come back to one issue that has come up twice, which is about time in the doctor/patient encounter and whether the encounter is going to go away and be configured differently. I actually think that face to face time between doctors and patients is never going to go away. It is what patients value and doctors value. It is the critical component of care in any phase of life. And I think that one thing that should be considered by regulators is the effect of regulations on that time. I would give you the specific example that in Medicare reimbursement now physicians are required to ask a whole lot of questions to meet compliance with Medicare reimbursement rules and it is completely opposed to what all patients would tell you and what research would tell you about what good quality communication is about. Good quality communication is about open-ended questions. The discussion we have had about trying to understand the person in front of you, and how the disease is affecting them. And regulations tell you you have to ask a series of 20 or 30 close-ended questions about what kinds of symptoms you have if you are going to bill at a higher level.

And I think that is the kind of way regulatory issues impact on the doctor/patient actual encounter that these policy-makers should take into consideration. I think the time that exists has been eroded by regulatory constraints in a real way and undermining what doctors and patients value.

MR. HYMAN: Quickly.

MS. SOFAER: Quickly, yes. To the FTC, you have heard a lot of echos in here about the fact that competition may not be the best mechanism for achieving quality goals. And I just want to reinforce that, that it is going to be a mix of competition on some factors, regulation on other factors. And the third thing that I want to talk about is the potential need or collaboration across different stakeholder groups at the national, state, and local level in order to figure out because these are not little tweaks to the system. These are significant overhauls to the system that are going to be needed in order to be able to make the kinds of changes in the practice of medicine that we are talking about today.

MR. HYMAN: Well, I would like to thank our panel for a wonderful afternoon session. And can I get a round of applause from the audience.

(Applause.)

MR. HYMAN: We will reconvene these hearings on June the 10th, when we will take up the subject of market entry, and we will hold hearings June 10th, 11th, and 12th in this room.

Thank you very much.

(Whereupon, the hearing was concluded.)

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CERTIFICATION OF REPORTER

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DATE: MAY 30, 2003

I HEREBY CERTIFY that the transcript contained herein is a full and accurate transcript of the tapes transcribed by me on the above cause before the FEDERAL TRADE COMMISSION to the best of my knowledge and belief.

DATED: JUNE 11, 2003

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LISA SIRARD

CERTIFICATION OF PROOFREADER

I HEREBY CERTIFY that I proofread the transcript for accuracy in spelling, hyphenation, punctuation and format.

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SARA J. VANCE