FEDERAL TRADE COMMISSION

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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. BYE: Good morning, and welcome back to the FTC and Department of Justice hearing on health care and competition law and policy.

My name is Matthew Bye.

Today we're going to consider issues on the provision of quality information in relation to hospitals as part of a series of panels focusing on quality of care. Tomorrow we'll look at the provision of quality information in relation to physicians, and in early June, we'll look at market entry and quality of care.

We have nine distinguished panelists this morning, and we've only got until 12:30 p.m. So I'll very briefly introduce each of the panelists and ask them to stand up and wave, in the order they'll give their presentations.

The panel's complete biographies are available in the hand-outs.

Due to the limited time we have available, I encourage panelists to stick to the time allocated for their presentations. Cecile Kohrs, our legal assistant, will wave when your time is up, and if that doesn't suffice, we have a SWAT team waiting outside to drag people away.

Gloria Bazzoli is professor of health

administration at Virginia Commonwealth University.

Judith Hibbard is a professor in the department of planning and policy management at the University of Oregon.

Patrick Romano is an associate professor of medicine in pediatrics at the University of California at Davis.

Daniel Kessler is a professor at Stanford Business School.

Louise Probst is executive director at the Gateway Purchasers Coalition in St. Louis.

Paul Conlon is vice president of clinical quality at Trinity Health Services.

Nancy Davenport-Ennis is the president and chief executive officer of the National Patient Advocate Foundation.

Nancy will be talking about certificate of need issues generally, as opposed to quality issues more specifically. So, don't assume that she just walked into the wrong conference.

Charles Kahn is president of the Federation of American Hospitals.

And William Sage is a professor at Columbia University School of Law.

Professor Bazzoli, would you like to start with

your presentation?

DR. BAZZOLI: And just to make sure you think I didn't happen to walk into the wrong session, I'm going to be talking mostly about what has happened to the hospital industry over the last 20 or so years, especially focusing on organizational change, structural change.

I'm going to be providing some evidence on how the industry has changed, what kinds of changes have been implemented, what this means for the hospital industry and markets, and how this affects the financial circumstances of hospitals.

I think this provides some context for the quality issue, because obviously hospitals need finances, they need resources if they're going to invest in quality.

To begin, let me give you just a brief synopsis of what has happened in the last 20 or so years, and we'll go into some detail in subsequent slides, but first, if we go back to the 1980s, go back 20 years or so, back to, let's say, 1982, we had a hospital industry that was largely autonomous. Some hospitals were in systems, but systems were -- only represented about 25 percent of hospitals, 30 percent of hospitals at that point.

Hospitals were very worried about government regulation and rate-setting, but quite frankly, they were pretty much in the driver's seat, making their own decisions, acting on their own.

In the '90s, the world changed quite a bit, as you probably all know. I call this the era of payers, both private payers and public payers. Hospitals were losing ground to managed care. They were facing constraints, especially as we get into the late 1990s, not only on the private side but also on the public side.

Then we get to the 2000s, and what happened at that point? Well, we ended up with an industry largely consolidated but I would call quite bifurcated, some doing very, very well given the consolidation that occurred, and some doing miserably, and quite frankly, the variation and performance over this time period from the '80s to 2000s has changed.

We've seen quite a larger dispersion of financial performance of hospitals in this period.

Well, a lot has happened. I just gave you the synopsis. A lot has happened since the '80s, and I want to go through this a bit, and to do that, I want to use what I think is kind of an interesting way of setting the context here, which is to go back to Paul Starr's book on the social transformation of American medicine.

While Starr focused largely on medicine, he did spend some time talking about what he thought would happen to the hospital industry, and that's what I want to use as kind of a frame-work to think about what we thought would happen and what actually did happen to the hospital industry.

I think looking at Starr is interesting, because it is 20 years ago, and quite frankly, it's interesting because many of those who predicted what was going to happen to the industry painted a similar picture. So, Starr, in many ways, was a -- you know, kind of able to see early on what he thought the industry was going to do, and many seem to have followed his lead.

So, what was his vision for hospitals?

Well, let's think about what health care looked like back in the '80s, and what I'm showing you here is, you know, a lot of little hospitals hanging around, physicians, also independent, practicing, going about their daily business, and what Starr was saying is that the forces that were underway in the '80s was going to change, fundamentally change this picture, and the only way that hospitals would survive is if they came together in some way, through systems or through merger.

Physicians also would have to come together in some way.

They could then come together vertically and form what Starr called the regional/national health care conglomerates.

These were organizations not based in the local community but regional and national, where the locus of control will have moved from the local community to these larger organizations, their boards, their stakeholders, their stockholders, in some instances, if they're for profit.

So, this was the idea that Starr had about how the world was going to change, and again, if you think about it, people that came after him, you know, some of the notions of the advisory boards, Shortell and his idea of organized delivery systems -- all of that movement seems to have picked up this wave that Starr started in 1982.

Well, there were very specific pathways that Starr thought would lead to these national regional health care conglomerates, these multi-market, multi-product firms, and here are the pathways that he suggested.

These are not mutually exclusive. They were intended to be occurring jointly, some of them overlap a bit, but basically what he expected was a change in hospital ownership for some, not all, hospitals to for-

profit. He also expected horizontal integration through the development of multi-hospital systems, diversification and corporate restructuring in what he called poly-corporate enterprises, and these are organizations with multiple subsidiaries that offer multiple products in multiple markets, vertical integration of providers into HMO's, into models that looked like a Kaiser-type health plan, Kaiser health plan model, and finally, increased industry concentration of ownership and control.

And again, these are not mutually exclusive, and quite frankly, any of the first four here would lead to the fifth pathway that he suggested.

So, what have I been doing? I've been doing research trying to answer these key questions, namely: What is it that came to pass and what did not in terms of Starr's predictions? Why didn't some things come to pass and why did others not? What does this mean for the hospital industry and markets today, and how has this affected financial status as we see it currently? Okay.

So, these are the kinds of questions I've been looking at recently, again given my interest in what Starr had predicted, and I want to present some of the evidence here today.

First, I want to talk about horizontal

integration of hospitals and kind of combine the notion of conversion to for-profit with this development of hospital systems. Quite frankly, when we think about Starr's predictions about the development of multi-hospital systems, he had it right, all right?

We have seen tremendous growth in multi-hospital systems across the U.S. Back in '79, when Starr was writing this book, 31 percent of hospitals were in systems. By 2001, about 54 percent of hospitals were in systems, and an additional 13 percent were in looser health networks, many of which are stepping stones to future system development.

However -- this is where Starr is wrong -- the systems are still predominantly not for profit, and they are still local in their focus, all right?

So, we don't see the growth of for-profit chains. We don't see the growth of national regional health systems, whether they be for-profit and not-for-profit, and I wanted to show you a little bit of evidence in support of that.

Here are some data on changes in hospital -- excuse me -- system ownership type between 1990 and 2001, and just very easily, you can see the for-profit share has declined from about one-third in 1990 to under 30 percent in 2001, with a little bit of growth in the

voluntary non-for-profit ownership category.

Looking at kind of the local versus regional/national aspects of systems, here are some data that focuses on basically how many MSA's hospital -- excuse me -- systems own hospitals, all right? So, I'm classifying systems based on the number of MSA's in which they own hospitals here.

If a system is regional or national, we would expect that it would own hospitals in multiple MSA's. How many? It's not clear. You know, there are 300 MSA's across the country, and what are the thresholds for regional and national is not clear, but certainly we wouldn't expect a regional or national system to own hospitals in simply one MSA.

And what we can see here looking at these data is that, increasingly, systems, between 1990 and 2001, focused on owning hospitals in one MSA, all right? Similarly, we've seen a decline in the number of systems that own hospitals in four or more MSA's.

These data suggest to me that systems are becoming more localized, not regional and national, as was expected by Starr and by many others, okay?

Well, that was one set of predictions that focused on for-profit, ownership change, and also system development.

Starr and many others predicted that hospitals would be getting involved with what they called diversification into these poly-corporate forms, and what that really meant is they'd be getting involved with different types of health and non-health-related ventures to expand what they were basically doing, which was acute care delivery.

These were some of the things that people suggested -- not only Starr, but others suggested hospitals would get involved in, some things very close to what they're doing now -- outpatient services, for example -- but some things extremely far away -- health management consulting services, real estate management, that kind of thing. These were the kinds of predictions that we saw for what hospitals would be doing, what was expected they would be doing as we advanced into the 1990s and 2000s.

Well, what did hospitals do in reality? I don't have any numbers here, but let me just synthesize what one can see from the literature.

Hospitals did experiment with different kinds of services and ventures. Some of them actually did get involved, believe it or not, in real estate management, but increasingly, over time, they limited their diversification to those services directly linked to

their inpatient and outpatient acute care services, all right? So, they experimented and then they decided to come back closer to home in terms of the services they offered.

So, things like developing ambulatory surgery centers, for example, things like developing nursing homes, building nursing homes because of concerns about transitions to skilled nursing care after acute care episodes. Those are the kinds of things we see hospitals involved nowadays, not the real estate management activities or hospital consulting services.

Also, the evidence shows that hospitals very easily, readily, will add and drop services, depending on reimbursement opportunities.

Home health care is an excellent example. When home health care reimbursement was very good, all the hospitals or a lot of hospitals were really moving to add those services to their complement. What happened with VBA and the reduction in payment for home health? They started dropping that service, all right?

So they're not adding these services to ultimately become this poly-corporate form. They're adding these services to create new revenue bases and then dropping them whenever those revenue opportunities disappear.

Finally, if we look at hospitals now, in 2003, what do we see? What we see is their strategy tends to focus on being a technology leader in a market. They want to advertise themselves as having the fanciest equipment in orthopedic surgery, in cardiac care, all right? That's the way they are positioning themselves in the market, not as a diversified corporate form, okay?

Does this sound like the medical arms race? Yes. And in fact, Paul Ginsberg, when he was here, talked about, in a sense, the return of the strategy to the medical arms race of the '80s.

Well, what about vertical integration? Starr and many that followed him believed that government and employers would press hospitals to become more efficient, they would push for integrated health care delivery and financing like the Kaiser health plan or group health cooperative, and hospitals and other health care providers, mainly physicians, would grudgingly move to make -- to develop these systems to survive in the market.

Further, Starr noted that -- and others, as well, noted that the initial development of systems would be a platform for vertical integration.

Well, what does the evidence say? Well, it looked like hospitals were going to move that way in the

early '90s, but then much of this has dissipated.

This is data looking at '94 to 2001, and again, looking at systems and the kind of vertical activities they've been involved with in terms of integrating physicians, in terms of developing insurance activities, and what do we see?

We see that a lot of activity in 1994, the first year AHA collected these kind of data, in contractually affiliated with physicians and purchasing physician practices, but over time, these activities have dissipated.

Less than a third of hospitals report having contractual affiliations in 2001, and quite frankly, many of these affiliations are just empty shells. They still might have a PHO or MSO on paper, but that PHO or MSO is really not doing much of anything.

In terms of vertical integration into insurance, there wasn't much activity to begin with. About a fifth of hospitals -- or systems, excuse me, were doing these kinds of things back in the early 1990s. That was pretty much sitting there. It looks like it's on the decline, especially in 2000 and 2001.

So, vertical activity looked like -- especially on the physician side -- looked like it was going to happen but then quickly dissipated.

The final prediction of Starr was this notion of the concentration of ownership and control, and the idea here was that multi-hospital systems or this poly-corporate form would not only centralize ownership of different types of subsidiaries but also centralize control, and Starr believed that the shift in control would move from local communities to these national/regional corporate organizations. That was the prediction.

What was the reality?

Well, first, recall that I've said that most systems are local, all right. So, if there's been a shift of control, maybe it's gone from -- when I was in Chicago -- maybe it's gone from Park Ridge office to Skokie, where Advocate Health Systems' parent office is, but that move from Park Ridge to Skokie is not very far.

So if there's been some movement, it's not been very far to a centralized parent.

But on top of that, when we look at systems, about 70 percent of systems delegate certain authorities, decision-making responsibilities to their affiliate hospitals. Only about 30 percent of systems have what I would call a command-and-control model where you have one board making decisions system-wide for all of its affiliates.

There's a lot of -- there's a mixture of decentralized and centralized control that we see with these kinds of systems, and while I'm not going to say when you see one system, you see one system, because I tend to be -- I'm in the business of classifying systems -- there is a great deal of variability from the extremes of highly centralized to highly decentralized.

So, the question -- the next question one has to wonder about is why were all these predictions wrong? Where did we go wrong? And we can't blame Starr solely for this. Many who followed him made similar kinds of predictions. Why is it that these predictions are so off the mark, other than the growth in multi-hospital systems?

Well, first -- these are the kinds of things I've identified through my research. First, there was the assumption that the pressures on hospitals and other health providers would be unrelenting and uni-directional, all right? So, there was this notion that the pressures from government, from managed care, would keep up and would keep forcing hospitals down this track, if you will, this train going down the track, with only one destination possible, and that was these regional/national health care conglomerates. That proved to be false, especially given the managed care backlash

in the late 1990s.

Also, one thing I think that writers didn't consider was that, as hospitals consolidated, they were more able to fend off these pressures as they consolidated. So quite frankly, their power, their ability to fend off the desires of weakening managed care organizations was increasing. So this is an interesting combination of forces.

Thirdly, I don't think writers realized the extent of organizational inertia when it comes to hospitals. There's a saying that, you know, the writing is always clearer when you back's against the wall.

Quite frankly, I think what's true for hospitals is the writing is only clear if we push their backs through the wall and we hold them there for quite some time, because at that point the level of pain is so extreme something has to happen, but simply pushing them on the wall doesn't mean that they're going to stay there and doesn't mean that they're going to change or really implement the writing that's on the wall.

A couple other things.

Why did health care remain local? I don't think Starr or others realized the importance of local connections. Hospitals' legitimacy is based on local communities, local stakeholders, not on regional/national

stakeholders, all right? I don't think that was appreciated. Further, I -- finally, I don't think these predictors, these prognosticators, realized the resilience of the not-for-profit form, the ability to exist as-is for many years, even under financial distress, without radical change.

So these are some of the reasons why I think many of these predictions of Starr and others that followed him were wrong.

So, what does the industry look like now? I've kind of hinted at this a bit. We have many hospitals consolidated in local health systems and networks, about 70 percent of them. Systems and networks vary in degree of centralized control.

Let me point -- you know, kind of paint two extremes for you.

The one extreme, we have systems where all decisions and policy is made by one board for the system. At the other extreme, we have systems and networks that are basically shells, all right?

Perhaps there is some centralized administrative functions, some centralized purchasing, maybe some centralized capital financing, but that's it, and the hospitals themselves call the shots.

An example of that would be CareGroup in

Boston. Quite frankly, the hospitals there are only together because of bond financing, but all of the decisions that are made are made by the individual hospitals in terms of how they're going to use their capital, what services they offer, medical staff, governing bylaws, and things like that.

Finally, there is a large minority, about 30 percent of hospitals, not involved with systems or networks, and that's either by choice or because they're simply undesirable.

So, that's what the industry looks like.

I wanted to kind of switch gears and say, if we have this very diversified set of systems out there in the world, what does that mean in terms of negotiating with health plans? What does that mean in terms of financial performance?

And let me begin -- before I get to financial performance -- talk about how this plays out with health plan negotiations, because I think this is particularly interesting, especially from an antitrust perspective.

Again, we have some centralized systems, very strong, where the parent is calling the shots, and those kinds of systems have a lot of power in health plan negotiations. They hold a lot of the beds locally, and they can -- they wield a lot of power when it comes to

discussions with health plans about contract terms.

So that's one possibility.

Another possibility are these systems, especially decentralized ones in networks, and quite frankly, these systems have very little power when it comes to health plan negotiations, all right?

Any power that exists resides in individual affiliates, and quite frankly, those individual affiliates, if they're particularly powerful, don't want their strength diluted by the system being their spokesperson with the health plans, all right, and we do see that happen in a number of markets.

For hospitals not in systems, we see two extremes, as well.

We see those hospitals that did not join systems or networks by choice -- namely, they didn't see the value of participating in these arrangements -- they tend to be strong. They don't need systems. They don't need networks. They're doing just fine on their own.

But on the other extreme, we're seeing systems, especially hospitals that were not joining systems because they are undesirable -- they have very little strength, okay?

So, again, what have I painted for you here? I've painted for you a world of substantial diversity,

very powerful hospital players in some instances and very weak players in another instance, and again, what does that mean in terms of negotiations, in terms of what hospitals can get? Some of them get very good terms, and some of them are getting very poor terms in their negotiations.

It also means that averages are extremely deceiving. So, if we look at an average of total margin for the hospital industry of 4 percent, 3 percent, that's masking the fact that some hospitals are doing extremely well, all right, maybe 10, 12 percent in terms of margins, maybe even higher, whereas a lot of them are doing quite poorly, all right?

Well, I just said averages were bad, so let me, as every professor would do, now give you some averages, but I will talk about diversity in a moment.

This gives you a sense of what payment-to-cost ratios have been over time, and of course, if the payment-to-cost ratio is equal to 1, payment equals cost, and we can see that, for payers like Medicare and Medicaid, basically, over time, the values are pretty much honing in on 1. Okay. So, payments are coming close to costs, although people are worried about Medicaid, given the state budget crisis currently.

But again, where hospitals and systems are able

to use their power is not on the Medicare and Medicaid side, it's on the private payer side, and if we look at private payer averages, we can see there's been quite a bit of decline since 1991.

Back in 1991, payments were about 30 percent higher than costs, all right? That has drifted down, on average, to about 113 percent, or 1.13 -- a ratio of 1.13 in 2001, so 13 percent higher.

Again, realize there is a distribution around this average, and this distribution has been expanding between 1991 and 2001, and one could very readily imagine hospitals, if the average is 1.13, with an average of less than 1, and if Medicare and Medicaid are paying about 1, we're talking about a hospital than can be in a financial difficulty, especially if we consider charity care, patients which certainly are paying less than cost.

So I gave you the averages.

Let's look at some of the distributional aspects and, in particular, look at the percent of hospitals with negative total margins.

Now, this is total, so this is Medicare, Medicaid, private, taking into account self-insured, charity care, and also other sources of hospital income, including investment income, non-operating income, and what do we see?

We see that there's a lot of hospitals in the U.S. that are making total -- their total margins are negative. About a third, 33 percent of hospitals, all hospitals in the U.S., had negative margins in 2000, and this varies by hospitals.

Major teaching hospitals -- 40 percent of major teaching hospitals in the U.S. have negative total margins; 37 percent of large urban hospitals have negative total margins, all right?

So, this gives you a sense of the distribution in terms of the percentage of hospitals that are, you know, again, not doing particularly well.

In just a couple of moments, I just want to talk about the safety net. The safety net, in particular, in is an area of concern, a lot of pressures on hospitals in the 1990s and 2000s, tons of cost pressures on them currently. On top of that, add some of the pressures that I have here for the safety net, and what we've seen is the total margins of DSH hospitals -- these are hospitals that receive Medicare DSH -- declining over time, and in particular, if you looked at non-DSH hospitals, these are their average total margins over time.

This is the DSH rural. They're not doing that bad. But this is the DSH -- the DSH, large urban

hospitals, and you can see the trend is not very promising. About 40 percent of large urban DSH -- Medicare DSH hospitals have negative total margins in 2000, all right?

So, again, we're talking about quite a bit of bifurcation.

I think a lot of the change that occurred in the industry over these years has gotten us to this point.

And for my last slide, I want to talk about what does the future have to hold for hospitals.

First, the pressures that we're seeing now will continue.

Some pressures are actually good, to the extent that we're seeing increasing demand for health care services. That's going to add to the revenue side. And actually, demand for hospital services, both inpatient and outpatient, has been growing since the year 2000.

But on the cost side, we're seeing increasing insurance costs. With the current recession, I'm sure we're going to start seeing an increasing number of uninsured. There's declining payments, support, or worries about support from the states, given the state budget crises.

There's concern on the hospital side about more

price-sensitive consumers. Consumers are now facing big increases in their out-of-pocket costs for health-care services, and hospitals are worried about how that's going to affect their private payer streams.

In terms of financial performance, I think that there's going to be continued bifurcation. We're going to continue to see the dispersion of performance spread between what I would call the have's and the have-not's. Is that going to force some hospitals to close? I would say probably not. I think we'll see a few but not many. There's a lot of political support for hospitals that are on the brink of closing, a lot of pressure to keep hospitals open, and quite frankly, not-for-profit hospitals typically don't close, even when they're under extreme stress.

Finally, what kinds of structure or organizational change do we expect, should we expect, and I would only want to conclude with the point that I think we shouldn't fall into this prediction trap ever again.

A lot of predictions were made about what was going to happen to hospitals in the '80s, in the '90s, and I certainly, for one, do not want to be part of making predictions and having someone do a presentation like this in 20 years and showing how I'm completely wrong.

So thank you very much.

(Applause.)

MR. BYE: Thank you.

Professor Hibbard?

DR. HIBBARD: Good morning.

I'm going to address two questions this morning. What will make hospital performance reports, public reporting more effective with consumers, and what will motivate hospitals to improve?

I want to start with talking about the consumer issues. There are many barriers to consumers using performance reports. You know, we've seen that they have not been widely embraced by consumers, and I'm going to talk about two barriers here.

One is just simply the invisibility of the quality gap. That is, consumers are not aware of the quality problems that have been observed in health care recently.

And the second issue is the difficulty that consumers have in using the performance reports that have been disseminated. The reports have not really been designed to help people make choices.

First, let me talk a little bit about the invisibility of the quality gap. This is some data from a survey that we did in a community recently, and the

first bar is at a baseline before there was any public report. And we asked, do you think there are differences among area hospitals in the chance of being harmed by a medical mistake, and we also asked, do you think there are differences in the hospitals in the chance of having a complication that could have been prevented?

So, around 50 or 60 percent said no, there really aren't any differences.

So, a majority of people feel that health care and hospitals and providers -- pretty uniform in terms of their quality of care provided. Now, that changed after there was a release of the public report, which is the second bar.

Now, we were interested in this question about -- because it's such a huge barrier to people being interested in quality information if they really don't think there's an issue, and we were interested in what if we just simply suggested that something bad might happen if you chose poorly, and we did a little experiment where we -- it was a laboratory experiment, so we randomly assigned people to two conditions.

One group got a CAHPS report, which is the Consumer Assessment of Health Plan Study report on people's experience in care, and on the front of the report, it said "Get the best quality care," and you open

it up and it shows the health plans and how they scored on different aspects of care.

We gave another group the same report, except we headlined it on the front cover "Avoid problems in health plans." And what we found was just simply suggesting that something bad might happen, that to the group that had that negative frame, they actually understood the information better, they rated the information more highly, and they weighted it more in their choices. They were more willing to drive further, pay more, and even give up their regular provider more often than the group that got the message, you know, get the best quality care.

So, one of the take-away messages we got from that are people are risk-averse, but they just don't know that they have some risk to be concerned about, and if we tell them, it can make a difference.

But right now, there is not -- no one is taking on that role of telling the public about the quality problems that are out there.

Now, I said that the second problem is the difficult that people have in using current reports, the way that they're designed. There's many variables to be reviewed and to process in a public report. In order to use them, you often have to differentially weigh

different factors, to make trade-offs, you have to bring all the variables together, and quite frankly, those are cognitive tasks that human beings aren't very good at, and it's hard work, and let me just give you a visual example here.

This is a well-known -- this is one page out of a well-known hospital report. It's one page out of 56 pages. This one reports on stroke. I'm showing you this as an example for why these are difficult.

The first challenge that a consumer would have in looking at this is there's -- so, length of stay, readmission rates are two key variables that are shown here, but it isn't always clear to consumers what is good and what is bad. Is a length of stay good or is it bad, a longer length of stay? People who have been in managed care might think that a longer length of stay is good, because it shows that, you know, they're taking care of people that really need it.

So, you don't even -- if you look at this, you're not even sure what is good, what is bad, which is the first thing that you need to know, and then, of course, there's the problem of what if it's good on one and not so good on another measure? What do you do with that, especially when you don't know how important these things are or what they even mean?

And then, of course, there is the money issue, the average charge, and again, if you do not understand what the quality information is telling you and you do want to know about quality, some people will use cost as a proxy for quality. So, they will go with a higher-priced option here. So, this report is not really helping people, and it's a lot of hard work.

So, if you step back and you look, the quality problem is not visible to people. They don't really think that there are differences. And then we give them these reports that are really hard to use and that require a lot of hard work. So, is it really any wonder that people aren't using them?

So, we undertook a series of studies looking at how can we make reports more effective, and we began with controlled laboratory studies where we randomly assigned people and they got the same information but presented in different formats, and looked at what really helps people use information to make choices.

We applied that, what we found in the laboratory, to design a public report and then were involved in the evaluation of the impact of that report on consumers and on providers -- in this case, a hospital.

So I want to share with you just the headline

findings from the laboratory studies and a bit from the evaluation.

So, when we started the laboratory studies, we knew what people really wanted from a public report. What they want is they want to know which is the best one and maybe which ones to avoid. They really don't want to work hard. They don't want to synthesize and interpret and translate and do all these things that current reports make them do.

So, in the laboratory, we tested this concept from cognitive psychology called evaluability, and what evaluability does is it's a way of presenting data that makes it easier for the viewer to quickly and easily see better and worse options. It basically lets you map a good/bad scale onto information.

That other slide I showed you, it was almost impossible to map a good/bad scale onto those hospitals. You just couldn't tell, especially if you didn't know what was up and what was down.

So we tested different ways of presenting the same information, and we used this concept, and the idea of the evaluability is it takes a lot of the work out of using comparative information for choice.

So let me just give you an example, so you know what I'm talking about here.

We gave one group of people a report to look at. This has one performance measure and cost information, and we gave another group the very same information. This is arranged alphabetically. We gave another group the same information arranged by performance within cost strata.

And we evaluated people's choices according to whether they chose the highest-performing option within a cost strata. Didn't matter which cost strata they wanted to go with. And not too surprisingly, we found that, if you order it for them or essentially make it easier, more people will maximize on quality within whatever cost strata they are choosing.

So, we learned a lot from these laboratory studies. One thing we learned was almost anything you do in the way you present information makes a difference in what people -- how people interpret it and use it, and the second thing we learned is that if you make it easier, if you make it evaluable, it will actually -- it's much more likely to actually get used in choice, weighted in people's choices.

So, we had this nice opportunity to apply what we learned in the lab in a real world setting. We worked with the alliance, with the Employer Purchasing Cooperative in Wisconsin.

They were producing a report on 24 hospitals in south central Wisconsin. The report rated hospitals on complications and deaths. It's based on administrative data. It was risk-adjusted.

The alliance did a really nice job on wide dissemination. The members were sent the report directly. The report was inserted into the newspaper. It was controversial, so there were newspaper stories, and it was available on the web, and community groups and the library offered it, as well.

This is what the report looked like -- this is kind of a mock-up of what the report looked like, and we used four evaluability strategies in designing it. So, there were two summary measures, surgery and non-surgery, that summarized everything, and then there were three clinical areas in the report.

So, because we had two summary measures, we were able to order on performance, and this was within 2 hospital categories -- regional hospitals and community hospitals.

The second evaluability strategy was -- actually, the third -- ordering the summary, and then we used symbols that are inherently meaningful. Pluses mean good, minuses mean not so good.

And finally, I don't know if you can see it

well there. There's a color band, a light color band that highlights the top performers in each type of hospital category.

So a person can look at this report, and right away, they have an answer. They don't have to work hard to figure it out.

Now, you might note when you look at this report that there wasn't a lot of variation overall, but there was variation -- some variation in cardiac, and there was quite a bit of variation in maternity, which are, of course, things that the public is concerned about.

We looked at the impact of the report on the consumers and providers. I'm going to share with you about the evaluation on the consumers first.

We used a design where surveyed prior to the release of the report and then again after the release of the report, and we did both a panel of people, as well as a post-only group, and we used an employee sample and a random digit dial community sample.

Now, one thing about a report that's designed to be evaluable -- we hypothesized that it has the potential to have a kind of viral effect.

That is, if you can look at a report and quickly gain an impression of which are the better and

which are the worst options, you can keep that in your mind, you don't have to have the report in front of you, and you can then share that with other people, just like people share impressions about which are the good schools and which are the good restaurants and make recommendations based on these impressions, and that is how people make choices now.

So, it could be much more powerful than we had -- than we think about how people -- we want people to use reports. If it's evaluable, it could work in this other way, as well.

So that's kind of what we looked for when we evaluated, was there some evidence for this kind of viral impact?

Just to quickly show you who saw the report. Employees would much more likely to see it. The panel in the community survey was more likely to see it than the post-only, because we probably sensitized them to the -- seeing the report with our pre-survey, and then people were also exposed through the news stories, and they were also exposed because they heard about it from other people. So, there was some evidence there about a viral effect.

We asked people several questions about which hospital would they recommend overall, which hospital

would they recommend for the clinical areas that were reported in the report, and then we asked them some questions like which hospitals do you think have fewer mistakes, which hospitals have fewer preventable complications. We also asked which hospitals do you think have more mistakes and more preventable complications.

Now, what I'm showing you here is how many people named high-performing hospitals in the pre-survey, the blue line, and then how many named high-performing in that green stripe, how many reported a high-performing hospital in the post period, and we see a small bump there. This is everyone, not just people who saw the report.

So, there was a significant shift on which hospitals they thought were the high-performers after the report.

It's interesting that more people remembered the low performers, and so, we got a little bit bigger bump there.

This shows the same data, but it's broken out by how closely people looked at the report. If they didn't see it at all, they only read a little bit of it, or they read most of it, it made a bigger difference in their ability to identify high and lower -- low-

performing hospitals, and I should say this is two to four months after the release of the report. So, people did remember it.

We asked about -- did they talk to other people, their doctor, did they talk to anyone about it, friends and family, did they pass it along? And the blue part of the bar is if they were likely or very likely to, and the yellow part is that they already have. A, a fair amount of people planned to or already had talked to others about it, we asked if they would keep it for future reference and would they use it to select or make a recommendation, and again, a majority indicated that they would.

So, what we saw was that, by making the report evaluable, it did influence consumer views. We saw it had a small overall effect. If there was wider dissemination, we probably would have seen a larger effect. So exposure is a key factor, apparently.

We also -- and we saw evidence for a viral effect with people talking about it and making recommendations. We also saw some evidence that the report increased hospital motivation to improve.

Now, the data that we had -- that went into the report on performance -- we had it for all the hospitals in Wisconsin.

So, there were 24 hospitals in the public report, but there were another 91 non-alliance hospitals not in the service area, and for those hospitals, we randomly assigned them to two conditions.

One was to get no report -- they were kind of a control condition -- or to get a confidential private report on their own performance.

So, as I talk about the evaluation, I'll talk about the no report, the private report, and the public report hospitals, and we're going to compare them.

So we wanted to know, does making it public increase concerns about public image and market share, does it increase quality improvement efforts within the areas reported on, and are the low scorers the ones who are really doing more in quality improvement, and to what degree do private reports stimulate quality improvement activities?

So, the report came out in the fall, about nine months later. We surveyed hospitals, all the hospitals, and we wanted to include CEO's, medical directors, and quality improvement directors.

We got a pretty good response rate. We got at least one respondent from every hospital in the public report group, about, I believe, 92 percent in the private group, and about 84 percent in the no-report group.

Respondents in the -- who weren't in the public report hospitals were sent a copy of the public report so they could answer questions about it.

We asked them about how useful did they think the report would be for quality improvement, how accurate or basically how valid the data was, and how appropriate for public use was the information. This is kind of a dense slide, but basically, what we saw was that the public report people were most negative on all of those questions, and the private report group was most positive on those questions, although everyone was slightly negative, and those who had the lowest scores in the public report group were the most negative. They thought the data was not valid.

Okay. We asked what is the likelihood that this report would affect their hospital's public image, and for the other two groups, the no and the private report group, we asked them what is the likelihood that a report like this would affect your hospital's public image, and this is broken out by their scores, and we used the obstetrics score, because that we one was the most variable.

So as you can see, in the public report group, those who got low scores said this report is likely to detract from their public image, and those who got high

scores said this report is likely to enhance our public image. And the other two groups, the private and no report group, it didn't matter what their scores were. They didn't think it was going to affect -- anything like this would affect their public image.

So it seems like those in the public condition really felt that this was going to impact their public image either negatively or positively.

We asked the exact same question about their market share, and I don't have a slide on this, but basically, it didn't have any impact. It didn't matter what their score was. It didn't matter what condition they were in -- private, public, or no. They didn't think it was going to affect their market share. And we have started to look at the market share data, and they're right, so far.

Then we asked them -- we looked at their quality improvement efforts, and the -- because obstetrics was the one that had the most variability, we asked about seven different quality improvement activities that could be undertaken to improve on the complications in obstetrics, and this shows the number of activities that groups are undertaking.

There's significantly more in the public report group, the private report group has a medium amount, and

the no report group has the least amount of attention to quality improvement in this area.

This is broken out by their scores, and again, those with poor scores in the public report group are doing the most in obstetrics to improve. The other two groups pretty much -- are doing pretty much the same.

Now, the hospitals thought that the high -- the poor scores in obstetrics were due to hemorrhage after delivery, and so, we asked specifically about that, did they have any QI activities that focus on reducing hemorrhage after delivery?

So this is just those who got poor scores in the three conditions, and this is how many of the hospitals with poor scores are focusing on quality improvement to reduce hemorrhage after delivery, and what we see is a tremendous difference between the public report, the private, and the no report.

But the private report hospitals who had poor scores -- they knew that they had poor scores. But they were much less likely to be focusing on this issue. So what we saw was that making performance public did stimulate quality improvement activities, and it stimulated it above what was stimulated by a confidential, private report.

Now, I would say that there are probably three

essential elements of what -- for others to observe the kind of effects that we saw in this situation.

One is that it's important that a report be widely disseminated not just to employees but to the community, and probably the more widely disseminated, the better.

The hospitals need to know that there's going to be another public report in the future, so they have the motivation to improve.

The report needs to be highly evaluable, or to put it another way, very explicit about high performers and low performers to work for both the hospitals and for consumers.

So, what we saw was that a report that's designed to really work for consumers does increase the impact on consumers, and it makes it easier to use the information, and it may have created a kind of viral effect.

It also raised provider concerns about their public image and it appeared to be a motivator, that concern about their public image, a motivator to improve.

I'm going to leave you with one of the dilemmas that I see in all of this, is that what helps consumers the most there seems to be the most resistance from providers on. So, evaluable reports that are explicit

about high performers and low performers and any kind of negative framing is also strongly resisted.

So, as long as reporting is voluntary and providers influence the way data is presented, it's going to have a impact on the usefulness and the usability of these reports.

Thanks.

(Applause.)

MR. BYE: Thank you.

Professor Romano?

DR. ROMANO: Thank you.

I'm going to be talking about public reporting on provider quality, focusing on hospital quality. I'll be reviewing some of the literature and highlighting some of the work that we have done in this field.

So, in general -- and I apologize for the translation of the bullets, didn't work, for some reason, between computer platforms, some kind of amusing little symbol there.

Anyway, if we look at the idea of how public reporting is supposed to work, you may consider both market-oriented and public service-oriented goals.

So, market-oriented goals really focus on providing information that addresses the asymmetry of information the marketplace and empowering consumers to

demand better health care, giving them the information, the tools that they need to make better-informed choices that theoretically maximize their utility.

They may do this directly or through their primary care physicians who make referrals or order services on their behalf.

Now, of course, in some markets, consumers don't really have the ability to choose hospitals directly, because their constrained by contractual arrangements. So, public reporting may have a role in providing information so that smart purchasers or smart payers can make informed choices acting as agents on behalf of consumers.

So, that's also consistent, I think, with this market-oriented strategy.

A somewhat different strategy is sort of viewing health care as a public service which is dominated by professionals.

The idea here is really to encourage professionals to recognize and fix deficiencies in health-care quality through a kind of self-regulatory behavior, the idea being that public reporting focuses attention on these problems and gives professionals a little bit extra motivation, as Judy has pointed out, to address problems.

So, let's look at some of the evidence from prior studies and from our studies on the impact of hospital report cards, and we'll start by looking at the impact on hospital volume, market share, if you will, specifically.

These were three of the earlier studies. Bruce Vladek and colleagues looked at the impact of the first HCFA mortality release on occupancy rates in New York City hospitals.

Fourteen hospitals were classified as high mortality, nine as low mortality. They found no changes in occupancy rates after the public release.

Mennemeyer and colleagues looked at a broader time-frame, the same series of reports, the HCFA mortality reports, looking across the country at the effect of outlier status.

They found that a doubling of the standardized mortality ratio -- that is, the ratio of observed to expected deaths reported in these reports -- a doubling of that ratio was associated with 46 fewer discharges per year at the hospital level, using a particular model, so-called fixed effects model, with a lag dependent variable, but that was less than a 1 percent decrease in total hospital volume, so a very small effect, although it was statistically significant, and it was sensitive to

the model specification.

So, it's a little bit unclear whether that was really important.

Interesting contrast -- they also looked at the impact of press reports of isolated, avoidable deaths at these hospitals, and they found a 9 percent decrease in volume associated with those media reports, suggesting that those isolated press accounts were much more powerful than the HCFA mortality releases. Of course, no one would accuse those HCFA reports of being evaluable using the criteria that Judy has given us.

Dana Mukamel and colleagues, Al Mushlin, looked at the effects of the CABG mortality reports in New York on hospital market share and basically found no significant effects, although the study really was under-powered. There were some effects that might be construed as being clinically meaningful, but they didn't reach the threshold for statistical significance.

However, they did find a 1 percent higher mortality rate was associated with the loss of market share for surgeons, higher in the first report but lower in subsequent reports, but still significant. So, perhaps a great effect on surgeon volume.

In our studies, we looked at the outcomes of hospital report cards in California and New York. This

is work that will be coming out in Medical Care in the next few months.

We really asked whether hospitals publicly recognized for good performance experience volume changes in the year after publication, are these effects immediate or delayed, are they transient or persistent, and we were very curious about whether favorable outliers really attract more patients just for the condition that's studied or whether there are spill-over effects.

So, once a hospital gets a good report for CABG, does that affect their market share for all cardiac services or for all services, and we were also interested in whether patients would start bypassing the local hospital to go to a hospital that was further away, after that hospital received a favorable report.

Finally, we were curious about the impacts of reporting on disparities, because we're concerned that certain types of consumers are better equipped to use these report cards than others, and so, socio-economically disadvantaged persons, in particular, may be less responsive to report cards and may tend to be clustered at hospitals that rate worse, potentially exacerbating disparities in care.

There were three target conditions for these report cards.

The reports in New York focused on coronary bypass surgery. One report looked at angioplasty, as well, but that wasn't the focus of our evaluation.

The reports in California looked at acute MI, series of three reports, actually, and one report on complications following back surgery.

We identified for each of these reports a target condition, as well as some related conditions where we expected that volume might track along, these spill-over effects might be particularly prominent.

We used regression models. I won't bore you with the details. Basically, it was a time series regression approach. We tested a variety of models, including both ordinary least squares and auto-regressive models. We ended up using the auto-regressive models in California because of significant first order of correlation, but we used the OLS models in New York, because they're a little easier to interpret.

We did a variety of stratified analyses, and we adjusted for a variety of factors, including the statewide hospital volume in each month. In other words, if MI's were generally increasing in prevalence, we factored that out.

We also factored out hospital effects that were present before publication of the report card.

We also, in some of our analyses, factored out unrelated volume in the same month. So, if a hospital, in general, was picking up increasing market share, we adjusted that out to look at the impact specifically on the target condition and related conditions.

We also looked at the effects of hospital charges and various statistical interaction.

This is a summary of our results, looking at New York, and let me walk you through this briefly.

It turned out that all the significant effects that we found were in the first four months after publication in New York.

So we're looking at, first, CABG, which is the target of the report card, then three related conditions and procedures -- heart attacks, angioplasty, and congestive heart failure -- and basically we found a big spike in the first month after public of the report card.

The hospitals rated better picked up an average of 13 extra patients in that month. The hospitals that were rated worse lost a few patients in the first couple of months -- four in the first month, seven in the second month.

There really wasn't any evidence of a spill-over effect for these other conditions, as you can see.

So, in summary, the average good outlier

hospital admitted about 13 extra patients during the first month after release. There was a 22 percent increase. The net effect over the whole first year was 24 additional patients.

The poor outliers did experience a bit of a decrease in the first two months after release, a 16 percent decrease. It was about 12 patients, as you can see. And there was a very modest spill-over effect, basically limited to AMI admissions at poor CABG outliers, where there was an 18 percent decrease.

This is looking at the impact targeted on specific groups, and what you can see is interesting here is that this additional bonus, if you will, that the hospitals that got good marks received was basically limited to Medicare and indemnity patients. There was really no increase for Medicaid or uninsured patients at those hospitals, and the significant increase was limited to Medicare patients.

When we looked at ethnic characteristics, we found that the increase was entirely limited to white patients. There was absolutely no report card effect for minority patients.

What about in California? Well, in California, we found, really, much less evidence of effects of the report card, and what effects we did find really went

away after statistical adjustment.

You can see very modest increases in volume, less than one patient per month, at the hospitals that were rated as having better performance for lumbar diskectomy, really no effect, a minimal, non-significant effect for AMI, and no effect for cervical diskectomy.

We had to aggregate that data by quarter here, because the volumes were generally smaller, so we may have missed an effect in the first month.

When we looked at the stratification here, as you can see, as you recall from the previous slide, there was sort of modest effect for the hospitals that were rated better on AMI mortality in the first quarter and the fourth quarter after release, but actually, when we looked at the stratified analyses, some effects did emerge that were statistically significant, although -- of course, these may be artifacts of multiple testing.

You can see, in particular, the effect for HMO/PPO patients was statistically significant in the third and fourth quarters after release. So, the hospitals that got better marks for AMI tend to see more HMO/PPO patients during the second six months after public release.

Similarly, with the New York results, we found that report card effects were limited to white patients,

no effects for minority patients.

We also found a suggestion -- this was statistically significant in the fourth quarter -- that there was starting to be a movement of patients outside their catchment area towards the hospitals that got better marks for acute MI mortality.

So, that's a quick overview of some of our findings from California and New York.

I also wanted to mention an interesting study from BCAC from Minneapolis/St. Paul. This was a randomized controlled field trial with volunteer participants in which employers were recruited basically in their work-places to review the report card.

They were randomly assigned to either get open enrollment materials with or without the report card, and they evaluated them with a post-survey and found that the report card increased self-reported knowledge and increased anticipated switching to the specific care systems that were rated above-average. However, it didn't affect consumers' overall likelihood of switching care systems.

The report card recipients were also more likely to report that information about cost was not very important in selecting a care system. However, they weren't more likely to say that information about quality

was important. So, it's a little bit hard to interpret that finding.

Also, I think that Judy Hibbard's study -- I took out my slide on that, because I knew she'd be talking about that, but her studies also made interesting contribution to this field.

So, I won't belabor this, because Judy has really already talked about some of these issues. I think we've learned a fair amount about what works in terms of reaching consumers.

Comprehension is certainly important. There are problems of agency. In other words, we have to communicate to consumers better who's responsible for what, which indicators are really under the control of health plans, hospitals, so forth. The credibility of the source is very important. Context information is important. Judy's talked about the value of negative framing. Efficacy messages may be helpful to help less educated consumers understand that they really can do something to respond to this kind of information and improve the quality of health care that they receive.

Judy's talked about evaluability, and the bottom line is we still have to confront the fact, based on previous studies, that concerns about cost and covered benefits may still really dominate quality as a

consideration in consumers' minds.

Finally, I'll talk a little bit about the role of purchasers and how smart smart purchasers can really be.

A few studies have looked at this.

Gabel and colleagues reported basically that objective information about quality is rarely used by employers in making their health care purchasing decisions based on a survey that they did of large employers.

In a previous study by Judy Hibbard and colleagues, they found that purchasers in California, New York, Pennsylvania, and Cleveland did report using HEDIS data, CAHPS-type data, and NCQA accreditation in their contracting process, but not hospital report cards. One exception to that was in the Cleveland market.

In general, the purchasers who responded to this survey expressed concerns about the timeliness and validity of report cards, and they basically preferred to let health plans monitor providers. They saw it as being the health plan's role. We contract with health plans. We let the health plans figure out which hospitals and medical groups to contract with.

Adams Dudley and colleagues did a series of focus groups looking at purchasers' views, and they found

that purchasers really suffer from some confusion about multiple goals, uncertainty about best quality measures, some difficulty interpreting the hospital performance data that are available, some skepticism about, really, the impact of the interventions that they may implement, steerage and economic incentives, and concerns about changing balance of power and variable clout, the idea, as Gloria has mentioned, that health plans are losing clout in the marketplace and hospitals have organized themselves into structures and developed local connections that make it difficult for them to really -- or make it difficult for health plans to purchase as smartly as they might like to.

What do we know empirically? Well, Kevin Schulman and colleagues did a case study of three markets and found that only one of the three that had the most -- the highest level of HMO penetration had what he described as sophisticated contracting arrangements in which HMO's selected hospitals for tertiary care based on both price and quality.

In a study in New York, 60 percent of managed care organizations said that quality was the most important factor in selecting cardiac surgeons, but only two-thirds of those organizations had actually reviewed the CABG mortality reports that received so much

attention in New York, and only half would pay $1,000 for the information contained in those reports.

So, it suggests that at least a fair minority, if not half of folks, are giving lip service to the value of information about quality in contracting with cardiac surgeons and hospitals.

When she evaluated contracting choices, she found that those choices were pretty much random with respect to risk-adjusted mortality rate, but there was really a slight preference when she evaluated based on the high-mortality outlier hospitals and the low-mortality outlier hospitals. There was a very slight preference for the managed care organizations to contract with these high-quality outliers. So, really, minimal impact, as far as she was able to ascertain, on managed care contracting.

We did a study in California which is -- I think just came out in the American Journal of Managed Care, in which we interviewed health plan executives about what information they use in contracting and how they rate the importance of different sources of information, and basically, in this survey, what the managed care executives told us was that JCAHO accreditation was very important, the hospital location was important, price was very important. Disciplinary

actions by Federal and state agencies were an important signal that a hospital was in trouble, and so, that might be a hospital that they should avoid contracting with.

Then we come down to sort of more amorphous sort of criteria, if you will, the general reputation of the hospital, and it's something very difficult to evaluate, of course, the health plan's sense of the hospital's commitment to quality improvement processes. Not clear how they evaluate that.

Member satisfaction with hospital -- actually, this really wasn't, at this time, based on objective data. It was based on kind of a sense of what members were telling the health plans about their satisfaction with hospitals.

So, you can see that the sort of second tier of importance here falls to, really, amorphous criteria that are difficult to quantify.

It's not until you get down to re-admission rates, organ transplant success rates, length of stay, and mortality rates, objective information, which is clearly rated much lower in terms of importance by these health plan executives, information about process of care, preventable complications near the bottom of this list.

So about half of the health plan executives

gave a reasonable level of important to objective hospital quality indicators.

Now, we do know, though, that although health plans may not pay a lot of attention, hospitals and doctors do pay a lot of attention to these report cards. I think that's pretty clear.

So Eric Schneider and Arnie Epstein looked in Boston -- actually, this was in Pennsylvania they looked at this -- the impact of the report cards related to cardiac surgery, and they found that all the cardiac surgeons and most of the cardiologists they surveyed were aware of these reports. However, they had a lot of complaints. They were annoyed.

They complained about the methods, they complained about the way the reports were disseminated, and they generally said that the reports had minimal influence on their referral practices and really affected few of their discussions with patients.

Both cardiologists and surgeons reported discrimination against the sickest patients that resulted from the impact of the report cards.

Separate survey lower response rate in New York, two different surveys here, again showed that cardiologists and cardiac surgeons were very familiar with the CABG reports in New York but had a lot of

concerns. In these surveys, a little bit different methodology, higher percentage of cardiologists discussed the reports with their patients, but still clearly a minority.

In a study done in Pennsylvania, it was found that Pennsylvania hospitals were more likely than New Jersey hospitals, which at that point were not subject to CABG report cards, to use performance data to recruit surgeons, interestingly enough, and surgical residents. They also reported using the data to monitor the performance of the surgeons on their staffs, but they reported -- and they reported using the data to make some operational changes to improve clinical care. So, there were some impacts identified in these studies.

In our own studies, we interviewed hospital administrators and asked them a variety of questions in California and New York about their uses of the hospital report cards.

We found one thing very interesting, which was, as Judy suggested, that the hospitals that were rated poorly in the reports tended to be a lot more skeptical about the report cards, a lot more critical of the methods.

So the ratings, you can see, were much lower in the hospitals that were rated as having high mortality.

No difference according to AMI volume.

We also asked a series of questions, though, to specifically test whether the hospital administrators knew how these reports were done.

So we asked them yes/no questions about whether specific things were adjusted for in the analysis, and the answer to some was yes and the answer to some was no, and so, we tallied up the responses, and we found that, although the administrators at the high-mortality hospitals were much more critical of the reports, they were also much less knowledgeable about the methods that went into those reports.

So there was sort of a blanket criticism.

We also found, not surprisingly, that the hospitals with higher volume were better equipped to read the reports and understand them than the smaller hospitals.

We followed this up with a series of semi-structured telephone interviews with CQI leaders to find out exactly what they did, and we did get, really, some case studies, if you will, from these interviews.

Two-thirds of the hospitals really took no specific action. However, a number of the hospitals did do some specific things to improve the care that they provided to acute MI patients or to improve the reporting

of the data to the state.

Finally, a quick summary of observational studies on the impact on provider outcomes. If you look at these studies, the Longo study in Missouri found that the consumer guide stimulated increases in specific services, especially in competitive markets and among hospitals with low satisfaction ratings.

There's been an ongoing controversy about some of the impacts of the report cards in New York. Ed Hannan initially found a 41 percent decrease in risk-adjusted CABG mortality after report cards. Jerry O'Connor said, wait a minute, we have a private reporting program in northern New England in which there's no information released to the public, and we found a 24 percent decrease in risk-adjusted CABG mortality.

Ghali said, well, let's look at Massachusetts, which doesn't have any reporting system, and they also had a similar decrease in CABG mortality.

When Eric Peterson used CABG data for Medicare to look across the country, he found that there was a difference, a 33 percent decrease in New York, versus a 19 percent decrease nationwide, suggesting perhaps that providers have responded to this information by selectively decreasing mortality in New York.

In Cleveland, it was basically found that there

was a decrease in in-hospital mortality, but it was accounted for by a shifting of morality to the outpatient setting, a decrease in length of stay.

I will skip over this, really, because the authors of these studies are here and will talk about their own work.

So, our conclusions:

For consumers, first of all, the observed effects of report cards on consumer choice are small, transient, and hard to demonstrate in practice.

There's some evidence from the study you'll hear about probably in a few minutes that matching of high-risk patients to teaching hospitals, in particular, may improve, but there's some evidence from our work that disparities may increase, and as Judy has talked about, there are a variety of problems, a variety of barriers, really, to consumers' use of this information.

Is it available when it's needed? Is it considered salient? Is it believable? Is it interpretable or evaluable? Do consumers believe that quality varies across hospitals? And do consumers really have the ability to act on this information?

From the standpoint of purchasers, there are significant barriers to the use of this information. There's pressure from employers to offer maximum choice,

and it's really unclear from the standpoint of managed care organizations whether employers are delegating to them the responsibility for steering consumers.

Finally, for providers, hospital leaders have really grown to accept public disclosure, although they often assume that the data aren't adjusted for things that they are, not to say that there aren't a lot of limitations in the existing report cards, but those limitations are often exaggerated.

Hospitals do tend to criticize the messenger, not surprisingly.

Public reported outcomes data, I think, clearly has stimulated hospitals to develop QI activities. However, I think the population benefits that those activities have been more difficult to demonstrate and, at this point, aren't crystal clear.

Selection effects remain controversial, and we'll hear more about that in a minute.

I think we can conclude that current hospital outcome reports really don't meet the informational needs of the individuals on the front lines in provider organizations because of time delays and because of failure to integrate process and outcomes data in most of these reports.

So I'll stop there with these thoughts about

agendas for future research.

(Applause.)

MR. BYE: Thank you.

Professor Kessler?

DR. KESSLER: Thank you very much for having me here today, and thank you, Patrick, for giving me such a nice introduction to some of the materials that I'm going to talk about today.

I'm going to talk about the health care quality report cards, as well, and this is the overview of what I am going to do today.

First, I'm going to start off with a little review about the three -- as I categorize them, the three different types of report cards, and I see report cards as falling into the category of process report cards, survey report cards, and outcomes report cards.

Process report cards, as we'll talk about, have to do with the inputs used in medical treatment. Survey report cards have to do with the views of patients on the care that they received. And outcomes report cards, which is what people have been focusing on and what I'm going to focus on in my talk, have to do with reports on the health outcomes of different hospitals or doctors.

Then, after we've talked a bit about the different kinds of report cards, I'd like to talk a

little bit about what I see as the strengths and weaknesses of each type. I mean as with most things, I think all of these kinds of report cards can be helpful, and the question is just how is the best way to use them, what are the strengths that different types offer?

I'll focus on outcomes report cards, because that's what my research has been about, and the main weakness with outcomes report cards, as we see it, is that they provide the incentive for doctors and hospitals to select healthy patients in order to game the report card. I'll tell you more about why that's true and then conclude with a brief review of some of the research that I have done documenting the existence of this selection effect that Patrick so nicely introduced just a moment ago.

Okay.

So the first kind of report card that there is in the world is what I call a process report card, and what process report cards do is describe the inputs that a doctor, hospital, or health plan uses in treating its patients. So what are some examples of process report cards?

The percentage of women age 52 to 69 who received a mammogram to test for breast cancer within the past two years -- a very standard process report measure

on health plans.

The number of nursing staff hours per resident per day in a nursing home -- another inputs measure.

The existence of a computerized medication ordering or prescribing system that automatically checks for drug interactions and dosage errors -- all of these process measures are things that we think are positively correlated with outcomes, things that we think are probably good, and so, you make a report card on this and would hope that people would go towards the providers that use more of these things, rather than less.

What's an example of a process report card in the real world?

The Leapfrog Group, which is a voluntary program founded by the Business Roundtable and the Robert Wood Johnson Foundation, measures three key kinds of process inputs for hospitals, hospital patient safety measures.

They do a survey of hospitals that asks if hospitals have computerized physician order entry, what we just talked about a moment ago, what's called evidence-based hospital referral, sending patients who need certain kind of complicated procedures to hospitals that offer those procedures, and ICU physician specialist staffing -- does the hospital staff its ICU, its

intensive care unit, with doctors who are specialists in this field?

The Leapfrog Group collects this information on hospitals voluntarily and puts it out on the web if you -- I'm not affiliated with any of these groups, but if you want to check it out, you can go to the web and look at the reports.

Survey report cards, second type -- survey report cards present patient's subjective evaluations of quality of care and/or customer service.

What are some examples of survey report cards? On a scale of one to five, did your doctor and/or hospital employees respect your preferences in the course of your hospital stay? Did your doctor and/or the hospital employees adequately treat your pain that you experienced in the course of your hospital stay? Did your doctor and medical group schedule an appointment for you promptly? Not everything is about health outcomes. These other factors are often just as important to people.

What's an example of survey report cards?

Health Scope, which is run by the Pacific Business Group on Health, PBGH -- PBGH, whom I think you'll hear from Arnie Milstein either later today or you already have, who is the medical director, I believe for

PBGH -- it's a nonprofit coalition of major California employers that puts out a survey and other report cards, as well, through this Health Scope subsidiary.

PBGH has about 48, I think, members now, representing 3 million employees and about $4 billion in annual health care expenditures.

Health Scope is also available publicly on the web to everybody. You can go and check it out, and -- I don't know if you can see here -- you can click on your California county and get reports on the health plans, hospitals, or medical groups in that county, including but not limited to survey data about patients' views of those groups.

Finally, outcomes report cards, which is most of what we have been focusing on today and what I'm going to spend the rest of my time talking about -- what outcomes report cards do is present average levels of adverse health outcomes, usually mortality or cardiac complications rates, that are experienced by patients who are in a plan or treated by a particular doctor or hospitals.

Outcomes report cards are generally, as Patrick was talking about, risk-adjusted, adjusted for the characteristics of the people that the doctor or the hospital sees -- you'd need to do that in order to

control for differences in patient populations -- and then published in a public forum.

So, examples of outcome report cards -- the percentage of patients who got cardiac bypass surgery who died within 90 days of the surgery, percentage of patients in a nursing home who suffer from pressure sores -- that's an example of the CMS's current nursing home outcomes report cards -- or the percentage of heart attack patients who were readmitted to the hospital within 90 days of the onset of their illness.

What's an example of an outcome report card? I just picked this one. This is one that we studied in the report I'm going to talk about in a moment.

Pennsylvania publishes an outcome report card on cardiac bypass surgery, and I'm afraid the type is a little small here, but the way that this outcome report card works is -- and Gloria talked a little bit about this, I believe, earlier -- is that it publishes a list of all the hospitals and all the cardiac surgeons in Pennsylvania that presents both their actual mortality and what the average mortality for hospitals or doctors like this hospital or doctor would be if they had similar patient populations.

So, if a hospital's actual mortality is lower than the average mortality for a doctor or hospital who

had a similar patient population -- that is, if the little dot is below the bar, the bar is the confidence interval for what that particular hospital on the left panel or doctor on the right panel mortality would have been had they had the average, if the dot's below the bar, then that's a good thing, because the hospital's mortality is below what was expected.

If the dot is above the bar, that's a bad thing, and you can see there are a couple of cardiac surgeons who don't look like they're doing so well, with dots way, way, way far out to the right of the bar, might not -- you know, at least in theory, might not want to go to them.

So, what are the strengths and weaknesses of each of these kinds of report cards?

Process report cards are very easy to develop, because claims and encounter data capture very neatly the medical -- the inputs used in the medical care production. However, on the other hand, they have a couple of weaknesses. They focus on a fairly limited range of mainly preventive medical services, not necessarily what you really would want to know about, and second, and probably more importantly, they measure whether a service was provided, yes or no, but not its appropriateness, not its quality, and not its importance

in producing good health. So, on that dimension, you know, those are the pluses and minuses of process report cards.

Survey report cards -- also potentially quite valuable on the subjective aspects of medical care, but they, too, don't capture the extent to which policies or treatment decisions of a doctor, hospital, or health plan leads to objective improvements in patient health.

Now, outcomes report cards, in some sense, are the answer to both of these weaknesses, but because health outcomes are a product both of the skill and effort of the doctors and the characteristics of the patients that they treat, outcomes report cards might encourage doctors or hospitals to game the system by avoiding sick patients or seeking healthy patients.

How does that work?

Well, in theory, for example, in the cardiac surgery realm, one medically appropriate factor in the decision about whether or not to give someone cardiac bypass surgery is that patient's health status, as I understand it. I'm not a doctor, and hopefully the physicians in the audience will jump in if I get this wrong.

If you have a patient who suffers from, you know, very advanced cardiac disease and has other co-

morbidities and is very sick, you can't give them bypass surgery, because to do so, you know, might kill them.

So these facts give doctors and hospitals the opportunity to decline to include patients in their panel for valid medical reasons, and for that reason, even though outcomes report cards adjust for differences across doctors and hospitals in the characteristics of their patient panel, doctors and hospitals are likely to have better information on the characteristics of the patients that they see than even very detailed databases, and so, by virtue of that fact, they can then pick the relatively healthier patients that they can see are healthier but are not healthier in terms of data that's collected, pick them for inclusion to their panel and thereby improve their ratings.

Well, myself and some of my colleagues at Stanford and at Northwestern wanted to look into this hypothesis, and what we did was studied the consequences of the cardiac bypass surgery report cards that were adopted in New York and Pennsylvania in the 1990's, and this research is published in detail in the June 2003 issue of the Journal Political Economy, which is also available on the web for download.

What we did was use longitudinal data on the treatment decisions, medical expenditures, and health

outcomes of essentially all the fee-for-service elderly Medicare beneficiaries from 1987 to 1994 who had various kinds of cardiac illness, and the way we looked at this problem was we said, well, the effective report cards in New York and Pennsylvania is the difference in trends in various factors, which I'll talk about in a moment, in those states after adoption of report cards versus before, compared to the trends that happened in other states, in control states over the same period.

How did we try to assess these report cards with these Medicare data?

Well, previous work had said, okay, we're going to look at bypass surgery patients in New York and Pennsylvania and control states and ask what happened to them in the report card states versus other states.

The problem with that is that if this selection behavior that we hypothesize might be occurring is actually going on, then you can't look at the consequences of CABG report cards or the population of CABG patients, because the report cards may have affected the characteristics of the population itself in terms of their un-observable composition of their un-observable illness vary.

So our solution was to study the consequences of report cards for heart attack patients, elderly heart

attack patients, under the assumption -- and here's where the sort of leap of faith necessary to believe our results comes in -- under the assumption that the care of heart attack patients is affected by these CABG report cards but the composition of the AMI population is not, and I say leap of faith -- it's not 100 percent leap of faith. There are reasons to believe that care of AMI patients would be affected by CABG report cards, and there are also reasons to believe that the composition of the AMI population wouldn't be affected.

AMI is a relatively exogenous health event with more or less 100 percent hospitalization this country in the elderly, and so, it's not a terrible assumption, and if you want to see more about what's behind it, I encourage you to download the paper, and we talk about it in detail there.

Well, what's the basic finding? I'm just going to step you through the first table of the paper and then end it there.

The basic finding -- let me just start out by introducing this table. What this table shows are the mean expenditures in the year prior to admission for AMI or for bypass surgery for all of the fee-for-service elderly Medicare beneficiaries in the United States for two years, 1990 and 1994, and going from left to right,

you see the mean expenditures in the year prior to admission for those patients -- for all AMI patients, for all patients who got bypass surgery, and then for the AMI patients who got bypass surgery. Some people get bypass surgery even without having had a heart attack. Some heart attack patients get bypass surgery; some heart attack patients don't.

The reason that I'm presenting you with the mean expenditures in the year prior to admission for AMI or bypass surgery is that that, in our view, is a good measure of how severe the patient's illness was when they showed up at the hospital either for their AMI or for their bypass, okay? And, you know, as the mean expenditures in the year prior to admission goes up, that's somebody who's relatively sicker upon presentation for their illness.

So, how do you read this table?

Well, let me ask you to focus on the left-most three rows for a moment, and what those -- left-most three columns, sorry.

What those columns show you is that, for AMI patients, before either of those report cards was adopted in 1990 versus after the New York and Pennsylvania report cards were adopted in 1994, the trends in the health status on admission for those patients, as measured by

expenditures in the year prior to illness, were roughly the same in New York and Pennsylvania and everyplace else, in all other states -- that's the second row of the table -- and in the neighboring states -- Connecticut, Maryland, and New Jersey.

In each of the three locales -- New York and Pennsylvania, everyplace else, Connecticut, Maryland, and New Jersey -- expenditures went up -- prior to AMI, expenditures went up for this patient population by 8 to 9 percent, and that's a standard -- and this is in real dollar terms -- and that's a standard finding that's consistent with the dramatic increase in treatment intensity, in surgical treatment intensity, basically, for AMI that occurred throughout the country over the 1990's.

Okay.

Now, let's move to the right -- more right-most columns and ask what happened to the illness severity of CABG patients in New York and Pennsylvania versus everywhere else after report cards versus before.

Well, what happened was CABG patients' illness severity declined by more in New York and Pennsylvania relative to everywhere else. So, for example, if you look at the middle three columns, what that says is that, after report cards versus before, in New York and

Pennsylvania, expenditures in the year prior to admission for bypass surgery for those patients went down by 6.99 percent, okay?

But if you ask what happened to expenditures in the year prior to bypass surgery for patients from all other states, they were flat. They went up by -- I guess that's 8/100ths of a percent, and if you ask what happened to expenditures in the year to admission for bypass surgery patients in Connecticut, Maryland, and New Jersey, they went down a little bit but only by 1.62 percent.

So, that says that the patients who got bypass surgery in New York and Pennsylvania were getting healthier somehow relative to patients in other states over the period during which these report cards were adopted.

If you look at the right-most three columns, you see essentially the same thing going on if you look only at AMI patients who got bypass within one year of admission.

In New York and Pennsylvania, their expenditures prior to admission went down by 8.83 percent, but in other places, their expenditures either went up a little bit or went down less than 8.83 percent, again suggesting that those patients in New York and

Pennsylvania were becoming healthier relative to their cohorts in other places, and the reason I presented you with the left-most three columns on all AMI patients in the first place is this is not some artifact of cardiac treatment or what's going on with elderly people who have related illnesses. For AMI patients, trends in prior expenditures are all pretty similar no matter where they're coming from.

So, what conclusions do I want you to draw from this? What am I going to leave you with from this analysis? There was selection going on. I hope I've convinced you of that. I'm not going to present you with the detailed results behind the rest of the paper, but I'll just summarize it for you here.

As it turns out, the selection of healthier patients for bypass surgery had adverse consequences for patients, had adverse consequences for the population of AMI patients.

If you look at the Medicare expenditures and health outcomes of AMI patients in New York and Pennsylvania versus everywhere else, in a table like the one I just showed you, what you'll see is that report cards led to higher costs for those patients and worse health outcomes, higher costs for both healthier patients and sicker patients. That is to say, patients with and

without prior-year expenditures.

The healthier patients had higher costs because providers in New York and Pennsylvania expanded bypass surgeries to them coincident with report cards, and the sicker patients had higher costs in spite of the fact that they had declining or stable bypass surgery and other surgical intervention rates.

For the healthier patients, report cards led to roughly unchanged outcomes -- not much one way or the other -- but for the sicker patients, patients who had prior-year expenditures prior to their AMI, they had much worse health outcomes in New York and Pennsylvania versus everywhere else, much higher rates of readmission with heart failure and AMI, and in some specifications, higher rates of mortality.

So, in conclusion, there are these three kinds of report cards out there -- process, survey, and outcomes report cards. I think there's a role for all of them. Each has strengths and weaknesses.

We focused on outcome report cards in our study. Outcome report cards have the strength that they provide objective measures of differences in quality of care but the weakness that they're subject to gaming by providers that have important consequences for patients.

And I don't want to leave on too glum a note.

I think that outcomes report cards are an important component of any report card program and are salvageable, but in their design, we have to be aware of this gaming problem and try to work on designing them to minimize opportunities for doing so.

In fact, many states -- California, included -- have already had this same idea, not at all due to us, but part of the way to address this concern is by basing a report card on all patients who have an illness -- say, AMI patients -- rather than patients who get a procedure, like CABG, which makes it harder for hospitals, for example, to try to select against patients receiving the service.

There are other new approaches to this that we're currently working on, and that's where I think research and work on outcomes report cards might go.

Thank you.

(Applause.)

MR. BYE: Thanks very much.

Louise Probst up next, and after her, we'll have a 10-minute break.

MS. PROBST: Thank you.

I appreciate being able to come to the hearings today and your interest in health care competition in local markets.

Today's topic of hospital quality and information available to consumers is of primary importance to the employers that I represent.

I'm here representing the St. Louis Area Business Health Coalition and Gateway Purchasers for Health. We're a coalition serving the St. Louis market with a mission to create a competitive health care environment in which financial services are aligned towards the improvements in cost, quality, and access.

We represent about 40 large employers in the St. Louis bi-state area.

I thought what I'd do today is talk just briefly about our health care market and then talk a little bit about the information that we have and we'd like to have.

First, I sort of went back to 1994. That's the last year when our hospitals were independent, and it's about that time that the mergers began.

We had 30-plus independent hospitals serving the St. Louis MSA at that time. Today, we have four systems. These are systems that have given up their -- each hospital has given up their governing board. There's one centralized decision-making body. And four independent hospitals serving the St. Louis MSA.

I've given you the market share of each of the

four systems. That totals up to about 70 percent. We feel like that's a fairly consolidated health care market.

Particularly, there's one hospital in one of the systems that, for different reasons, by many consumers, is seen is a must-have hospital, which makes it a little bit tougher, but really, every one of the systems has a must-have hospital for a given employer or a given, you know, consumer population, and all the systems require -- it's all or nothing.

The other thing that we didn't indicate here is that some of those independent hospitals contract with the systems. So, we didn't put them inside, because they're not owned, but there may be some stronger ties in terms of their negotiations.

A little bit about the change in our corporate climate in St. Louis, because I think this happened simultaneously, and it's kind of interesting. I know it's happened in a lot of cities, but health care is really a major industry where I live.

Our largest employer in the state is a hospital system, and if you list the top 10 employers in the St. Louis market, there would be a couple of hospital systems there, so --

We also have found a pretty interesting -- a

recent Kaiser Family Foundation report found that 8.3 percent of Missouri's employment is in health care, compared to a national average of about 3.4 percent.

In 1994, we were ranked third behind New York and Chicago for the number of Fortune 500 headquarters, and just recently I read -- and I'm sorry, I threw the magazine out before I realized I needed it, but we're number 12 or 13 these days.

So, that's a pretty big change in, you know, a few number of years.

Never dreamed I would be in front of a group like this talking about the Herfindahl-Hirschman Index. It's a -- the name is a lot more intimidating than the math, but this is a measure that we actually learned of for working with both of your organizations when you did some work in the Missouri market on hospital and health plan mergers, and we've used it to sort of take a look at our own market from time to time.

In 1997, or using 1997 discharges, we did an analysis of St. Louis relative to a series of other markets, and what we found is that we had a fairly concentrated health care market, and for the people that aren't familiar with this, this is a relative index that looks at how consolidated the market is.

The math is simply the market share squared,

and then to get that for the whole market, you sum it. So, that's how we did the math.

And we used discharge data. It is hard to define what is a hospital's product these days, because they are so horizontally integrated, but we chose to use discharges. So, it's an inpatient measure.

And as you can see, an un-concentrated market is anything below 1,000. An indicator of a moderately concentrated market is 1,000 to 1,800, and above 1,800 is a highly consolidated market, and that's Rochester, Denver, and St. Louis.

Our market actually had one system break-up. We used to have four systems and only two independents, and so, our HHI came to 1,718, although we haven't noticed any major changes in the competitiveness of the market.

This is a slide that our employers have used for some time, and it really came to us by a group of St. Louis providers who came to us -- actually, they came to us back in 1996, and they asked us to help them to get the health plans to pay them on contract capitation, more of a risk-sharing arrangement, and they told us that they knew, as a group, that they and probably a lot of the market were doing way too many surgeries, oftentimes more than twice the national average.

They had a cardiologist who stood up and said, you know, we could reduce coronary angioplasties by 70 percent in 30 days, and then the ENT folks told us they could reduce laryngotomies by 50 percent in 30 days, and you know, it didn't get much further than that, because the employers just got really upset, and the reality is that these providers understood they had a problem, they knew the power of financial incentives, and they were asking us to help them.

They did have the opportunity to get some contract capitation, and what they found over time when they studied it was that the rate of surgery, indeed, dropped within 30 days. You know, knowing which surgeries were sort of in that gray area was easily enough to figure out.

And what was also interesting is, for the period of time that they watched it, they never really dropped down below that national average.

So, there must be pretty clear consensus around when to do and when to not do surgery, and it was just sort of the gray area.

But this really led the employers -- they refer to this slide a lot, because it shows, one, the power of financial incentives, the variation that might exist, and sort of the need for, we think, transparency.

What is it the employers want to know about hospital quality? I think that was one of the questions, and it's just really simple. We want to know if there are differences in the safety and quality of health outcomes across providers.

Now, sometimes hospitals tell us there's no difference, and other times they tell us there are differences. It depends, you know, on sort of the discussion that you're having.

Other folks that have studied it in their own markets -- and I think -- I believe that there are differences, but if there are no differences, we just want to move forward and buy on price, and if there are differences, then we think we need to inform the consumers, reward excellence, encourage improvements, and continue the measurement process.

So it's as simple as that.

Employers in our market are a part of the Leapfrog Group, and we did ask St. Louis employers to report to Leapfrog.

If you look at this slide, it's kind of confusing. The map at the left just shows you, if you aren't familiar with Leapfrog, the different cities that were in the first two regional roll-outs in which employers in the market came together to invite their

hospitals to report on this voluntary survey.

The table at the side shows the two different colors. The darker blue is the first wave, and these were the hospitals -- the communities that went out initially. So, this would be two-year old data.

And the second wave would be folks that just went out in 2002 asking hospitals to report. And you can see that, by the end of 2002, every community had moved ahead of St. Louis. We're the little tiny blip on the far end where just one hospital has reported.

So one hospital out of 31 decided to report to Leapfrog, and on the other hand, there's Seattle, Wichita, Savannah, who -- you know, these communities have been able to get 100 percent.

It's interesting, also, that Seattle was the market that had the lowest HHI. So, you know, perhaps there is some correlation between market concentration and the information that's available to consumers, and if anyone wants to study it, that would be great.

We were asked, you know, in one of the questions, why would the hospitals be hesitant to report? I don't want to assume to speak for the hospitals in my market -- they can do that -- but I think our assumptions from having talked to them is that, even though there were some concerns about the standards, they really

appear more to object to public reporting than the actual safety measures, and we saw that because many of the hospitals in our market use intensivists.

We happen to have two intensivist training programs in St. Louis, and closed ICU's with intensivist coverage has been the standard of care for 20 or 22 years. So, it's a long time, and it's pretty common in our metropolitan area.

Many of the hospitals meet the volume thresholds, and several hospitals are implementing CPOE. One actually has hardware installed, and the other are in the planning stages.

The real issue that we could really put our finger on, seemed to be the most problematic, was the volume standard, and that's particularly complicated in a market that's so concentrated by systems, because a system will have high-volume and low-volume hospitals within it, and it makes it a little bit problematic.

If you're an independent, high-volume hospital, you know, you want to take out a billboard, but if you're in a system, you're less likely, you know, to want to go forward and do that.

We think that version 2.0, which some of you may be familiar with Leapfrog -- Leapfrog went through an open comment period and revised their standards. We

think the new standards -- we think the improvements have been very good ones and that they address a lot of the issues and concerns that hospitals have. Particularly in the low-volume area, it allows you to submit other data to qualify for the volume criteria.

So, we're hoping that we'll see some change and that St. Louis will come in line with some of the other cities in terms of reporting this information on patient safety.

What type of information do the hospitals want to give us or have they made available to consumers in the market? And they've really made a lot of information available. And if you look at their newsletters, which we read all of them, or you look at the web-sites, lots of quality information, a lot of quality activities. And so, we don't really have any reason to think that our hospitals aren't quality providers. I mean they're working hard to make these improvements, and they've invested a lot.

The kinds of things we find on their web-sites and in their newsletters are their quality awards, the grants and other recognitions that they've received, and almost every one of them has some sort of quality award that they have received.

I do have to note that SSM, from our market,

just recently was the first hospital organization to win the Malcolm Baldrige award, which I think is a real accomplishment.

They also talk about hospital-specific clinical initiatives that they're engaged in, narrative descriptions of processes that they have in place to show -- to improve quality and to show their commitment, and a lot of comments that if you're concerned about health care quality, you should talk to your provider. One hospital actually has information that counters Leapfrog, which I found kind of interesting.

What information do we want that really isn't available?

Well, I think you can all guess. We want standardized information. We want to be able to make side-by-side comparisons, and that's not something that is available at all.

You know, all the hospitals use patient satisfaction data. A lot of them use the Picker instrument. You know, that would be nice, if they could even all just give us the satisfaction survey using a common tool.

We very much would like the hospital discharge data set. There are 22 states in which that's publicly available. Missouri is not one. And it's not because

employers have not, you know, tried to get that made available. We just haven't been successful yet. But next year is another legislative session.

And then, finally, the risk-adjusted cost and other comparisons would really be important, and sometimes the health plans have these, and so, what you heard in some of your past testimonies is that health plans would like to use or are using in certain markets variable co-pay products that would allow consumers that make a choice to use a lower-cost or higher-quality, higher-value facility to benefit from that by getting some savings and not having to pay quite as much.

We have some plans in our market that have wanted to do that, but they've not been able to do it, because the hospital systems say, if you do that, we won't participate in your product.

A couple of health plans indicate that they have been -- I guess I should say encouraged or they have actually ended up signing language in their contracts that prohibit them from sharing this kind of information with consumers and developing these kind of products.

So, even though we've had some mergers of health plans and we have probably a fairly concentrated health plan market, we still have this other situation.

We have the Informed Purchasing Data

Collaborative, which is a group of 50 or some employers that have joined together with five health plans to share data so that they can have the opportunity to get some of our own data. We have several hundred thousand lives in a database now and are working on that.

I just got the time signal, which is why I sped up.

What is our urgency? Well, obviously, I think you know that -- you've read the IOM reports, you know the urgency from a quality standpoint, but also, costs have gone up.

The average per member, per month medical cost of our employers in 1996 was $90, and some employers are seeing PMPM medical costs of 180 today.

So, a lot of information out there that is in use by our member companies, and so, I'll just leave that with you.

Some of the hospitals do have valid concerns, and I just want to, you know, briefly say they are concerned that they will be compared against niche providers that don't have the same burdens and the same cost structures, and we recognize that those are some concerns that are valid and that we need to work with them to try to improve those.

In terms of conclusions, we really think it

would be great if your organizations could establish some information standards or other indicators that would be present in a balanced market, maybe publish the HHI's or your assessment of different markets so that we can understand how well we're doing in our markets.

We think other efforts to define standardized measures really need to move forward as quickly as possible.

We need innovations in health plans and other things to help understand how consumers want to use this information, and we could also use some help defining charity care and some of those other community services that hospitals provide that they justly need to have factored in the considerations of their cost structures.

So I want to thank you very much for the opportunity to share with you and look forward to the further testimony.

(Applause.)

MR. BYE: Thanks very much.

We will start back around 37 past, if that is okay.

(A brief recess was taken.)

MR. BYE: We'll start back now with Paul Conlon.

MR. CONLON: Good morning.

It's a great opportunity to be here on behalf of Trinity Health, and let me just say a few words about Trinity Health.

We provide inpatient services from coast to coast. We have Holy Cross Hospital here in Silver Spring, Maryland, with a high concentration of hospitals in Ohio, Michigan, Indiana, Iowa, a hospital in Boise, Idaho, a hospital in Fresno, California, but we are coast to coast. There are 45 hospitals in our system, about 25 we actually own, about 20 that we manage.

There are 340 or so outpatient facilities, 24 long-term care facilities, home health, charity care in the range of $350 million a year.

There are 45,000 employees within Trinity Health, and as a pretty large employer, we are concerned about health care quality and how we share that information with our own employees.

There are 7,000 physicians on our staff. Of those 7,000 physicians, 440 are actually employed physicians, which really says that we are living in a private practice model and that we're working with physicians who have their own private businesses and they're maintaining their own payrolls and their own insurance costs, and that creates a different type of relationship than the employed model.

Operating revenue, about $5 billion a year, and assets of $5.8 billion.

A few other messages about Trinity. We deliver 1 percent of the nation's babies, provide 1 percent of the inpatient cardiovascular care in the United States, provide 1 percent of the inpatient orthopedic care in the United States.

Our mission is to serve together in the spirit of the gospel to heal body, mind, spirit, to improve the health of our communities, and to steward the resources entrusted to us, and as we talk today about quality indicators and tracking quality, I think you hear a message that comes through that we take this mission very, very seriously, particularly as we attempt to steward the resources that are entrusted to us.

On principles that we use to track clinical quality measures, first and foremost is to use evidence-based indicators, and this is a lot easier said than it is done. There are many indicators out there that large groups and coalitions and others have adopted as evidence-based, but when you really study the evidence, you find that it may not be as strong as what people had hoped it would be.

They are not bad people trying to do bad things. We just want to make sure that the evidence that

we use is valid and it's strong.

A key point for most hospitals across the country is this next point, and that is the value of the indicator must exceed the burden of the data capture.

All too often there are those that suggest that you get indicator X that costs an awful lot of money to gather than information and time and resources that is taken away from someplace else, and as we heard earlier today, for the third of the hospitals in the United States with negative margins, it's hard for those hospitals to take scarce resources and dedicate it to quality -- data collection for quality improvement purposes.

So we must look at indicators where the value is exceedingly great, that the burden of data capture is relatively small, so we can make best use of that particular indicator.

Next is to use indicators with national benchmarks, and this is very important, because many times, even as our own system -- as we first came together three years ago as a system, we looked internally to how we were doing, and we could compare one hospital in our system to the next or one nursing home to the next.

The problem with that is we didn't know if we

were the best of the best or the worst of the worst, and it's important for us to measure our performance against national benchmarks.

We have a corporate goal that we are going to be top quartile providers across the country, that to achieve that goal you must measure against national benchmarks.

Prioritize the focus, focus on a critical few indicators that drives clinical improvement well beyond the focused indicators.

Let me tell you a brief story here.

We have chosen two patient safety indicators, and they're related to medication safety, and they're going to sound extremely simple to you, and that is that the height and weight and the allergy information is available on the pharmacy profile.

Now, that information is available in the chart, but is it resident in the electronic pharmacy profile, where all the dose range checking is done and the allergy checking is done and the like?

We had numbers that were not so good. We now have numbers where all of our hospitals are in top quartile performance. We've seen dramatic improvement in those two indicators.

But what's more important is we also have taken

a more comprehensive look at medication safety, and we've done the ISMP survey across all of our hospitals, and a year-and-a-half ago, our score was about 51 percent of the safe medication practices on the ISMP survey were adopted by our hospitals across the board. Today, it's at 69 percent. We focused on a few, but what we found is the clinicians that were charged with improving medication safety couldn't just rely upon doing those two, that that translated into conversations about how do they do other things, that the corporate message extends well beyond the specific indicators.

We have similar examples in heart disease, AMI, and pneumonia care.

Next key principle for us is that we let the data drive the analysis, that we don't go in looking at our data to understand -- to explain a bias that we may have. We open the data up, we look at it, we drill into it, and then we try to find out where the biases may be and try to identify where the opportunities for improvement are, and the data, nine out of 10 times, will identify key process improvement opportunities.

At a system, within a system, there are some attributes about reporting that makes it unique.

First and foremost, it is safe. It creates an environment of sharing without the posturing associated

with competitor reporting.

We are not saying that we shouldn't have public reporting, but I must -- and actually, one of the other speakers talked a little bit earlier today about Jerry O'Connor and the Northern New England Heart Consortium activity.

That is all private activity that's being done. They saw a 24 percent level of improvement in their own local activity. Safe environment for cardiac surgeons in northern New England to improve their quality.

We had Dr. O'Connor come to our organization, talk about that, and we adopted many of the same methodologies. Safe environment allows the clinicians to candidly discuss not only what goes well but also what hasn't gone so well, what has been unsuccessful, what has failed, and there are tremendous learnings from those organizations sharing among one another about the failures as well as the improvements.

In our system, unlike in the competitive market, where, in the competitive market, you're typically rewarded for the innovation, the new thing that's done, we also reward for the replication.

One site was able to reduce vaginal laceration rates by 40 percent. How did they do it? Next year, another site comes along. We adopted what site A did and

guess what? Today, we've reduced ours by 60 percent. That has to be rewarded, as well. So, not only are the innovators rewarded but also are those that have made other levels of improvement.

As a system, our goal is to improve locally, and you heard earlier today about the different models, models that have local focus of care and models that have a corporate level of care.

We kind of are a hybrid of the two. All of our hospitals have local boards, but we also have a corporate board. We have a corporate quality committee for our system. There are local quality committees within our system, as well.

So there's corporate and local. Our goal is to improve locally, and guess what? It rolls up at a system level and we see system level improvement.

The goal is not to compete with our colleagues within our system but to leverage and to share mutually so that we all do better, and that is really true.

When we present our quality indicators, we present data over time and we use reliable data.

If we find that the data are not reliable, we've looked at it, the indicator, we see tremendous variation in what's going on, we talk to the sites about how they collected the data, we don't report it, because

we don't want to create distrust with our constituents, with our colleagues, and that's critical.

This is a partnership, and as we talk about improving the health of the community and the communities that we're doing business coalition partnership with -- and there are many, and many with five and eight and 10-year histories of doing that -- it's about developing collaboration with those businesses, so that everyone has an appreciation for the quality indicators.

It's critical that you only use reliable data or you create distrust.

Another important point that we've identified is to present data over time. You saw snapshots of report cards. They give you a picture of where you were in 2000, but you know what? Maybe between 2000 and 2003, there have been huge improvements.

Showing that demonstration, that improvement, those initiatives is great, and it's critical for us, and you know, sometimes you just celebrate the organizations that went from bottom quartile to the mid-quartile because they made some improvement, but they still may not be at the top.

Another key attribute that we have an advantage of in our work within the system is the transparency of data. No matter who you are, any one of the 45,000

employees within Trinity and the 7,000 physicians that we have can look at any one of our quality indicators for any one of our hospitals. That information is transparent.

It's not about who is good and who is bad. It is all about how do we get better, and you can't get better unless you understand the gap in your own individual performance.

Reporting activities -- there are monthly and quarterly updates on 18 acute care indicators, and I would say, of those 18, really there are 10 that are our core indicators that we spend most of the time focusing on. There are tables, there are graphs, control charts, run charts for all of the indicators at both the local and at the system level.

There are quarterly updates for long-term care indicators and same type of thing at the local and the system level.

We do what we call in-depth reports. They're called standing reports. They're in-depth review of major service lines -- cardiovascular services, orthopedics, maternal child care, patient safety -- where we look at structure, process, outcome measures in each of those major categories, for the major disease states in those categories, and do an annual report, state of

the art, within Trinity Health, each and every year, on patient safety.

This provides us with the opportunities to identify our deficiencies and identify our opportunities for improvement, and guess what? The next year's report we start with what did we saw we were going to do last year and did we make the improvements we had to make? It is a great catalyst for improving care.

All of this information, as I indicated before, is posted on our intranet site. It is our most popular intranet site. It has about 17 hits a month against this intranet site from people across Trinity. That's a lot of people looking at this data, tracking the information, trying to understand what's going on.

As we indicated before, we want national comparative data, and that has been a major problem for us to gather, a major problem, but we are striving to gather it wherever we can and however we can do it, whatever means that we can get to that, and system-level data.

The performance is reviewed monthly on conference calls with local clinical quality contacts and quarterly with a clinical leadership council which is made up of all the chiefs of medical staff, vice president of medical affairs, and patient care executives

at all of our hospitals. In fact, they meet in two weeks at Detroit at the airport to go over some of these data.

Reporting to all levels of the organization -- we've indicated staff to local boards, to corporate level boards. There are clinical collaboration teams that have come together working on specific projects to share those type of learnings, particularly around the major service lines, and there are annual clinical conferences, which is an incredibly unique experience.

This is administrators, clinicians alike, showing up for three days to discuss the state of the organization, but what's really unique about it, 36 break-out sessions, the vast majority focus on clinical quality improvement activities, 125 poster sessions, 800 participants for three days in Dearborn, Michigan. These are clinical tool kits.

I guess I got the two-minute warning here.

Some of the challenges at the system level -- and I want to briefly talk about the challenges at the national level, as well, in public reporting.

Incomplete data. Incomplete data is a major problem. We've heard today a lot about data that comes from the claims data, the UB-92 information and the like, but if you try to find whether a patient has smoked two packs per day of cigarettes on that UB-92, you can't find

it. It is a consistent co-morbidity.

If you can try to determine whether the patient developed the UTI while in the hospital or prior to hospital admission, it isn't there on the UB-92. It says they had a UTI. You don't know if they had it before they showed up or after.

So, you have to be very careful about the use of administrative data. It's very efficient, but it isn't always accurate and it's not always robust.

Even when indicators are nationally recognized, they are frequently unclear, captured irregularly, and not rapidly improved.

I'll spend one brief second talking about antibiotics and community-acquired pneumonia. If you call the various agencies that are promoting this indicator today, which is an important indicator, and you ask them, if a patient receives a dose of an antibiotic in the physician's office 20 minutes before they show up in the emergency department and are admitted to the hospital, do they get credit for administering that antibiotic, and the answer is no.

So if a patient gets a dose of rocephin in the physician's office at 10:00 o'clock in the morning, is admitted to the hospital at 11:00, and gets the next dose at 10:00 o'clock the next morning, which would be the

appropriate time, they have a 23-hour time to antibiotic. That is an indicator that has been tested by Medicare and has been tested by the pros and has been out there, but until it got into general population use, no one saw that deficiency, and there's a series of others with almost all these indicators.

So it's really important for us to look at the indicators retrospectively, quickly, and make some corrections to that.

Lack of adherence to the definitions is a problem between those people that are doing the reporting and also some very obvious definitional inadequacies that have to be corrected quickly or you create distrust.

The next point is data that does not describe what has to improve is not very helpful to us.

Public reporting -- I'm going to try to go through these quickly, and I'm sorry about the time. Public reporting should be meaningful and responsible information to describe the performance of providers. We support it. We continue to work at AHA and FAH and Medicare in their current initiatives. We'll hear a little bit about that later. Providers have an opportunity -- should have an opportunity to contribute to what information is shared with the public and how it is to be shared.

There are those that talk about this negative style of reporting creates greater interest. We all can look at the Washington Post or any newspaper and see that the headlines are almost always negative. That shouldn't surprise any of us.

But I think what we're not understanding in health care is that we have a crisis blooming right now in recruiting good and bright people to health care and that one of the negative consequences of the continual negative reporting about health care is that the best and the brightest don't look at it as an attractive field to enter, and so, who is going to care for people down the road, when the average age of a nurse is in the mid-'40s in the United States? Who is going to provide that care if we can't attract young women and men to those fields?

Benefits of responsible public reporting include informed public, informed providers, improved performance, and I would argue that it may be the last that is actually the first, that the greatest value is the improved performance, that this puts a light on things, it creates an opportunity to see benchmarks, understanding where the gap in performance is, and to share the information, but we want to do it in a responsible and respectful manner.

I kind of covered these earlier on the system

level so I'm going to skip them, and I'll skip those, too. There are hand-outs for people.

Reporting on health care quality is difficult if it is to be done well. It requires testing of the indicators, of the definitions, of the data collection, and clearly of the presentation, what are we trying to communicate and how we're going to do it.

And lastly, this has been part of our mission, and Catherine McAuley is the founder of the system at Mercy, one of our founding organizations, and nearly 200 years ago, she said the more experience we acquire, the more capable we are -- we become of discerning deficiency and making some improvement, and that's true, and we're supportive of quality improvement initiatives that are looked at, responsible reporting, but we have to be careful of untoward, unanticipated consequences.

Thank you.

(Applause.)

MR. BYE: Thanks, Paul.

Nancy Davenport-Ennis is the next speaker.

MS. DAVENPORT-ENNIS: Certainly it has been fascinating to listen to each of you talk about the particular details as it relates to hospitals, communications, and improved measurements. I would ask that you switch gears for the next few minutes, because

my remarks will not be on the topic for today but, rather, will be on a topic that will be addressed on June the 10th, when I'm not available to be here.

I would like to thank you for the invitation to be with you today. I do appear before you as the CEO of two national organizations that I'd like you to understand so that you can understand the foundation of information that I will provide.

The two organizations are the National Patient Advocate Foundation, which is a policy organization, and the Patient Advocate Foundation.

The Patient Advocate Foundation is a nonprofit 501©)(3) direct patient services organization. In the calendar year of 2002, we handled requests for help from 2.5 million Americans who were confronting some form of access to care issue.

We resolved those issues on behalf of patients at no charge. We do handle patient cases from all 50 states in the United States. We have a staff of both professionally trained case managers, oncology nurse case managers, social workers, coding and billing specialists, as well as a team of attorneys who help us in the area of arbitration and mediation.

It is based on the experience of our patient cases that I come to speak to you today on the results

that we see happening in America for patients who are in states that still have CON laws in effect as the patients are trying to get, particularly, to radiation therapy.

In the calendar year of 2002, 93.8 percent of our patient cases involved cancer cases. So, I think it's important for you to understand that a lot of our work is done within that field.

As you also know when you're dealing with cancer patients, you are dealing with very complex regimens of care and protocols that are very specific.

I am here, also, because we are not the only ones that have a concern about patient access in the states that have CON laws.

I would like to share with you comments from a letter written on March the 24th by Congressman Stearns of Florida, who is the chairperson of the Subcommittee on Commerce, Trade, and Consumer Protection for the Committee of Energy and Commerce.

As you know, Congress has taken action over the last 30 years in an attempt to address health care cost inflation. Of particular relevance to this inquiry are section 1122 of the Social Security Act Amendments of 1972, the National Health Planning and Resources Development Act of 1974, and the amendments of that Act that were enacted in 1979.

Through these measures, Congress sought to control the development and utilization of health care services through a regulatory regime known as the Certificate of Need. This experiment in health care market control ultimately was viewed as a failure, and Congress repealed the National Health Planning and Resource Development Act in 1986.

Since then, 14 states have either repealed or abandoned the CON regime that the Federal Government had previously required them to establish. Thirty-six states and the District of Columbia still maintain some form of CON regulation.

CON was established by Congress and implemented by the states in an effort to retain rising health care costs, to prevent unnecessary duplication of resources and services, and expand consumer access to quality health care services.

It is similarly important to note that CON was established at a time when Federal reimbursement for health care was made on a cost-plus basis, which did not provide the cost control capability of today's prospective payment system.

In my capacity as chairman, I do desire that we explore all facets of competition and understand what the access to care issues are confronting patients in the

states that have the CON in place.

According to the American Cancer Society, one in every two men and one in every three women in this country will be diagnosed with cancer at some point during their lifetime.

These are very chilling statistics. Certainly all of us in this room know someone that has faced this disease and perhaps knows the difficulty of the journey they've traveled.

I think it is also very important to note that, in 1998, for the first time, we were able to report to America that the incidence of cancer was turning the curve and it was being reduced.

Those of us that work heavily in the field of cancer care feel that we are seeing a decline in the number of cancer diagnoses because of the National Cancer Act of 1971.

The National Cancer Act of 1971 essentially moved health care into community settings and made health care at the community level more available than it had been prior to the National Cancer Act of 1971.

However, our progress is being denied to many Americans who need it most. Due to the regulatory restrictions created by the Certificate of Need, many patients are unable to access the care they need unless

they live near a hospital or a major medical center or can drive from a medical oncology clinic to a radiation facility. For low-income, seriously ill, and rural patients, this often is simply not possible. As a result, these patients are unable to enjoy the benefits of all that America's war on cancer provides.

Let me share one example of one patient that we helped.

A 43-year-old male from the State of Oregon, diagnosed with throat cancer called us because he had been directed to receive radiation care that was located 100 miles away from his home. He was to get radiation daily for six weeks.

His wife, he determined, could not take time off work as a care-giver to take him every day, because the journey and the treatment itself would have negated her ability, essentially, to work for six weeks. On the third day of radiation therapy, he drove himself 100 miles, he received his therapy, and on the way home, he passed out at the wheel of his car.

He went into a ravine. His car happened to be noticed by a neighbor from his community, who stopped and investigated, to still find this patient unconscious in this car from complications and side-effects of both his illness and the therapy that he had had earlier in the

day.

When we say that the treatment is not available for many patients, let us consider a 44-year-old woman in Illinois, a breast cancer patient, who was again instructed that her radiation therapy would have to be given to her at a site that was two hours away.

Her health plan agreed to pay for temporary housing for her for six weeks so that she could remain in the location to have the care. Her concern was an absence from home from children and from neighbors and from all that were her support group in handling cancer issues.

Our concern as an agency that is concerned about the cost of health care delivery in this country is what is the increased cost to the health plan population for providing housing at a remote location for one to get treatment at a more remote location that requires a two-hour travel one-way from home?

As I'm certain you know, disease knows no geographic boundary. Disease does not recede or accelerate in response to government regulation, and disease does not wait to strike until the necessary health care resources are in place.

That is why, to be successful in our battle against diseases, patients must have access to care that

is geographically and financially accessible.

With respect to cancer, this necessity is even more acute. Cancer treatment often requires daily visits to the site of care and often results in debilitating side-effects such as nausea and fatigue that themselves must be treated by skilled specialists.

In addition, cancer treatment often entails a combination of medical oncology, often called chemotherapy, and radiation oncology interventions, and many of those chemotherapy interventions have to happen within a prescribed period of time before you actually administer radiation.

State Certificate of Need statutes and regulations often have the effect of requiring cancer patients who need a combination of therapy and radiation therapy to travel to two separate locations to receive them. In fact, providers who have radiation therapy facilities have long used CON to prevent others, including cancer care givers, from providing integrated medical and radiation treatment.

There are several distinct and disturbing consequences that result from CON and its impact on cancer treatment.

Number one, the science of cancer treatment today often requires exactly what CON's frequently

prevent -- i.e., the integration of chemotherapy and radiation therapy. The resulting travel and financial co-payment burden falls most heavily on the elderly and the poor patients, who must receive chemo and radiation therapy in the same day at different locations over a period of months or even years, and I must relate to you it's not only the elderly and it's not only the disabled. It's also the 13-year-old child that we helped from the State of Tennessee, who was going to be required to travel two hours one way for radiation therapy for brain metastases that he was dealing with.

His family ultimately made the decision not to pursue the radiation therapy because of the side-effects the child was having and the result of his declining health condition as he tried to travel, get radiation, and deal with the side-effects of the illness.

In light of these problems, the National Patient Advocate Foundation has long advocated for CON reform. For cancer patients, CON reform could be a lifesaver. By allowing the integration of cancer care in communities nationwide, CON reform would enable all patients with cancer, regardless of their location or financial need, to realize the hope of survival.

Specifically, we have sought CON repeal in many states so that the development of integrated cancer care

centers would be allowed.

Our rationale for this position is based on the scientific and demographic realities of cancer.

That is why we firmly believe that removal of CONs would, number one, allow cancer patients to receive chemo and radiation therapy in one location; number two, eliminate the geographic obstacles that currently impede the ability of poor and elderly patients to access care; three, allow oncologists and radiologists to more effectively manage combination cancer therapy, to reduce cost and increase quality of care, and to allow rural and suburban cancer patients to receive treatment without overly burdensome travel distances, while permitting the advancing science of cancer treatment to be translated into improved care in the community setting.

In closing, please allow me to make a personal emphasis from this perspective. I am a two-time cancer survivor, which is not important to this discussion, but what is important is that I am also the mother-in-law to a young man who was diagnosed with cancer at the age of 19 and an aunt to a niece who was 29 at the age of her diagnosis and succumbed at 34 of brain metastasis.

We were one of the families that were confronted with the decisions of making a determination not to consider onerous radiation therapy because the 80-

minute ride one-way to get the therapy and the return with the side-effects was too debilitating for her, as well as too emotionally debilitating for her family.

I would say to you we are sensitive to the cost issues that are involved with the CON issue, but in this United States, indeed, we need to look at creating venues for access to care that provide for coordinated care of both chemotherapy and radiation within the community setting and allowing health plans to effectively help us manage the cost, as they have many mechanisms in place to regulate over-usage and over-referral to any center, whether it is a hospital or whether it is a community program.

I thank all of you for your attention during my remarks, and I hope that, as I leave this podium today, that you will remember every chart and graph that you have seen today, that you will capture every statistic that you have seen today, and that you will remember that, behind every single one of them, there is a face, there is a heart, and there is a family that is suffering with disease and debilitation.

Thank you so much.

(Applause.)

MR. BYE: Thanks, Nancy.

We have Chip Kahn up next.

Just one note.

We've been a little ambitious in our scheduling and are going to run overtime. In order to give our remaining two presenters time to fully discuss the issues they're intending to, we will run overtime. We also, unfortunately, won't have time for discussion but encourage people to submit comments for the record. We really appreciate everyone coming along today and understand if you have to depart a few minutes early.

MR. KAHN: Thank you. I'll try to be quick to try to get us back on schedule.

I'm here on behalf of the Federation of American Hospitals, and I'm pleased to offer our views on the quality of hospital care and consumer information to improve consumer understanding of hospital care.

At the outset, it is important for me to point out that the mission of the Federation member companies and their hospitals is to provide high-quality care to the patients we serve.

We believe that it is the responsibility of hospitals to provide high-quality care and safe environments and that better informed consumers will make better personal health care decisions.

So, we believe the hearings today provide a good opportunity for us to describe what hospitals are

doing to enhance the quality of care and the health care choices of Americans.

Today's FTC hearing on quality and consumer information is timely. We are entering an important period in the evolution of measurement and improvement of hospital quality, as well as a potential for disseminating these measurements to third-party payers and consumers. The growing energy and momentum surrounding health care consumerism has been fueled by the capacity of the internet, making it possible to disseminate information about health care services and health more broadly than ever before.

By all accounts, the American public wants more information about health care services. A public opinion survey conducted for the Federation last fall found significant support for a web-site that evaluates hospitals on the treatment of certain diseases and new procedures. Almost half of the survey respondents, 45 percent, said that that information could be the most significant factor or an important factor in helping them decide the hospitals they choose to seek care from.

From our point of view, there are two primary objectives for the collection of information on hospital quality measures.

First and foremost, such information can serve

as a critical tool for clinicians and hospitals to learn about their relative performance so that improvements in care can be made, and second, such information can enable consumers to make better health care choices.

Unfortunately, despite the best of intentions, many of the varied hospital quality reporting efforts in place today are working at cross purposes regarding these two objectives. These reporting efforts are creating expensive, burdensome, and unpredictable requirements on hospitals.

At the same time, the current mix of quality reporting approaches has produced frequently incomplete, poorly analyzed, conflicting, and even misleading information for clinicians, hospitals, and consumers alike, and I think there's been a mix between these process kinds of standards, which were mentioned earlier, and looking at outcomes, and I think we heard earlier that you could even get from the outcomes side some adverse incentives for providers if the information is not properly delivered.

A growing number of states have or are considering hospital quality reporting programs, and many others are beginning reporting programs, and obviously, Leapfrog is there, and also, this spring, J.D. Powers and the Associates and Health Grades joined forces to develop

their own measurement tool which would be released soon and give an excellence rating for hospitals.

All of these efforts are attempting to empower consumers with information to make them better decision-makers about their care. However, they raise many questions regarding whether or not this consumerism model will actually work in health care.

As a first step, providers really need valid and standardized information on their quality performance to allow them to measure improvement and compare their improvement to other hospitals.

Currently, there is no standardized information collected across all hospitals.

The Joint Commission on Accreditation of Health Care Organizations and the National Quality Forum, the states, insurers and other payers, the business community, consumer organizations, commercial enterprises are all advocating reporting initiatives. However, many of these parties are proceeding on separate tracks. Clearly, we need a more rational and coordinate approach.

A second issue is understanding whether and how consumers will use information about hospital quality, since patients generally do not choose their hospitals. Patients generally go to the hospital based on where their physicians have admitting privileges and where the

hospital is located.

The current hospital reporting programs have generally not addressed whether or not information about hospital quality is to be used within the physician-patient relationship.

To begin to come to grips with these concerns, hospitals and regulators have developed a quality initiative, a public resource on hospital performance.

To meet the goal of creating a rationale framework for providing evidence-based quality information for the purpose of improving hospital quality and informing consumers, hospitals, led by the American Hospital Association, the Federation, and the Association of American Medical Colleges have initiated an effort to address our nation's currently fragmented and disjoined data collection and quality reporting efforts.

Working in conjunction with several public and private sector organizations, our purpose is to forge a shared national strategy for hospital quality measurement and public accountability.

Together, we want to build a national uniform framework available to all payers and the public that provides valid and useful quality data, improves hospital care, and provides the public with meaningful information.

The organizations began this collaborative effort mid-2002 and with strong support from HHS, Secretary Tommy Thompson and CMS Administrator Tom Scully.

In addition the hospital groups, the initial partners in the collaborative effort included CMS, the Agency for Health Care Research and Quality, JCHO, and NQF. We announced the quality initiative in December 2002 and have since been joined by the AFL-CIO and the AARP. Since then, a number of other organizations have joined the quality initiative.

Earlier this month we sent to every hospital in the country a pledge package encouraging them to participate in the quality initiative. We asked hospitals to submit to CMS their performance on 10 measures related to their treatment of cardiac illness and pneumonia.

These 10 measures were selected because they were supported by evidence showing their effectiveness, because frequently hospitals already collect this data, and because these measures were agreed upon universally by quality experts, including the NQF.

This is important to stress, that what we were seeking were measures that were generally already used and measures that had sort of proven effectiveness by

those who judge hospital performance.

These 10 measures are just the first step in building a national, standardized hospital quality measures database. Over time, the plan is to add meaningful and evidence-based measures that cover high-priority national medical conditions.

I am pleased to report that the majority of the Federation members plan to participate in the quality initiative. Our largest members expect to have 100 percent of their hospitals participating.

Beginning this summer, the CMS web-site, www.cmshhs.gov, will post the first round of data submitted by the hospitals. The web-site targeted to clinicians will be updated quarterly.

During 2003, a three-state pilot program in Arizona, Maryland, and New York will test ways to maximize the usefulness of the quality data to consumers. Based on the pilot test, the information will be displayed on the HHS web-site, www.medicare.gov, a site aimed at the public at large in 2004.

Today our energies are focused on three goals: encouraging hospitals to participate in the quality initiative; ensuring that the first round of implementation goes smoothly; and beginning the consensus process for determining which set of quality measures

should be added next.

Selecting the next 10 measures will be based on national priority conditions identified earlier this year by the Institute of Medicine.

The quality initiative has huge significance within the context of today's hearing. We can begin to answer several questions which have, until now, been academic. These questions include: Will hospitals act on the reported results and implement changes to improve their quality performance? We certainly believe they will. Otherwise, we wouldn't be involved in the initiative. What will we learn from the role of physicians as the critical link between patients and hospitals? How does consumerism work in a system where physicians largely direct decisions for patients as consumers? Is quality information that is meaningful to clinicians also meaningful to consumers? What information will be meaningful to consumers? We saw some of that this morning presented. Can a national infrastructure be created and maintained that identifies valid evidence-based on standardized measures applicable to all hospitals?

In addition to these big picture questions, there are a number of systems and political issues that need to be resolved if the quality initiative is to

become a permanent and widespread program.

Improvements in information technology are essential for hospitals to improve data about a growing number of medical conditions.

Bar-coding medications, as proposed by the Food and Drug Administration, will go a long way towards reducing medical errors, especially if unit dose packages are included.

Computerized physician order entry holds great hope in reducing medication errors and improving patient care, especially when integrated with other clinical databases. However, a range of issues prevents CPOE's broader implementations immediately. Widespread, off-the-shelf software for CPOE is just beginning to be developed, and there are significant costs and training requirements. And, as in almost all issues regarding hospital care, the key to successful CPOE implementation is ultimately physician compliance.

Finally, for hospitals to implement widespread quality reporting, it will become essential to be able to extract data from electronic medical records rather than from paper. The increasing burden on clinical staff time to collect and report data will not be sustainable otherwise.

The definition of good quality measure, another

challenge to building a national framework, is defining what constitutes a good quality measure.

We believe that good quality measure must be based on widely accepted evidence that the practice improves quality, that it is feasible to collect while still allowing hospitals to fulfill their primary mission of providing patient care, and that it is meaningful to users, both clinicians and consumers.

Finally, a good measure must be one that all hospitals can implement, so that it can be adopted universally and compared between institutions.

When evaluating against these criteria, many worthy ideas are just that. They do not rise to the level of becoming a standard for hospitals.

Examples of such efforts include the use of hospital intensivists and nurse staffing ratios. Neither is based on adequate evidence, nor can they be implemented by all hospitals.

Although not a measure of clinical care, patient satisfaction or experience while hospitalized is believed to be related to hospital quality and, therefore, should be included in any public reporting on hospital performance. AHRQ and CMS have developed a draft survey instrument designed to measure patients' perception of their care that will be tested during 2003

in three states.

CMS indicates that it will require all hospitals to conduct such surveys once the survey instrument is finalized.

CMS also will ask hospitals to publicly disclose their results on the previously mentioned government web-sites.

The Federation supports the concept of measuring patient satisfaction with their hospital stays. In fact, most Federation members and most hospitals routinely conduct such surveys.

However, several issues need to be resolved before the Federation can support this kind of proposal, particularly if it is mandatory.

The survey tool must be designed to provide consumers useful information that has a demonstrated link to quality. Also, this survey should not repeat or duplicate current hospital survey efforts.

Given all of the competing demands for hospital quality information, hospitals simply cannot afford to take an additional cost of a redundant survey that does not lead to quality improvement in hospital services, as well as hospital care.

As I have indicated earlier, many different types of organizations, both public and private, have

begun hospital quality reporting initiatives. We strongly believe that these fragmented and disjointed efforts must be united under a common and standardized infrastructure so that consumers can have access to common information that applies to all hospitals.

Achieving this level of cooperation across so many players will not be easy. However, we believe that the greater good warrants that leaders of all stakeholder organizations support a single common approach.

The three hospital associations I mentioned -- AHA, the Federation, and AAMC -- along with CMS, AHRQ, JCAHO, and NQF, have worked together to begin this process. The Federation seeks to continue this collective effort, and we encourage others to join and strengthen our initiative rather than begin their own efforts.

We hope that this general effort of collecting information will both serve the clinician and, ultimately, serve the consumer in giving information that can be compared across hospitals. And so, we're very hopeful that the initiative that will begin this summer will bear fruit and hopefully rationalize the system that is, in a sense, developing today on measures and other kinds of quality assessment of hospitals.

Thank you.

(Applause.)

MR. BYE: Thanks.

Professor Sage is our final speaker this morning.

MR. SAGE: Thanks, Matthew.

When I arrived here this morning, I was told -- and I quote -- that I would be batting clean-up. I discover, instead, that I'm hitting ninth, and there's a difference.

My topic today is why competition law matters to health care quality, and I'll focus mainly on what courts have done in antitrust cases over the last 20 years. My conclusions derive mainly from work that I've done with Professor Peter Hammer at Michigan, with Professor David Hyman at Maryland, and Professor Warren Greenberg at George Washington University.

Competition law has long been the forgotten stepchild of health care quality. Two recent IOM reports emphasize the point. Quality, framed dramatically as safety, burst onto the agenda in 1999 with the public of To Err Is Human and the IOM's subsequent report, Crossing the Quality Chasm, emphasize the importance of economic incentives and market forces in preventing errors and improving quality.

Amazingly, the IOM reports did not mention

competition law.

However, it's only a slight exaggeration to view antitrust law as the engine that powered the emergence of a competitive market in health care.

One way that competition law engaged with health care quality in antitrust law's early years was by opening the door to alternative practitioners and forms of practice. The initial salvos in the legal battle for health care competition focused on supply side competition.

After consolidating its political power during the early 20th century, organized medicine waged no holds barred campaigns to ward off outside challenges to the autonomy of physicians and their monopoly on licensure. One target was prepaid group practice. Another was chiropractors.

Cases successfully challenging these activities constituted antitrust law's first forays into health care quality and notified physicians that the right of professionals to practice the healing arts was to be determined through legitimate political or regulatory processes and not economic vigilantism disguised as patient protection.

A second way that competition law got involved in quality was to overcome quality as a trump card.

Before the mid-1970's, physicians invoked quality with impunity to excuse anti-competitive conduct. Physicians asserted that the lay public could not reliably distinguish appropriate from substandard services, and many commentators believed there was a learned professions exception to the antitrust laws.

The Supreme Court dispelled this impression in Goldfarb versus Virginia State Bar, and other cases confirmed and extended the reasoning.

In Indiana Federation of Dentists, the defendants collectively refused to provide dental x-rays to insurers who sought to verify the need for treatment, arguing that patients' welfare was improved when treatment decisions were left to professional discretion. The Supreme Court flatly rejected the claim, reasoning that it amounted to nothing less than a fronted assault on the basic policy of the Sherman Act.

Another thing antitrust law accomplished was to improve access and quality by generating price competition. Policy analysts are used to thinking of a three-legged stool of health care resting on separate and distinct components of cost, quality, and access, but these legs are interconnected, and lower cost can itself enhance quality.

Competition law prevents providers from

collectively increasing prices above their competitive levels or blocking the development of cheaper forms of health care delivery.

So, what has competition law accomplished with respect to quality?

Well, in the last 28 years since Goldfarb, thousands of antitrust suits involving the professions have been filed, most initiated by private parties rather than the Federal Government. Litigation frequently touched on quality, but quality was seldom a central concern of the parties or the courts.

Four themes emerge from close analysis of the case law. First, courts failed to develop specific theories of quality but, instead, followed standard economic assumptions that quality would improve in tandem with price as the medical profession's competitive strangle-hold was broken.

Second, courts began to identify quality with consumers' preferences, as well as professional standards. Because competition law is explicitly based on a model of consumer sovereignty, it encourages consumers to treat health care like any other market in which they insist on value for money and on the information necessary to make buying decisions.

Third, courts started to look beyond physicians

to other components of the health care system with the power to define and influence quality through competitive interaction.

Fourth, courts began to reassess their attitude toward quality-oriented self-regulation by the medical profession.

While maintaining the position developed in Goldfarb and Indiana Federation that consumer welfare must ultimately be defined by consumers, competition law is becoming more open to collective action by health professionals, as long as it is designed to remedy specific market failures.

Let me emphasize a few specific points. First, competition law has empowered hospitals to define quality. Perhaps the clearest effect of competition law on quality was to allow the hospital to escape its image as a doctors' workshop and to establish itself as an independent clinical and economic actor.

Impelled primarily by Medicare cost containment, hospitals began to assert control over clinician staffing of certain departments through exclusive contracts with physician groups.

Physicians who lost their affiliations often sued, claiming competitive injury. For the most part, courts were unsympathetic to physicians' complaints,

holding that the hospitals' competitive interests in reducing costs and assuring quality entitled it to limit physicians' access. In other words, antitrust courts effectively analogized hospitals to producers and physicians to retailers of hospital services.

Drawing on experience in other industries where distributors challenged restrictions imposed by manufacturers, competition law concluded that, in part for quality reasons, inter-brand competition between hospitals for patients was more beneficial to consumers than was intra-brand competition between doctors working in a single hospital.

Antitrust law also preserved professional peer review, and courts were similarly inhospitable to the large number of claims brought by physicians whose hospital privileges were restricted after peer review.

Now, Congress immunized bona fide peer review by passing HCQI in 1986, but even without that statute, judges had very little difficulty distinguishing physicians' economic interests from their professional commitments to quality.

In one respect, I would point out staff privileges cases have had problematic effects on the legal analysis of quality-based competition. Although traditional peer review was protected, courts began using

quality to remove conduct from the purview of competition law rather than factor in quality into an overall competitive mix.

Courts also managed to assert choice as a competitive consideration. The FTC successfully challenged professional opposition to new forms of health care delivery and financing, such as HMO's, non-physician practitioners, hospital-sponsored clinics, and out-of-town brand name providers.

Among the few victories won by private plaintiffs in staff privileges litigation were cases involving demonstrably different styles of medical practice that would otherwise be unavailable to patients.

Overall, I think, courts have been much quicker to grasp the competitive importance of assuring consumers a range of health care products and services than they have been to examine the direct effects of provider conduct on clinical processes or clinical outcomes.

Now, courts may feel more comfortable judging dimensions of quality that do not require technical knowledge, but the recognition that consumers' definitions of quality are broader than those of professionals was itself a critical insight.

On the flip side, courts managed to limit choice to its competitive meaning and not simply reject

certain conduct by regarding choice as an absolute constraint on marketplace behavior.

Courts hearing a health care dispute never wavered from the view that antitrust law protects the competitive process and not individual competitors.

Two observations flow from this approach. First, competition law helped the health care system distance itself from physicians' traditional argument that free choice by patient of physician and physician of patient was essential to quality. Instead, courts embraced the idea that choice matters to quality only insofar as consumers value it. This approach is evident in a series of antitrust cases challenging health insurers that contracted selectively with providers. Limiting choice of physician to enable choice among forms of insurance was considered quality enhancing and, thus pro-competitive.

Second, by assessing limits on choices, they affect entire markets, not individual patient-physician relationships. Competition law raises the possibility of defining quality in population-based terms in future cases.

A fifth point is that competition law empowered purchasers to define quality.

A consequence of competition law's commitment

to consumers has been its willingness to accommodate the preferences of health insurers acting as purchasers rather than those of physicians and hospitals acting as health care sellers.

In health care, the historical overhang of guild protective behavior by physicians led courts to look elsewhere for patients' economic agents, indirectly empowering insurers and employers to articulate competitive preferences for price and quality.

Although competition law imposes some restrictions on very large purchasers, the fact that consumer welfare is the touchstone for competitive analysis implies that buyer-initiated changes are generally encouraged.

Sixth, courts encouraged disclosure and prevented deception. Information, as we've heard this morning, occupies a special place in the evolution of health care competition law.

Long before mandatory disclosure requirements and consumer report cards, courts struck down efforts by professional associations to limit the collection and dissemination of such information.

An important early case was brought by the FTC against the AMA and resulted in the AMA's being enjoined from enforcing ethical restrictions on advertising.

Subsequent cases followed a similar pattern, and private plaintiffs alleging informational harm enjoy a much higher success rate than those who bring any other type of private health care antitrust claim.

Now, of course, accurate abundant information is an important element of quality-based competition, because it enables consumers to define and exercise their preferences along many dimensions of quality.

The biggest challenge for courts, evident in the California Dental decision, has been to balance the pro-competitive effects of accurate information against the anticompetitive effects of false or misleading information. Now, some commentators view California Dental as a resurrection of a footnote to Goldfarb, preserving anti-competitive prerogatives for the learned professions. However, the case can be interpreted simply as requiring lower courts to carefully evaluate professional self-regulation based on its actual effects in the marketplace.

So let me conclude by suggesting a few ways -- a few things that competition law perhaps should do next with respect to quality.

As I have said, competition law has successfully defended price competition in health care, and courts have made some progress incorporating quality

as a competitive dimension directly. However, the recent rapid conversion of the health care system to market governance places, I think, greater demands on competition law. For market processes to result in the appropriate mix of cost, quality, and output, competition law must be pro-active. In other words, quality must be fully factored into the competitive mix, allowing consumers to weigh both price and non-price characteristics of health care. Courts have had few guideposts for this endeavor.

Developing an effective analytic framework requires reconciling opposite notions of quality. Competition law treats quality as one attribute of a good or service which must be traded off against price and other attributes, while the medical profession has historically regarding quality as a irreducible minimum to be determined by physicians without reference to cost.

The rise and subsequent decline of managed care has not eliminated this conflict, but it has changed the landscape in important ways.

First, managed care has sensitized judges to trade-off's between price and quality. Indiana Federation was written as if the primary reason for utilization review was the elimination of waste. A judge familiar with managed care would be more likely to

perceive the review procedures as enforcing a price-quality trade-off.

Second, the battle between managed care and pharmaceutical companies, played out in the market through pharmacy benefit management and direct-to-consumer drug advertising, has highlighted the importance of non-physicians in the health-care system.

Third, managed care has increased judicial skepticism regarding the motives of insurance companies that claim to be agents of consumers. Courts may well have become more willing to accept the medical profession and nonprofit hospitals as patient representatives.

Fourth, the bottom-line orientation of some managed care plans has forced the question of whether a market model is compatible with traditional social objectives in medicine such as compassion, charity, and trust.

The first thing that courts -- that competition should do in the future is to treat all quality claims as empirical issues. Courts have historically regarded -- relied on presumptions and burdens of proof to handle health care antitrust claims.

As noted previously, California Dental requires judges to decide quality cases based on objective empirical evidence. Unfortunately, statistical analysis

of quality is, as yet, virtually invisible in antitrust litigation. For example, the well-established relationship between hospital volume and quality has yet to be reflected in legal analysis.

A second thing competition law should do is preserve technological innovation at the patent-antitrust interface. Legal protection of innovation depends on a complex interaction between patent law and antitrust law, the former granting a conditional monopoly as an incentive to future inventors, the latter attempting to confine the monopoly narrowly to benefit current consumers. These factors make it particularly important for the FTC and DOJ to make pharmaceutical and medical innovation cases an enforcement priority, as, indeed, they have done in recent years.

A third thing competition law can do is to foster organizational and informational improvement. The IOM's two reports repeatedly emphasize the adverse quality implications of a fragmented health-care delivery system. Competition law can help to address this problem, because it encourages providers to integrate clinically and economically.

More generally, direct economic incentives for providers to improve clinical processes are insufficient. This public good aspect of health-care production

suggests that competition policy should look favorably on collective strategies for knowledge generation, figuring out the right thing to do, and knowledge dissemination, getting people to do it. The FTC and DOJ have taken a step in this direction by concluding that providers who integrate clinically by developing clinical guidelines or shared information systems may qualify for antitrust protection.

A fourth item on the future agenda is to address risk selection and insurance issues. A more detailed examination of insurance risk may be necessary if competition policy is to promote clinical quality and efficient price-quality trade-off's.

As a general matter, competition policy is agnostic to the axis along with competition occurs and simply defers to market preferences, but health insurance bears an uneasy relationship to both competition and quality. Insured patients may be insensitive to the price of health care services, leading them to select services of high apparent quality but low cost-effectiveness. On the other hand, competition in insurance markets may be more vigorous in attracting people at low risk than in promotion efficiency in health care delivery.

A fifth agenda item is to protect consumers

directly. Health care competition policy is emphasized antitrust, leaving consumer protection enforcers to focus on out-and-out fraud such as cancer cures, miracle weight-loss products, and the like.

Consumer protection in health care more generally is an unexplored frontier. For example, new but unproven medical treatments that are not subject to FDA regulation or human subjects research controls may be appropriate subjects for consumer protection enforcement if they are marketed inappropriately.

A sixth item on the agenda is to assimilate public purchasing. Public dollars make up about 45 percent of the 1.3 trillion that the U.S. spends annually on health care. Public purchasing distorts prices, over-builds capacity, and skews the development and dissemination of technology. Competition law has largely ignored this reality and indulged the belief that U.S. health care is a private system governed by private competition. In the future, close attention should be paid to the government as both a source of and a remedy for private market failure. For example, competition policy could influence the use of government purchasing power to develop and implement market-oriented solutions to quality problems such as standardized consumer information.

Finally, Congress, the enforcement agencies, and the courts must also decide whether and how consideration such as charity, access for the uninsured, and therapeutic trust between patients and providers, atypical subjects for economic analysis, should be incorporated into competition policy.

These issues have surfaced primarily in challenges to nonprofit hospital mergers, perhaps explaining some unexpected results in those cases.

In FTC vs. Butterworth Health Corporation, for example, the District Court dismissed the concerns of paying customers, managed care organizations, because they purchased care selectively for their own enrollees. Instead, the court looked to the interests of hypothetical consumers, including people who could not afford medical care but, nonetheless, needed it.

In addition, courts may misperceive antitrust claims involving hospital mergers as calling into question the overall trustworthiness of major community institutions. The goal of a hospital merger case is to prevent the acquisition of market power that will be exploited economically. However, nonprofit health facilities are widely presumed to be acting in the public interest, and this expectation is an important part of the reason for according them nonprofit status in the

first instance.

In Butterworth, for example, the court assumed that increased revenue to the merged hospital would be spent by the board of trustees on improving quality and helping the uninsured.

Similar judicial instincts may come into play in the recently-filed antitrust challenge to the National Residents Matching Program, which confronts courts with the uneasy possibility that overturning collective restrictions on salaries for medical trainees will increase operating costs and reduce access to services at teaching hospitals. Competition policy must grapple more explicitly with these beliefs and effects, if only to avoid leaving them to the ad hoc impulses of Federal district court judges.

Thank you.

(Applause.)

MR. BYE: I'd like to thank all our panelists for their excellent presentations this morning and note that we'll start back at 2 p.m.

Thank you.

(Applause.)

(Whereupon, a luncheon recess was taken.)

A F T E R N O O N S E S S I O N

MR. BYE: Good afternoon, and welcome back to the Federal Trade Commission and Department of Justice hearings on health care and competition law and policy. My name is Matthew Bye.

In this afternoon's session, we'll continue to explore issues on the provision of quality information in relation to hospitals.

We are fortunate to have eight expert panelists with us this afternoon. I'll briefly introduce each of the panelists in the order that they will give their presentations. The panelists' complete biographies are available in the hand-outs. Following the presentations, we will move to a very brief panel discussion.

We are waiting for one more panelist, but he will come in a bit later this afternoon.

Irene Fraser directs the Center for Organization and Delivery Studies of the Agency for Healthcare Research and Quality.

Stuart Guterman directs the Office of Research, Development, and Information at the Center for Medicare and Medicaid Services.

Suzanne Delbanco is the executive director of the Leapfrog Group.

Nancy Foster is the senior associate director

for health policy at the American Hospital Association.

Woodrow Myers is the executive vice president and chief medical officer at WellPoint Health Networks.

Anthony Tirone is the director of Federal relations at the Joint Commission on Accreditation of Healthcare Organizations.

Arnold Milstein is the medical director at the Pacific Business Group on Health.

We have an additional panelist who wasn't mentioned on the hand-out's, and that is Cathy Stoddard, who is a registered nurse at District 1199P at the Allegheny General Hospital and is representing the Service Employees International Union.

I might ask the panelists to relocate to the audience, because we'll be giving presentations for the first almost two-and-a-half hours, and it might be easier for you to watch PowerPoints if you're seated in the audience, and also ask Irene to commence.

MS. FRASER: Well, good afternoon.

I would like to do several things this afternoon. One is to identify the role of our agency, the Agency for Healthcare Research and Quality. Our role in quality, to talk about four interrelated quality initiatives at AHRQ -- there are many others, but these are the four I am going to be talking about today -- and

then to get some input from you on some future steps and ways that we might work with the various organizations that are represented here.

There's been, of course, a great deal of press coverage and a great deal of concern about quality in the media and in the American public in the last several years, and this is tied very much to concerns about cost, as well.

For those of you in the back who can't read the caption there, he's saying to the patient, "If you're wondering why your bill has that additional charge of $22,000, it's because Dr. Cromborg lost his Rolex watch somewhere inside you."

So, the concerns about quality lead to three different but interrelated questions. The first is how good is care in the United States or at any particular geographical level one might look at?

A second question is how can I improve care? And that's a question that's asked by people that are looking not to tracking, per se, but to internal quality improvement, whether that be within a hospital or within a health plan, within a clinic, et cetera.

And then the third question is how can policy improve care? And that's the kind of question that organizations like the Federal Trade Commission, state

regulatory agencies, Congress ask. What kinds of things can we do to make sure, from the policy side, that quality can improve?

The answers to all of these kinds of questions are really quite complex and require a lot of things from researchers, as well as others.

They require good measures, so that we're measuring the right thing accurately, and there are a lot of people, many of whom you will be hearing from today, who are in the business of developing those measures.

It also requires populating those measures. It requires actually having data produced from those measures. It requires good methodologies for aligning the data and a good presentation format so that it all makes sense.

You need that for all of the questions, but the kinds of needs that you have are going to vary, depending on which question you're asking, and that's something that's going to come up a couple of times in my presentation and may be a topic for discussion later.

You need -- not only if you really want to improve care, whether you are a policy maker or a clinician or even a consumer looking to use your own market power, it really requires not just data and measures but information on actually how to act on that

in order to improve care.

So, you need to know what kinds of clinical interventions or changes could be helpful, what kinds of training programs can make people more adept at implementing some of these changes, and you need to know how the payment system affects quality. You need better IT, et cetera, and the role of the consumer can be key, as well.

The role of the Agency for Healthcare Research and Quality, which is part of the Department of Health and Human Services, is to conduct and support research that can be used in endeavors such as the one that we're describing. To then synthesize and disseminate that research and then to find ways to actively promote the implementation of evidence-based approaches, whether that be from our research or the research of others.

So, we like to think of that as kind of a hierarchy of research. What's important is to have research that can improve other research, that can improve the state of knowledge, but we're really -- our job is not done until that research actually gets put to use to improve policies and practices and ultimately health care and outcomes and efficiency.

I'm going to give four illustrations of initiatives that are conducted by the agency in the area

of quality but that have either an existing or strong potential impact on cost and efficiency, as well.

The first of these is the National Health Care Quality Report. Several years ago, Congress mandated that we produce each year a report on the state of quality in the country, national trends in the quality of health care provided to the American people, and 2003 is now upon us. The end of fiscal year 2003 is, in fact, in September, and along around September 30th, this is probably something that you all will be seeing. Our report will be going to Congress and then made public shortly thereafter.

It has been a very long exciting but strenuous activity involving a lot of activity with all sorts of players around the country.

One of these players was the Institute of Medicine, which helped us in providing a conceptual framework for the report, because of course, the first question that you have to ask when you're asked to report on quality is, well, what do you mean by quality, what kind of quality, for whom, under what kinds of circumstances, and this conceptual framework has been very helpful.

What the Institute of Medicine, after consulting with lots of folks, came up with was four

particular domains of quality -- effectiveness, safety, timeliness, and patient-centeredness -- that we are going to try to populate with data in the national quality report.

There's actually two other dimensions of quality that will be running through it. The first is equity, and the second, which I'll talk about a little bit more later, which is not explicitly running through here but is sort of a gleam in our eye for the future is efficiency. The domain of efficiency is not really explicitly addressed in any great detail in this first report.

So those are kind of the components, the columns, if you will.

In terms of the rows, obviously health care has a lot of different dimensions, from preventing illness all the way through end-of-life care, staying healthy, getting better, living with illness or disability, and end-of-life care, and it's important as we assess the quality of health care in the country to make sure that we are assessing all of those different domains, and so, that's the overall structure of the report.

There's been a massive effort, as I mentioned, in terms of helping to design the report, a lot of consultation not only across the department but with

many, many other organizations in the private and public sectors, as well. All in all, there are about 150 measures of all of these different components of quality, with a whole array of data sources.

In this first report, most of the data sources come from Federal agencies simply because we needed data that was fairly readily available and available to us and that was collected on a national scale. Our hope is that with each report, the proportion of data from other sources will be increasing.

In terms of reporting, we're not thinking about a single report but really both a web-based and a paper-based report that takes various forms, depending on the particular audience, whether that be policy makers, analysts, or the general public.

We see the quality report has having many, many potential uses, again varying depending on the audience -- to inform policy makers, to monitor progress over time, provide some benchmarks for the future, identify some areas for improvement, and help serve as a catalyst for action, both in improving quality and improving the quality of the measures and the data themselves.

So, we expect that, with this first national health care quality report, that we can provide a baseline nationally; we can provide the overall framework

that states and markets and localities can use to drill down and report some of the same data at the local and market and state level.

Also, it is serving already as a mechanism through which to unify some of the measurement and improvement efforts across the department, since we have had many, many, many meetings across the department in designing this. It has helped to unify some of those efforts. And finally, it's a prototype for later refinements.

Greg Meyer, who was the -- formerly the director of our Center for Quality Improvement and Patient Safety within the agency, who was leading this effort, used to say that a main goal for the agency was for there to be a second report, that this is really a prototype and we expect to be improving it with each addition.

There are many challenges, several of them that I think are germane to some of the discussions that you all have been having here, and actually, yesterday, the agency and the Federal Trade Commission cosponsored a small expert meeting to talk about -- right here in this room, in fact -- to talk about some of the common issues and research concerns that we had, and some of these challenges very much came out in those discussions

yesterday.

The first is moving from national to market-level data, because it's not enough from a consumer perspective or even from the perspective of most policy makers to know the state of quality nationally. What you want to know is what's the state of quality in your market.

Moving from measurement to improvement -- I think that's going to be a big impetus as soon as the first one comes out, and it's certainly one we've been giving a great deal of thought to, is how you can empower people that are reading the first report to use that as a basis for quality improvement. And then, finally, thinking about adding a cost and efficiency dimension to future reports.

A second initiative that I'm going to mention to you is the health care cost and utilization project. This is a state, Federal, private sector partnership among, now, 34 states, either state data organizations or state hospital associations, are the major players with that, and the agency, and basically, what we do in this initiative is take all of the hospital discharge data in those states -- so, it's now 34 states of hospital discharge data -- so, it's from every single hospital, basically, in those states -- and we put it into a

uniform database that can be used for cross-state analysis and improvement.

Because of which states these are, the database now has 80 percent of all of the hospital discharges in the country.

So it's complete for 34 states, but even if you look nationally, it's 80 percent, actually soon to be 90 percent of all of the discharges in the country.

It also includes web-based products and software tools.

It includes not only clinical data but charge data, data by payer, et cetera, a capacity to move that data to the cost level, and it's now going beyond the inpatient arena to include emergency department and ambulatory surgery. From this, we put together several publicly-available databases. The state inpatient databases, which are basically what we got from the states but we returned back to the states in a uniform format, so that you could do a research project looking at four states or five states and looking at them over time.

The state outpatient databases, which is a growing set of databases from the ambulatory surgery area -- I think there's now about 15 states of ambulatory surgery data and about seven states of emergency

department data.

From all of this, we also distill a nationwide inpatient sample, which represents 20 percent of all of the hospitals in the country, weighted to approximate a national sample, and so, that can be done for national studies, and then, more recently, a kids inpatient database where we extract from all of the children's discharges in our overall 80 percent that we've accumulated, so that we can get a richer database just for children, because children aren't hospitalized as often, many of their diseases are quite infrequent, so you need a different kind of sampling methodology to really be able to speak to the children or to children's diseases.

The strengths of this database are that it captures all of the hospital stays in a state, which then means that you can do market-level analyses, which is the reason I'm bringing it all up in this context.

You can do sub-population focus, so that you can even look at, you know, Hispanics within a given market, because it's not a survey, it's rich enough, it's robust enough that you can look at the way -- you can dig all the way down to those small cells.

You can also look at very rare diseases or procedures. You can look at care for the uninsured, as

well as other -- those that are covered by various payers, and you can link it to others. There's 10 years of data, so you can also do trend analyses.

From this, we have developed a whole variety of tools -- a clinical classification software, which is a grouper for doing analyses that combine some of the ICD-9 and ICD-10 codes; some co-morbidity software; quality indicators, which I will mention in a minute in a little bit more detail, and then a variety of fact books and statistics and so forth.

Much of the data are up on the web, through something called HCUPnet, which is really a very easy point-and-click mechanism through which to get data not only at the national level but at the state level, as well.

What HCUP -- one of the lessons that we learned from HCUP is that there are ways, fairly inexpensively, to get data that can be useful at the market level and that can be a very high-value effort, and so, if you take data that providers are already collecting as sort of the first principle and then partner with the people who really have it and know it -- in this case, state data organizations or hospital associations -- turn it quickly into information and then in a form that the audience wants it and can use. You can then enable analysis and

improvement at various levels all the way down to the provider level. So we've been trying to apply this formula to other efforts.

I'm going to just very briefly mention four of these. We have an HIV research network, which is 18 very large providers of HIV care in the country, and they have been pooling their data.

We are in the process of creating a medical group practice database that the -- this is an effort that the MGMA is leading for us in collaboration with some others -- the integrated delivery system research network and the market file.

I'm going to just say a couple of things about the integrated delivery system research network.

This is a consortium of -- it's actually a consortium of consortia. It's nine practice-based research consortia which actually represents managed care organizations, hospitals, other providers across a continuum of care in health care markets in all 50 states. They then work with us through task orders doing usually very quick turn-around studies using, for the most part, their own data. Most of these are funded by us, but others are co-funded by other Federal agencies, as well, and this is just -- gives you a glimpse of just the phenomenal size and breadth of this network.

All together, it covers over 50 million patients, and it includes all kinds of delivery sites. It includes the uninsured. It includes Medicare, Medicaid, demographics, rural, urban, et cetera. So, almost -- it's a huge database and has a huge research capacity.

The final data piece that I wanted to mention is still very much kind of a gleam in our eye, but we've had some feasibility studies done on it and have taken some of the original steps on it, and this is to create something that we're calling the market file.

The genesis for this is that we've been funding studies of health care markets for many years, but there are some severe problems with the data that we've discovered, not just the data themselves but the use of the data. Data that can get down to the market level are quite rare. A lot of -- most of the data that you can find that has some of the economic and social variables that you might be interested in are nationwide samples, but then you can't drill down to the market level.

They're drawn just from one provider, whether that be hospitals or physicians. They're single-purpose. In many cases, they were created by the people that wrote the grant application. We give them the money, they buy the data, then they have the data. If somebody else

wants to do a similar study, we've got to pay them to do it all over again, or someone else does. And they're inconsistent. Different studies will use different definitions of markets, different measures, et cetera.

So our thinking -- and this is something that we've had discussions with quite a few folks on and a feasibility study fairly recently -- is to start with all of the existing data, HCUP data, other data that are out there, bring together all of the available data on markets that exist now, do it in such a way that you can permit flexible boundaries for defining the market by what to exclude or include, and the researcher or policy analyst could make that determination, and provide one-stop shopping for both policy information and research data.

In some cases, the data files themselves would be downloadable. In other cases, there would just be a link to whoever you need to contact to get the permission to then download them. And there would be some high-quality documentation of the data, et cetera.

So this is something that is still, as I mentioned, a gleam in our eye. We've taken some of the preliminary steps, but we certainly welcome input on it.

A third thing that I wanted to mention actually ties back to the HCUP data. In the early 1990's, the

HCUP state partners asked us to help find ways to help them make better use of their data and ours, and what they asked for was some basic measures of quality that they could use as screening tools for state-level or hospital-level quality improvement, and the primary constraint was that it had to be something that all of the states -- then I think it was only nine or 12 -- all of the states could use.

So it had to all come from the hospital discharge data, without any kind of need for linking, and based on readily available data elements, elements that all of the states had.

We did that actually intramurally in a first shot way.

There was a lot of interest, a lot of use made of it, but then when it became clear that we were going to be doing the National Health Care Quality Report, we decided that we wanted to do a second cut at this, a more systematic approach that would actually provide some risk-adjustment mechanisms, et cetera, because it was expected that we would be using data -- using the quality indicators in the National Health Care Quality Report, as, indeed, we have.

And so, we let a contract to our Evidence-Based Practice Center at Stanford UCSF to assess the quality

indicators that we had in use at the time and develop some new ones for use in the National Health Care Quality Report. And they had a very elaborate and sophisticated methodology involving a lot of technical experts and users and an evaluation framework, literature review, et cetera. I'm not going to go through the whole methodology, but it was extremely rigorous, and then they created three different modules of quality indicators.

The first are the prevention quality indicators, which some of you may just know by the term "ambulatory care sensitive conditions." These are just things where you take hospital discharge data and it will tell you how many admissions there were in your area for, say, pediatric asthma.

You know that shouldn't be a very common kind of admission, that if people were taking -- getting the right kind of preventive care and had other good health promotion in the community, there wouldn't be very many admissions. So, you can use that kind of as a rough window on the community.

A second module comes closer to measuring the quality actually in the inpatient arena. These are the inpatient quality indicators. And then, finally, the latest module, which is a set of patient safety indicators.

National data using both the prevention quality indicators and the patient safety indicators are in the National Health Care Quality Report, and our expectation is that state data will be added later, as well. In fact, there are some illustrations in there of uses of state data.

The quality indicators have been and we expect will be used for a whole variety of things, answering those fundamental three questions that I posed at the beginning of how good is quality, how can I improve it, and what are some of the policy issues.

It's been used for tracking. It's been used for research, for quality improvement, and probably most germane to the Federal Trade Commission, it's also being used actually in somewhat of an off-label use for quality reporting.

The people that developed them did not develop them for this purpose, but there are, in fact, two states -- the Texas Health Care Information Council and the Niagara Health Quality Coalition in New York -- that are using them for statewide reporting at the hospital level of data, and it will be very interesting to see what impact that has on the market.

Some future directions for the quality indicators are to continue to refine them, particularly

in light of their current use for reporting, which was really not an originally expected use; to expand them in some new areas, including pediatric; to expand them in the outpatient arena; and to try to find some expanded data sets that include some of the -- the richer data sets in some of the states.

The final thing that I'm just going to mention very briefly is that we do have a body of both intramural and extramural research on markets and competition and, in fact, have a program announcement in this area that is on the streets at the moment.

And there are a whole variety of questions related to competition and markets that are addressed through that ongoing research and that we have a continuing interest in seeing in the future related to the competition itself: the factors leading to consolidation; and the impact of consolidation both on quality in general but also on different subsets of quality, on different patients with different types of insurance, because it's likely there's market segmentation going on there, and so, consolidations might have an impact on one -- a disproportionate impact on one type of group.

Whether or not they lead to clinical integration -- a question that came up yesterday is when

you have a consolidation of -- a merger of two hospitals, does that -- each doing, you know, 100 CABG's a year -- does that mean that now they're doing 200 CABG's or does that mean you have two sites each doing 100 CABG's?

What's the role of incentives in mediating the link, financial incentives in mediating the link between competition and quality?

We're doing a good bit of work, along with the Robert Wood Johnson Foundation, a project called Rewarding Results that is looking at the issue of financial incentives, and you may hear more about that from Suzanne.

And then, what is the impact of the report cards such as the ones that we're seeing in New York and Texas?

So, that's all I have, and here's some web-sites for further information.

Thank you.

(Applause.)

MR. BYE: Thanks very much, Irene.

Stuart Guterman is up next.

Also, I'd just like to point out to panelists that Cecile Kohrs, from our office, is keeping track of time. So when she waves the two-minute and stop signs, we would appreciate it if you could conclude.

MR. GUTERMAN: Thanks, Matthew.

When I was contacted to give this talk, I was asked to address the issue of consumer information and quality in hospitals, and that's primarily what I'll focus on, but I'll stretch the mandate a little bit.

Actually, the way CMS is focusing on the use of information, we really have three users of information that we're focusing on.

Of course, the agency itself as a purchaser has used information for a long time, although we're certainly accelerating our use of information and getting into the payment policy and information and quality arena. I'll talk a little bit about that at the end. And we've been trying to find better ways to use information to enhance the quality of care, and being collectors of a lot of information, the process of paying bills. So, we've been focusing on that more and more.

The two sort of arenas that we have entered into much more aggressively recently are providing information to Medicare beneficiaries or their agents, because we think that -- and it's certainly the belief of the administrator, Tom Scully, that it's very important to have information out there to allow people to make good decisions in terms of which providers to use, and I'll review that, as well.

And then a third use of information, which actually is a byproduct of the second, is the providers themselves, because I think it was well documented in the State of Pennsylvania that when the State of Pennsylvania started putting out quality information on hospitals, that there was actually relatively little use of the information by consumers of hospital services but a lot of that information was put to use by the providers themselves, because no hospital wanted to be at the bottom of the list when it came to quality.

And so, there was a lot of effect of improvements in quality affected by the availability of information, because hospitals would look at the information and hospital administrators would call physicians and department administrators on the carpet for looking bad and try to figure out ways to improve their performance.

So, first I'm going to cover CMS's strategies for improving quality. I'll talk about some of the efforts we've made to put information out there for consumers and providers to use, and then I'll talk about a couple of initiatives that focus particularly on hospital quality improvement, including one that I can talk about now because even though the project hasn't been approved yet, it was the subject of a Wall Street

Journal article. So, I'll just cover what was in the article and won't be violating any policies.

This is a chart that we frequently use to sort of portray -- the main thing here is the bottom line -- to portray the different approaches to improving quality on the part of the agency. We can support improvements in provision of care. We can try to promote collaborations and partnerships.

We also -- we recently changed the names of what used to be called the peer review organizations, which were created in the early '80s as essentially utilization review entities and now are called quality improvement organizations, and it's not just a cosmetic -- it's not just a name change.

The purpose -- these organizations that are contractors of CMS actually are mandated to work with providers to explain what they can do better to use data to identify problem areas and to really improve quality, rather than just review utilization patterns.

We've put a lot of effort into providing information for consumers and other people who help make choices for our beneficiaries. We've tried to focus on coverage and payment that makes sense in order to provide better care for our beneficiaries. We are entering the area of rewarding desired performance more along

financial lines, and of course, we have a regulatory role, as well.

People complain about the 130,000 pages of regulations that the Medicare program issues, but many of those pages are intended to safeguard the Medicare beneficiaries, as well as the Federal Government, and it's what happens when you have to run a national program.

This is a graph that actually I've historically found hard to figure out, but I put it up to show one main idea in terms of how we view these things, because there's always an issue when you're trying to enhance quality whether you're going to reward improvement or establish thresholds that require a high level of quality, or the third option, which is the one that we subscribe to, which is to try to improve quality.

So if this red curve in the middle shows sort of the distribution of performance, what we'd like to do is get to the yellow curve, which means that we not only establish standards and try to get people to cluster around standards but also establish standards that are higher than the median standard that exists today, as opposed to merely establishing thresholds, which would get you something like the green curve, where the performance would be clustered around the threshold, but

the threshold might be lower than you'd want performance to be.

In November 2001, the secretary announced a set of new quality initiatives, the purpose of which were to empower consumers to make more informed decisions regarding their health care and to stimulate and support providers and clinicians to improve the quality of health care, and you can see more about what was said there on our web-site, cms.hhs.gov/quality.

We've begun -- one step in this is to produce information comparing providers. We started out in 1999 with information that compared health plans in each market area for beneficiaries. In 2001, we established a set of comparisons of dialysis facilities for end-stage renal disease patients, and we're always trying to improve on those, as well. I just came from a press briefing where we announced the release of a solicitation to do a capitation ESRD disease management demonstration that's intended to bring the benefits of coordinated care to the SRD population, and it involves collecting data and holding dialysis providers to quality standards.

We recently and very successfully, last year, issued a set of comparisons for nursing homes. We publish -- we take out full-page ads in local newspapers. We have the comparisons on our web-site, and that's

turned out very well. People have reacted very positively to it, including the nursing home industry, at least most of it, because it sort of provides a more explicit way of comparing facilities.

We've also come up with a comparison of home health agencies, which we've just put out there, and we're hoping in about a year to put out a similar set of information about hospitals.

It's interesting that, in most analysis, hospitals have been the focus -- first focus of analysis, because generally the data tend to be more easily available on hospitals than any other kind of provider, but you'll notice here that hospitals are bringing up the rear in terms of being able to publish information that compares quality of hospitals, and not because there's no data on hospitals -- there certainly is a plethora of data -- but there's really very little agreement, and it's very difficult to measure the performance of hospitals in terms of quality, and we feel we've come a long way.

Those of you have been in this business a while may remember, in the late '80s, when HCFA put out a set of hospital mortality data that compared individual hospitals, and that was the first attempt to really do this kind of thing, but we think that the state of the

science was not at a level where we could pull it off, and we were forced to use measures that are fairly -- they're very easy to measure, but they're very difficult to interpret the measure of.

So we've worked very hard to focus -- to develop some more standard measures of hospital quality, and the way we've done that is actually to do some hard work with AHRQ and other organizations, the National Quality Forum, to focus on process-oriented measures. It turns out process-oriented measures are a lot easier to rank hospitals on, because they're fairly standard and they require less risk adjustment, which is really the issue with things like mortality and other outcome measures.

We've got several initiatives to collect hospital quality information. There's a three-state pilot that we have underway where the quality improvement organizations are working with hospitals in three states to collect data on a set of measures, process-oriented measures, that will allow us to investigate the process of collecting the measures, the process of calculating them, the ability to post the information publicly, and then the effects of posting that information, and that's just getting underway.

Part of that three-state pilot will be testing

out a -- an instrument that we call HCAHPS.

The CAHPS survey has been a mainstay in evaluating managed care plans for several years now, and we've -- we're in the process of developing an instrument that can be used to get at the consumer's experience in using hospital care, and that's going to be tested out as part of this three-state pilot, as well.

Our objectives here are to provide useful and valid information to the public, to provide predictability for hospitals so that they know what the measures mean that we're publishing. The standardize data collection mechanisms, which is, to any of you who have tried it, harder than it sounds. To provide support to physicians, who, after all, are the ones who admit patients to hospitals, and other clinicians. And to get the information to hospitals to be able to improve the care that they deliver.

I'd like to mention for a minute the -- how important it is that we're focusing -- or the rationale for focusing on process-oriented measures. For a long time people who have been talking about quality have said, well, consumers don't buy health services, they buy health. Well, it turns out, I think, that that's wrong. Consumers actually buy health services. They want health, and they buy the set of health services they

think, you know, will provide that health, but it's much easier -- and more importantly, I guess, purchasers purchase health services.

So, it's much easier to incorporate a set of process-oriented measures to the purchase of health care than it is outcomes, because you really don't know what to pay for a patient who lives 30 days or 60 days or 90 days, but you know that if a hospital provides aspirin to a heart attack patient on admission, that that is going to lead to good outcomes.

But it's a process that you can measure, and you pretty well know what you have when you've got that measure, and I think that's an important shift in sort of the objective of measuring quality, because when you try to measure outcomes, it's sort of like saying, you know, for farmers, well, consumers don't buy food, they buy life, you know.

Well, actually, they buy food, and it's supposed to provide, you know, the rest, and it's much easier -- but the difficulty is that if you tell patients, well, you know, 90 percent of this hospital's heart attack patients got beta-blockers, it's much more difficult to explain than to say, well, you know, 95 percent of this hospital's heart attack patients lived for, you know, 90 days after admission. So, we have to

make that -- you know, we have to hook up that connection to be able to explain this information to consumers.

But it's much easier to measure, and it's much less controversial to discuss and to rank hospitals according to these measures, because they are more cut-and-dry, and they are no less associated with what you want as the end product of the health care system, which is quality outcomes.

Let me go on.

The three states in the hospital pilot are Maryland, New York, and Arizona, and the set of clinical measures -- we've got three conditions here that we're focusing on, and these are very specific clinical measures that we're focusing on, and we're developing a way to roll up the individual measures under each condition so that we can come up with a score by condition, and that will allow us to rank these hospitals.

Rewarding desired performance -- as was reported in the Wall Street Journal -- we are considering a project where we will pay for quality, and it would involve a hospital system that involves about, I think, about 500 hospitals that submit information that will allow us to measure quality. They will submit the -- the deal would be that they'd submit the information to us

and that we would calculate the scores and then pay extra for hospitals that are among the highest scorers among the participating hospitals.

We are told that we ought to pay some attention to reducing payment for the hospitals that are among the lower scorers, and that's sort of a catch, because demonstration projects, unlike the program in general, are voluntary. Well, the program is voluntary, too, but you sort of can't say no. And we're trying to work that out.

But the idea here is to provide a defined financial incentive to be among the highest performers on a set of very specific measures, and we'll be testing out how well that works and what kind of quality improvement we get in that project.

So for more information, you can go to our web-site, and we have information on all of the projects that have been approved, so the hospital quality payment project isn't on there yet. Hopefully it will be soon, when we get the final sort of conditions worked out.

And I thank you for inviting me, and feel free to contact me for more information about any of these projects. Thanks.

(Applause.)

MR. BYE: Thanks.

Nancy Foster is our next panelist. Suzanne, sorry.

MS. DELBANCO: Good morning, everyone. I'm going to be pretty brief and just tell you a little bit about where the Leapfrog Group came from, what our strategy is, and focus on the point of today's hearing, which is what our experiences have been like in trying to gather specific hospital information to share publicly with consumers and purchasers.

The Leapfrog Group consists of about 140 large private sector and public sector health care purchasing organizations who collectively buy benefits for about 33 million Americans and spend more than $57 billion each year in health care expenditures, and it came together essentially out of frustration.

Health care purchasers were seeing costs rising out of control, and that was five years ago, not compared to today, and felt that, as they were learning more and more about how the quality of care varied, that they had a sense of feeling that they were not in control of what they were buying, meaning they were spending more and more, but what they were buying could be good or bad, but they weren't differentiating in any way in their purchasing activities.

And so, the founders of Leapfrog got together

and tried to figure out how to leap over the gridlock in the health care system that was preventing us from taking advantage of the know-how and the technology that we have today to significantly improve the overall safety, quality, and value of health care for Americans, and as they thought about the health care system, while it's much more complex than just these four elements that I'm about to describe to you, they realized that every stakeholder in the health care system was, in part, responsible for the gridlock.

Health care purchasers -- and those were the group that founded Leapfrog -- were willing to sort of look in the mirror and say we haven't been buying right. We keep talking about the importance of quality, but when it comes down to it, we choose health care based on the cost.

Secondly, health plans, while doing an incredible amount of activity to improve the quality of care, often have information about how the providers and their networks varies but don't share that information with purchasers or individual consumer members who are trying to make informed health care decisions.

Health care providers, while I believe the vast overwhelming majority go into health care to make people's lives better, without seeing a business case for

re-engineering the way that care is being provided, it's very difficult to make anything but small incremental improvements in quality, because the incentives are simply not aligned in the health care system to do that.

And then lastly but not least importantly, the consumer, the member, the patient, the enrollee, the employee, whatever you like to call the individual person who's seeking health care, really hasn't been engaged, and I think it's, in part, because we haven't been providing information to consumers that is meaningful to each specific patient who has specific needs and is trying to make some specific decisions at a given point in time. So, we have a lot of work to do in that area.

All of this led to the desire to form a strategy for overcoming this gridlock, and in early 2000, the Leapfrog Group was launched, with the support of the Business Roundtable, with this two-pronged approach.

On the one hand, it's about an organized effort on the part of health care purchasers to start trying to buy right, to create a business case for health care providers to re-engineer and vastly improve the quality of the health care that they're providing, and on the other hand, it's about activating and engaging health care consumers to become more informed decision-makers for themselves, but also, frankly, part of the solution

by voting with their feet once they have information that they can use to make more informed decisions.

When our members join Leapfrog, the 140 purchasers I mentioned a minute ago, they are joining a common commitment to a set of purchasing principles that are essentially that two-pronged approach that I described to you.

They commit to inform and educate their employees, they commit to start comparing performance at the provider level where possible, and they also commit to start rewarding performance at the provider level.

To start, the basis for that information to consumers, that comparative performance, that rewarding of providers, focuses on three initial -- what we call safety leaps.

These are three specific practices we recommend that hospitals adopt to greatly improve the safety of care that they're providing to patients, and these are not easy practices to implement. They're not widespread, by any means, today, but we believe that if they are much more widespread sooner than they would have been without us, that patients overall will be much better off.

The three leaps are computerized physician order entry, which is the use of computers to make drug orders that is linked to error-prevention software to

make sure that drug orders are done correctly for patients who are hospitalized.

Secondly, we focus on staffing in the intensive care unit.

When patients are very ill in intensive care, we have found through the research that if their care is managed or at least co-managed by a doctor who has special training in critical care, known as an intensivist, they're much more likely to survive that ICU stay.

Thirdly, we focus on the idea of evidence-based referrals.

For certain patients who have the need for select high-risk surgeries or who have certain high-risk neonatal conditions, if they're referred to hospitals where we know their outcomes are likely to be better, that's a good situation for those patients.

Now, the question is how do you base those referrals? On what do you base them?

Stuart was talking about the difficulty of figuring out how to adjust outcomes in a way that fairly compares the severity of the cases that different hospitals see. There are process measures we can look at, and there are also volume measures that we can look at, which are essentially a structural type of measure

that can become the basis for referring patients.

We're aiming in all three of these categories, where we're really focusing right now on structures and processes, to move as quickly as we can towards outcomes-oriented information.

For example, with the intensivist staffing that I mentioned in the ICU, we're working with the joint commission to develop a risk adjustment methodology and public reporting program so that about a year from now hospitals can report publicly what their ICU outcomes look like compared to their peers across the country, and I can go into more detail about the other steps we're taking to make these measures more sophisticated if we have time at the end.

So, while Leapfrog is a national movement -- we've got employers with employees in every zip code in the nation -- we have focused our efforts regionally, because as all of us know, health care decisions, business transactions, et cetera, happen largely at the local level.

So we have 22 what we call regional roll-outs, and these are efforts to take what is nationally a purchaser-driven initiative and turn it into an effort that is much more about community-wide collaboration at the local level.

The areas on the map in green are the areas where we're working regionally. The very bright green areas are the three regions we just added this year.

In these regions, one of the first hallmark activities that the purchasers organize around is asking hospitals locally to report to a voluntary on-line survey that asks them about their progress towards implementing the three leaps I described.

Again, the survey is voluntary, it's on-line, and all the results that the hospitals report are publicly shared.

You can go to the Leapfrog Group web-site at leapfroggroup.org and see by state the hospitals who have participated and how much progress they're making towards implementing these practices.

Our experience with this has been very interesting. When we started, we had absolutely no idea if hospitals would choose to participate in this voluntary effort to share information with their communities, but we've been absolutely thrilled by the level of participation in many of the regions.

Across the 18 regions where we have made a concerted effort so far to get hospitals to participate, we've had about 60 percent of hospitals respond, and that varies tremendously region by region.

So, about four of the regions where we're working -- for example, the Seattle, Tacoma, Everett area of Washington State -- we've got 100 percent of hospitals who were invited responding to the survey, but in other parts of the country, we have far fewer.

I'm sure Louise Probst, who spoke on the panel this morning, probably mentioned that, in St. Louis, for example, we only have 3 percent of hospitals who were invited to report to the survey responding.

So, we have some work to do, if we maintain our data collection on a voluntary basis, to try to inspire more hospitals to share information.

In addition to the 18 regions where we've made a lot of effort to reach out to hospitals, another 250 or so hospitals have chosen to participate from other parts of the country, and that may be because we want to share the progress that they've made, it may be because employers locally have asked them to, but we're seeing a growing amount of participation with a total of 810 urban area acute care general hospitals filling out the survey.

Now, you might ask whether or not hospitals who have made significant progress towards implementing these leaps are more likely to respond to the survey. That's true to a certain degree but not entirely true.

Among hospitals who have participated, 54

percent meet at least one of the standards that we've set for these practices, but that also means that 46 percent are willing to participate even if they haven't made big progress in implementing this processes which today are still quite rare.

We then post the results on our web-site, and we're now receiving about 200,000 visits each month to the Leapfrog Group web-site, but let me emphasize for you that the Leapfrog Group web-site is by no means the only place where consumers and purchasers and others are seeing these data. Most of the major national health plans are now making these data available through consumer-oriented web-sites. We also have many other dissemination partners, labor unions, some of the commercial web vendors, who are making these data available, as well.

And when we report the data, as you can see here -- this is sort of an example of what the screens would look like if you were to choose a specific state and look for hospitals alphabetically.

You'll see that the darker the circle is filled in, the more progress the hospital has made towards implementing the practice that is being described there, whether it's computerized drug orders or the intensivist staffing, and for the evidence-based hospital referrals,

this is shortly going to be changed quite drastically.

This is focused here just on volume and whether or not a hospital meets the recommended volume threshold that Leapfrog has set, but as of next year, because of some changes we've been able to make to the way that we're going to describe the basis for referrals, this will also include some process and outcomes information, as well.

So, to get to the ultimate point here, health care purchasers who aim to engage their enrollee populations much more actively in becoming informed decision-makers and health care purchasers who also aim to improve the quality of care accessible to their individual enrollees need information as the basis for doing either of those activities.

The information that we make available publicly can be used by consumers, again, to make more informed decisions for themselves and also ultimately to vote with their feet and reinforce in the marketplace the efforts that certain providers have made to make sure that they're providing a superior care that is relevant to a given patient's needs.

On the other hand, providers can also use this information. Having public information that allows them, in some cases for the first time, to benchmark their own

performance against their peers not only can provide information to help them improve the quality of care that they're providing but also obviously can create some incentives to improve because of that public display of their performance.

Now, there are skeptics out there who believe that if we make information available to consumers, they're very unlikely to use it, and in fact, there have been some polls that suggest this.

For example, about six months ago, Harris Interactive had done a poll to try and figure out what proportion of Americans had actually seen quality report cards or various types of quality ratings and found that even though a sizeable minority -- for example, 25 percent of the adults they polled -- had seen information rating hospitals, very few of them said that they used it in actually making a decision.

Now, we could say that's because consumers don't have an appetite for this information or we could say it's because they don't have access to very much information at all or very much information that will actually be meaningful to their specific needs at that specific moment.

And so, one of the points that I'd really like to underscore today is the need to make information

available at the micro level where I, as a patient, needing a certain procedure done, can not only just compare one health system to another or one health plan to another but can ultimately compare an institution's performance to another and maybe not even just the entire hospital's performance but looking at a specific unit within the hospital that is relevant to me and maybe one day even having information about how effective that specific treatment is and whether or not it makes sense to get that treatment at a particular institution.

So while we are starting with this voluntary effort in Leapfrog -- and CMS and many others are doing other voluntary initiatives -- we have a long way to go before we can fairly judge whether or not consumers will actually make use of this information.

So I'll just conclude by saying that we believe that the leap over the gridlock has started. Just alone looking at how many purchasers have joined onto the Leapfrog effort -- when we started three years ago, there were seven; we're now at 140 -- gives me faith that purchasers are reexamining their role in the health care system and looking at ways that they can participate in making more information available and helping themselves, individual consumers, and even providers make more informed decisions.

We've seen a rapid growth in hospitals sharing information with their communities vis a vis the Leapfrog Group survey, and we've just released a new version of it, and we're hoping to see a lot of participation again in the second round.

We've calculated that, for all the hospitals that have participated, now about 70 percent of Americans have access to information about at least one hospital in their community, if not more, and our members, our 140 members, are essentially creating a massive consumer education campaign across the country by making these data available, along with other messages that help put them in context.

We estimate that at least 85 percent of our members have been actively communicated with their enrollees over the last year about these issues, and that's based on a member survey that we're just completing now.

In addition -- and I didn't have time to get into it today -- our members are slowly but surely taking on different ways of rewarding hospitals not only for sharing the information but, of course, also their performance on the particular measures that we're looking at, and we're eager to work with multiple partners to find ways to expand the efforts in these areas.

So thank you very much.

(Applause.)

MR. BYE: Thanks, Suzanne.

Nancy, would you like to be the next speaker?

MS. FOSTER: Thank you. Thank you, Matthew.

Good afternoon, and thank you for allowing me the opportunity to speak with you today about consumer information and hospital quality.

I'm Nancy Foster, the senior associate director of health policy at the American Hospital Association, which represents the nearly 5,000 hospitals, health systems, and other health care providers in this country. In this capacity, I provide policy guidance on issues of health care quality and patient safety.

Lest you think I've just recently come to this, let me tell you that at least half of my 25-year career in the health care field has been devoted specifically to the improvement of health care quality.

Prior to joining the AHA, I was coordinator of quality activities for the Agency for Health Care Research and Quality, where I managed the daily operations of the Department of Health and Human Services Patient Safety Task Force and the Quality Inter-Agency Coordination Task Force, an organization that brought the Federal agencies together to improve health care quality.

Prior to that, I coordinated research on patient safety and quality, and while at the Naval Hospital in Yokosuka, Japan, and at Georgetown University's department of medicine, I planned, initiated, and conducted quality improvement activities to improve the practices there.

For the past year, on behalf of the AHA, I have worked with hospital groups, government agencies, accrediting organizations, consumer groups, and others to develop and coordinate a national initiative that will supply useful information to the public about the quality of care hospitals provide.

This is the same initiative that those of you who were here this morning heard about from Chip Kahn and that was referred to in Stuart's presentation a little while ago. It is the initiative that will populate the hospital compare portion of the medicare.gov web-site that he referred to.

I'd like to begin today by telling you about the genesis of this ground-breaking, hospital-led initiative which demonstrates providers' commitment to sharing information with the public and encouraging continued quality improvement.

Hospital care is the single largest component of the health care in the United States. We treat 612

million outpatients and 109 million emergencies and perform 27 million surgeries and have delivered more than 4 million babies in 2001 alone.

Caring for hundreds of millions of ill and injured patients is an extraordinary responsibility, and it is a responsibility that hospitals take very seriously. Hospitals believe that each and every patient who enters their door deserves the guarantee of safe, high-quality care. As such, quality and patient safety are the cornerstones of every hospital's mission, and care givers are constantly striving to improve the safety and care they give.

Despite hospitals' efforts to ensure safe, high-quality care, we all know that mistakes do occur, and there is both overuse and under-use of some diagnostic and treatment procedures, as described in the Institute of Medicine's landmark reports, To Err is Human and Crossing the Quality Chasm.

Though the exact consequences of missteps in care are sometimes unknown, any preventable loss of life is unacceptable and underscores the need for comprehensive unified approach to quality improvement, which brings us to the discussion of hospital report cards.

The media attention surrounding medical errors,

the advent of the internet and other ways to access information almost instantaneously, and the influence of reform-minded baby boomers who have turned their attention to health care now that their parents and they, themselves, are making much more use of the health care system, have led to an overwhelming public demand for more and better information about hospitals, safety, and performance. And as a result, there has been a proliferation of quality measurement activities.

Organizations such as the Joint Commission on Accreditation of Health Care Organizations, states, hospitals, researchers, insurers, payers, the business communities, consumer organizations, commercial enterprises that compile and sell report cards, and the media have all offered the public different concepts of quality and different elements of relevant data.

A 1994 study by the California Office of Statewide Health Planning and Development identified two national published report cards, 30 statewide and regional report cards, and seven corporate report cards, and the number of organizations trying to collect and use quality data since 1994 has really exploded.

The type of information contained in report cards and rating systems varies dramatically, as we heard this morning. A year 2000 RAND report, Dying to Know:

Public Release of Information on Quality of Health Care, outlined just a few examples of the more than 100 indicators used by different health care report cards.

They include overall mortality rates, mortality rates for specific procedures, cardiac surgery intervention rates, cervical and breast cancer screening rates, immunization rates, the provision of post-hospitalization care for mental illness, checkups for new mothers, overall patient satisfaction, rates of complaints against providers, and the numbers of doctors with particular skills, including communication skills. Not only does the information differ from rating system to rating system to rating system, it is collected using different methodologies, and the validity and the reliability of the data are highly variable.

Providers are confused by the disparate ratings and rankings. The potential for confusing the public with incomplete, poorly analyzed, conflicting, and even misleading information is enormous.

This was demonstrated when the three auto makers -- GM, Chrysler, and Ford -- in the Michigan/Ohio area individually had been producing report cards to help their employees choose hospitals and health plans. Each report card, however, relied on different sets of performance measures and different databases from which

the information was collected.

As a result, the same hospital was often ranked differently from one report card to the next.

Since members of the same family often worked for different auto companies, within the same household they were receiving conflicting reports about which hospitals and which plans were better than others. Recognizing that they were confusing the very people they were trying to help, the auto makers ultimately decided to come together and create a unified approach to rating area providers.

Though as I will describe in a moment, America's hospitals share the goal of most report cards, which is to provide useful information to the public and providers, we must realize that achieving this goal is very difficult.

Many bright, well-educated people have tried, but most efforts have not been embraced by the public they were intended to inform, as has been reported in some studies that were referred to earlier today -- Minnemeyer's review of the HCFA mortality data, Mukamel's assessment of the use of the New York State data, and a study by Shaufler and Modosky which reviewed the literature about consumer report cards that had been published since 1995.

The challenges we face in creating meaningful information -- and by that, I don't mean just data but real information for the public -- are enormous. Let me run through a few of them.

First, we've heard somewhat today about the public's inattention to quality information. Despite the dramatic proliferation of report cards gauging hospital and health plan performance, there has been negligible effect on consumers' decisions.

As reported in the May 27th issue of the Journal of the American Medical Association, a survey of nearly 500 patients who had undergone CABG surgery, or coronary artery bypass graft surgery, at one of four hospitals rated in Pennsylvania's consumer guide, only 12 percent were aware of the report card on cardiac surgery which rated their surgeon or provider, and fewer than 1 percent knew the correct rating of their surgeon or provider and reported that it had been used to impact their selection of where they would seek service.

The study's authors, Eric Schneider and Arnie Epstein, concluded that the public values anecdotal reports from relatives and friends more than the objective reports from other sources such as the government and news media.

Another issue we must deal with are the

competing trusted sources of information that patients do seem to rely on, as referred to by Schneider and Epstein. The report cards and rating systems compete against many other trusted sources of information.

According to a 2000 Kaiser Family Foundation survey of more than 2,000 adults, only 4 percent of the adults had used information comparing quality of hospitals to make a decision about hospitals. Yet, 73 percent of those surveyed felt confident that they already had enough information to make the right decision the last time they had to choose a hospital.

This is perhaps explained by the fact that people rely more on family and friends and doctor referrals than on data displaced from third party resources. Sixty-three percent said their family and friends would have a lot of influence on their choice of a hospital, and 64 percent said the same about their doctor.

Compare that with only 12 percent who said that newspapers or magazines would have a lot of influence on their choice of provider and only 15 percent who said the same of government agencies with their quality reports. In fact, 62 percent said that they would choose a hospital that their family and friends had used for many years and in which they had not had any problems over a

hospital that is rated higher on one of these reports.

A third element that is crucial to the success of these reports is measuring the right elements.

Perhaps the greatest challenge in reporting quality information to the public is determining what information to measure and report.

Often information that is important to the public -- say, for instance, the coordination of care or how particular measures affect any given patient who has multiple conditions or different aspects of care about which they are concerned -- would affect them.

This information is not currently available. There are no scientific measures currently at our beck and call that would enable us to tell people about the quality of care on these elements. And even when we do have specific measures, we have to be sure they paint an accurate picture of hospital quality.

We've just heard from Suzanne about the Leapfrog Group's efforts and what the Leapfrog Group is. May I remind you that they focus on three safety practices -- computerized physician order entry, intensive care unit staffing, and evidence-based referral.

Let me talk a little bit about the ICU staffing. Though intensivists have been associated with

better intensive care outcome, the standard is not an indicator of broad hospital quality, as the ICU represents only a small portion of hospital care. Moreover, the initial definition which the Leapfrog Group used of an intensivist made it virtually impossible for most hospitals to meet this standard. Hospitals saw this as an unrealistic goal and were unwilling to subscribe to it.

The Leapfrog Group also steers members' employees towards hospitals using computerized physician order entry. This is well known as an important safety improving device which can help reduce medication errors, but it is not the only way to effectively reduce medication errors, and the goal here is really understanding how to effectively ensure that the patient gets the right medication at the right time, not implementation of CPOE. Furthermore, a recent estimate of the initial investment of acquiring a CPOE system for a large hospital was $7.9 million in the first year. For those hospitals that are financially strapped, as we heard this morning, that was not an investment they were able to make.

The Leapfrog Group has refined its list of patient safety practices, as Suzanne alluded to, in part based on some recommendations from hospitals, and we

would agree that their measures are better as a result of those refinements, but like Suzanne, we hope to move forward to get to the place where we're measuring critical elements of care, critical steps in the process, and outcome.

We also must ensure that the measures used are true indicators of the care provided and not of other factors. Mortality rates, as we've already heard today, if not properly adjusted for the health status of patients coming into the health care system -- the term of art being used is risk adjustment -- those mortality rates will say more about the severity of patients' conditions than they do about the quality of care provided. As such, the use of mortality rates can lead to damaging and unintended consequences.

Eric Schneider and Arnie Epstein did another study in 1996 looking at the influence of cardiac surgery performance reports on referral practices and access to care in which they surveyed cardiovascular specialists. That report suggests that using mortality rates as a performance indicator deters physicians from operating on risky or especially ill patients.

Physicians and hospitals respond to the incentives that are in front of them.

The physicians surveyed in this study

overwhelmingly indicated that the risk adjustment factor was inadequate, which meant that if they took riskier patients, they would be penalized in the public report.

And the final challenge that we heard a lot about this morning from Judy Hibbard and that you will probably hear more about from Shoshanna Safaer tomorrow is how to turn data into useful information. We want information that is meaningful and useful to both the public and to care givers. Much of the data collected is on highly clinical measures such as the rate of assessment of left ventricular dysfunction for heart failure patients.

What does this information mean to the average person and how does he or she use it? It would even be difficult for patients who have cardiac disease to understand how best to use this information, but for other patients seeking hospital care, it is impossible to understand how it might be relevant to them.

In one case -- the other issue is that we have measures that give competing directions to patients. For instance, in one case, a hospital may perform well on surgical outcomes but have a high infection rate. In another hospital, they may do really well on controlling their infections but not quite as well on their surgical outcome. How is a patient supposed to choose which

hospital would be best for them?

Finally, you heard from Paul Conlon this morning about the need to make sure that the data is actionable to the health care providers and from others today about how to make sure it's actionable to consumers.

Well, let me talk a little bit, again, about the hospital-led quality initiative, because despite the significant problems associated with hospital report cards, hospitals are committed to providing the public with the information they need to be active partners in health care decision-making. Even if consumers do not use quality information as a resource, hospitals' willingness to be held publicly accountable, to help strength public trust and confidence in the health care system, must be recognized.

Hospitals also recognize the valuable role data collection and reporting plays in ensuring continued improvement in safety and outcomes. By arming care-givers with evidence-based universally accepted standards of care, hospitals ensure that patients receive the most appropriate care no matter where they live or which hospital they choose.

To lead this effort, the AHA last fall partnered with the Association of American Medical

Colleges and the Federation of American Hospitals to develop a common framework for collecting and publicly sharing quality measures of patient care in our nation's hospitals.

On December 12th, these hospital groups, with the strong support of the Department of Health and Human Services, the Centers for Medicare and Medicaid Services, the Agency for Health Care Research and Quality, the Joint Commission on Accreditation of Health Care Organizations, the National Quality Forum, the AARP, and the AFL-CIO, announced a national initiative that will provide the public with meaningful, relevant, and easily understood information on hospital quality.

It will foster hospital and physician efforts to improve care while streamlining the duplicative and burdensome hospital reporting requirements now in place. It will standardize data collection priorities, and it will provide hospitals with a sense of predictability about what they are expected to deliver to the public in terms of information. This landmark public-private partnership marks an important step forward in developing predictable, useful, and understandable quality information about hospital patient care.

But how will it work? The initiative begins by asking hospitals to voluntarily report on the 10 measures

that Stuart showed you a little while ago.

These are the same 10 measures that are being used in the three-state pilot project, which is really a fertile ground for learning more about how we're going to improve this effort nationally in order to deliver the best information to the public.

These measures of heart attack, heart failure, and pneumonia were carefully selected based on their scientific validity and near universal acceptance. The Joint Commission and CMS use these measures already, and the National Quality Forum endorsed them as part of their core set for hospitals, meaning they had broad acceptance among purchasers, consumer organizations, and quality improvement organizations, as well.

Once data on these measures have been collected and analyzed by the CMS-approved quality improvement organization, it will be posted to the CMS web-site, initially on a site designed for use by health professionals, which is the www.cms.gov. That will happen this summer.

These data will eventually be turned into real information for the public based on input not only from the three state pilot projects but also experts in the field like Judy Hibbard and Shoshanna Safaer and Carol Conan and others. They will be migrated to this web-site

that is designed for public use in July of 2004.

It's important to note that this is a voluntary initiative, and a mere three weeks after we sent a letter to hospitals asking them to volunteer, we've already had, as of yesterday, 410 hospitals choose to pledge to participate in this initiative.

That is augmented by the hospitals that are already in Maryland, New York, and Arizona, where they had already committed to participate in the three-state pilot project, which will be coupled with this initiative.

Though we are pleased with the widespread support of the quality initiative from hospitals, accrediting organizations, government agencies, and quality and consumer groups alike, there are many challenges ahead. One of the greatest challenges in implementing the quality initiative will be translating the highly clinical data collected into information for the public.

Most of the standards currently available were designed for use by clinicians to lead to better outcomes. That's why they have been incorporated in CMS's efforts, which are designed to encourage quality improvement, the same for the Joint Commission.

They were not intended to help the average lay

person select a provider. Thus, much effort must be devoted to determining how best to shape and present this information in an accessible, user-friendly format before it is available publicly.

In addition to the clinical measures, we are devoted to including the HCAPS instrument, the survey data from the HCAPS instrument, which you have already heard about from other speakers. This is the patient experience of care survey, which will help us communicate to patients about the impressions of their family, friends, and others like them about the care they received.

Let me talk just a little bit -- because I see I'm out of time -- about the role of competition and fostering cooperation, and then I will close.

Ultimately, the key to quality improvement is cooperation. Quality improvement can be achieved only if hospitals work together with the doctors and other professionals and with each other to share suitable information about processes, procedures, and outcomes in an increasingly robust manner.

Some hospitals believe that the most effective method for doing so is through their system of hospitals. Others, such as those involved in the Northern New England Cardiovascular Disease Study Group, a regional

consortium of hospitals that develops and exchanges specified information concerning the treatment of cardiovascular disease, have found that clinical integration among hospitals and other providers is most effective.

The policies of the antitrust agencies should encourage hospitals to work together on quality matters with the greatest confidence that there are no antitrust or competitive barriers to exchanging suitable quality information and developing appropriate shared systems or protocols to implement those measures.

Similarly, we must be mindful that competition can generate some undesirable results. For example, Baker and colleagues reported in Medical Care in 2000 that in the Cleveland Health Care Quality Choice Program, which rated hospitals on inpatient mortality, there seemed to be a result that, as we heard about this morning from Pat Romano, that there is a significant decline in in-hospital deaths as a result of the publication of that data, but it was offset by an increase in deaths in the 30-day period post-discharge.

In other words, hospitals were discharging patients to home, where they died anyway.

At the same time, it is important to be cognizant of other barriers to cooperation between care

providers. To the extent that the antitrust agencies wish to foster the exchange of quality information among hospitals, other impediments, such as the onerous accounting requirements under the HIPPA medical privacy law must be addressed.

In conclusion, let me say that, though there are many challenges associated with performance reporting, America's hospitals are committed to providing patients with the information they need to make appropriate choices. Our goal also is to give clinicians the tools they need for decision-making so that patients do not have to choose a hospital based on quality.

The quality initiative is an important step toward achieving that reality, and the hospitals look forward to serving as the leaders on this front.

Thank you very much for your time.

(Applause.)

MR. BYE: Thanks, Nancy.

Woodrow Myers will give the next presentation.

MR. MYERS: Thank you very much. It's a pleasure to be here this afternoon and talk with you about quality and consumer information from the perspective of a health care company that today serves over 13.5 million members in the United States.

I am Woodrow Myers. I am chief medical officer

and executive vice president for WellPoint Health Networks. Our headquarters is in Thousand Oaks, California, and we serve the patients in all 50 states, but primarily through the states of California, Missouri, and Georgia, where we have Blue Cross/Blue Shield of Missouri, Blue Cross/Blue Shield of Georgia, Blue Cross of California, and then in many other states under the brand heading of Unicare.

Today, I'd like to just tell you just a bit very quickly about WellPoint's mission, talk about quality from our perspective, and then give you some examples of some programs that we have in place today that address quality issues, and then I'll make a quick conclusion.

Our mission at WellPoint is to provide health security by offering a choice of quality branded health and related financial services designed to meet the changing expectations of individuals, families, and their sponsors throughout a lifelong relationship.

I run the Health Care Quality Assurance Division of WellPoint, where we focus on quality to improve outcomes and promote patient safety, to ensure that physicians and hospitals follow quality standards to promote wellness, improve clinical outcomes, increase member satisfaction, and use technology to enhance

communication, and in addition, enhance the quality of care to our members by identifying and rewarding physicians who excel.

The Quality Assurance Division has a mission that includes facilitating the success of our business units and their service to payers and individual members by the timely recognition of medically necessary health care services and the elimination of unnecessary, non-value-added costs.

At WellPoint, we treat costs like many of our physician colleagues treat cholesterol. We look at the good costs and bad costs like you have good cholesterol and bad cholesterol, or HDL and LDL cholesterol, and we want more, obviously, of the HDL or the good costs that go into preventing disease, that go into helping our patients to avoid further problems down the road. And we certainly don't want to continue use the funds unnecessary for services that are duplicative or don't add value.

We're also very interested in optimizing the quality of our health care networks in collaboration with our physician and hospital partners, and ensuring that patients served by our products receive the information necessary to make the best decisions for themselves and their families.

We believe both consumers and employers want quality. They are our primary customers. Employers want evidence of cost-effective high-quality care. Their expenditures have gone up a great deal over the past several years, and they're increasingly concerned about making certain that those expenditures are targeted so that they are getting the best value for the money.

There is an increased individual focus on quality because of a number of questions that have been talked about here today and in prior testimony before the FTC. One cannot ignore the news reports that have challenged quality at many of the nation's leading institutions, and of course, the Duke transplant story very recently, as well as the Tenant Hospital writing situation very recently, have put quality on the front page, have put quality in the first five minutes of the news broadcast for many of our members, many of the providers' patients, that have made it a central focus far more than it has been before.

We cannot, of course, ignore the Institute of Medicine studies that have been referenced earlier and the studies that are in the hopper both within the Institute of Medicine and by other agencies as we really get our arms around this complicated set of issues that relates to improving the quality of care for members

around the country.

We also know that the government is accelerating its response to heightened consumer concerns. In fact, we've started tracking state legislation in our company because we see it growing relatively rapidly around the country. State legislators are reading the Institute of Medicine reports and are wondering whether or not there ought to be new laws in their states related to safety, related to quality, and certainly there's been a focus in the Congress of the United States, as well.

What is quality from the member perspective? Well, we, too, believe in efficacy, effectiveness, appropriateness, availability, timeliness, continuity, and safety, as has been mentioned by others, but from the member perspective, it's different than it is, I think, from the provider perspective in some respects. The member wants to know did the treatment plan work, how many visits did it take to reach the right -- does it take to reach the right plan, how much did my medical condition improve, is this the best type of care for my condition, are appointments available in a reasonable time-frame for initial and follow-up visits? They want to know are there early intervention options, was there a delay in treatment, will I see the same doctors when I

visit, do all of my physicians exchange my medical history and test results seamlessly, and will I suffer adverse reaction or injury from the treatments? These are all quality-related questions from the member perspective, and of course, it's difficult for us to get our arms around each of those and to provide either a metric or a web-site or a portal into this information from that individual member's perspective, but I don't think that the task is unsurmountable, and we are very much moving in that direction.

Hospitals and physicians are in the spotlight. Consumers increasingly will use quality and data and cost comparisons to choose their providers.

You've heard testimony today regarding some studies that have shown that, at this moment in time, a relatively small percentage -- in some efforts, a relatively small percentage of consumers are using that data, and I think that's to be expected, because I believe we're still in the infancy of our ability to present the data in the right fashion and that people are just now beginning to want to use it.

It's almost, in my mind, like asking, you know, two months or two years, even, after it was published whether the April edition of Consumer Reports drives decision-making with respect to car buying. We all know

today that virtually all consumers either go to the internet or get that edition of Consumer Reports before they buy a car, but that wasn't the way it was when it first started, when it first came out. So, clearly, in our minds, this is going to grow, it's going to improve over time, and we're not worried about that data today.

We know that physician compensation increasingly is based on quality of care measures as the industry shifts away from the gatekeeper model, as well.

So what is quality from the physician perspective? Well, it's a little different. Was the treatment rendered correctly? Did the patient get better? Is this the best type of care for this patient? Are physicians available when the patient needs them? Is care given when it can do the most good? Is there coordination among physicians? Is there compliance with infection control and other regulatory activities?

And again, it's difficult for us to develop metrics that go after each of these areas, but nonetheless, there are good folks that are really trying hard around the country. We're taking advantage of what they are doing. We are beginning to incorporate some of those metrics into our efforts at WellPoint, and I'll talk a little bit about that as we move forward.

Quality measurement at WellPoint is centered

around member and patient satisfaction, health outcome studies, physician and facility comparison ratings, accreditation and regulatory agency audits and ratings, and quality indicator metric sets that we have.

Physicians are an important ally in our improvement programs. Our incentive programs, one of which I'll describe, allows WellPoint to communicate quality improvement goals to the physicians in our networks, and we have relatively large networks around the country. WellPoint has quality incentive programs in most of our health plans today: in California, in our HMO and in our PPO; in Georgia, in our HMO; and in Missouri, in our HMO and in our PPO.

Now let me just move quickly to give you an example of one of the programs that we have for physicians. This is called PQIP or Physician Quality Incentive Program, and what you're seeing is the actual web-site of one of the providers in the program. In this particular case, the provider is looking at the specialty of family practice, and he's looking at all counties in California.

We have created this web-based reporting system on the clinical indicators that you see on the left. We have now about 13 clinical indicators such that a physician who has sufficient patients to have enough data

to be analyzed by our system can look at his or her performance vis a vis each of these indicators either comparing oneself to a specialty area that you are either in or want to become part of, like family practice, and/or you can look at the data with respect to all the counties in the State of California or in a specific county.

We are using the clinical indicators such as ace inhibitor use in congestive heart failure, long-term control drugs in asthma, and colo-rectal cancer screening. Many of these indicators, of course, are familiar to those of you who understand the NCQA quality effort in HEDIS, but we're adding them over time.

We're working with a company that helps us to make certain that our methodology is correct and that gives us some third-party oversight such that we're not putting these indicators out in a way that doesn't make good clinical sense, and then what we do is we look at the individual's performance with respect to his or her peers.

As you can see in this particular graphic, the 10 to 25th percentile is in yellow, 25th or 75th is in white, and the 75th to 90th is in green, and then if that person has an indicator available, then the little orange arrow sort of points to where they are vis a vis those

peers. It's updated on a quarterly basis.

These data are now available for about 11,000 physicians in our PPO network in the State of California, and we think it adds value, because we bring something to the table that it's very difficult for an individual physician or individual practice to have, and that's a denominator.

Many physicians today actually do have systems in their office where they can look at some of their own data, but it's very difficult for them to get access to data of others to compare their performance, and what we do for the physicians in our network in California is to provide that denominator for them.

We, in five counties, are now experimenting with an incentive program connected to these clinical performance indicators. We are looking at five counties in the San Francisco Bay area, where about 1,500 physicians are now eligible for a bonus program that's related to the score that they receive both in the clinical performance indicators and on other areas such as tenure and product, access to care, board certification, administrative cooperation and generic prescribing, and you can see a scale on the right. The higher the score, the more the available incentive for them, and if you do as well as one can do in each of the

categories, we've targeted the maximum amount this year to be $5,000, and we think that's a good place to start for our program in the bay area.

We are assessing the impact of this program through the help of the Rewarding Results efforts within the Robert Wood Johnson Foundation. We've been awarded a grant and are working with the RAND Corporation to look at the effectiveness of this particular approach for that group of physicians, but we are now taking these indicators, making them available, and now tying them to an incentive program that's available for our physicians.

This just shows by drug class how this particular individual rates with respect to his or her peers in the various classes for generic prescribing, and then we believe that there should be no black box. In other words, any of the indicators that we have there, they are freely available to the physician to take a look at, or his staff or her staff to take a look at, and we invite discussion. We, in fact, invite argument. If you think that the indicator is somehow invalid or you think that you can offer some improvements, please e-mail us, we'll look at your suggestions, and we'll try to improve it over time.

So we make all the methodology available to the physician, and here is just an example of the detail

that's behind, for instance, the indicator surrounding mammography screening.

So, that is what we're doing in one of our sites for physicians.

Let me turn now to something we're doing for consumers directly. It's a program that's called CBMO. It's the name of a company that we're working with to make this available.

It's a web-based, once again, interactive quality data information tool that offers quality measurements and comparison that enable our members to ask better questions, to make more informed choices, and to gain, we believe, control -- much more control over their health care decisions.

They use a variety of data sources, and the data sources vary depending upon the data that's available in a particular geography. They use publicly available Medicare data, hospital Leapfrog reports, as has been mentioned earlier, outcome studies, generally accepted hospital satisfaction surveys, and in California, there's a data set called OSHPOD, which they make available to us for the program, as well.

This is the welcome page for our Blue Cross of California members when they go to the CBMO site. You can see that, in this case, we're looking at cardiac

pacemaker surgery. There is, by the way, at the bottom, information on all the various common diseases that they can look at. Again, no black box. You get to see what we think and the methodology that we use. There's a whole section on preparing for procedure, and I'll come back to that in a moment.

There are on-line medical and encyclopedia links. So, if you really want to dig into what's going on in that particular arena, there are some links available to you to do that.

And something else that we think is important. We allow patients to connect to each other, so we created community chat rooms for patients with similar conditions to talk with each other about those conditions.

In this particular example, we've selected mastectomy and breast conserving surgery as the procedure. One enters one's zip code so that one can adjust and alter the variables as one looks at choosing a hospital. In this case, we've chosen 25 miles. This particular person could have chosen hospitals five miles from his or her zip code or up to 200 miles from his or her zip code, and then you can see a number of questions, and the person can rate each of these questions in terms of importance to them, the hospital and clinical quality experience, has this hospital performed a procedure more

times than others, has it had fewer patients with complications, how important is that to you, what's the public perception of the hospital's reputation, is it an accredited or certified facility, is it a teaching hospital, is it primarily for children, how many high-tech services does it have, does it have an ICU, does it have a critical care unit for cardiac problems, and you can decide how important each one of those happens to be.

In this example, what we've done is we've seen the list of hospitals that have come back for the procedure, mastectomy and breast conserving surgery, and we have selected, in this example, Cedars Sinai, UCLA Medical Center, and then -- off the screen -- it was too far down for us to get a comparison -- we picked St. John's Hospital, and so, what you can then do is compare sort of three hospitals side by side and look at each of the factors by each of the hospitals.

Our colleagues from the hospital industry -- I think they would agree with us that it is not a perfect approach. However, it is a heck of a lot better than having no information at all, and we have found that, when people really use this, they get excited about it.

It offers them an opportunity to see comparisons that they do not find easily available elsewhere, and it gives them some assurance that the

decision they're making is a correct one for themselves or their family, or it gives them some information that leads them to ask whether or not other alternatives might be available, and that's what we want. We want our members to have the information to make good decisions for themselves and their families.

There's a score that comes out, and we, again, allow people to sort of drill down into the score, to really understand as much as they want or as little as they want about how the methodology was used to create the score, and at the end, we also offer a little bit of an indication of the price.

We don't actually try to put a number in, because we know and you know that price and the cost varies, depending upon all the various issues, complications, and so on that might happen, but we do give them an indication of the relative expense of each of those facilities in our data over a period of time, and in this example, you can see that we use price tags, four being the most expensive and one, in general, being the least expensive.

We also help the patient -- and this is one of the pieces that I think we are most proud of -- we help the patient make a decision. In this case, we're going to drill down on Caesarean sections. You put in your zip

code, you then click on the questions to ask, and we give our members a list of the questions that she might want to ask her physician as she goes in for this usually elective procedure.

I think that's very useful, because as a physician, I've been in a situation many times where a patient has come into the office, and you know that they've got a lot of questions, but sometimes the patient gets a little frightened or they get what I think we call that deer in the headlights syndrome. Everything is churning in their mind, and it doesn't come out of the mouth in the form of a question, but of course, as soon as they get home, the questions start to flow, here are the things that we didn't ask.

What we encourage our members to do is take the list in with you. Pick the three or four most important questions, and then have that in front of you, and physicians actually like that, because they know that a more informed patient is a better patient, and so, I think think this gives the people that are part of our Blue Cross networks a good menu from which to choose as they move forward with the C-section experience and with all the other procedures that are available. So those are just two examples of what this health plan is doing to move forward in this direction.

Our conclusions are that consumers are learning more about health care quality variations and they want tools to compare and contrast providers. Those of us who are in the sort of tool generation perfecting industry or business or research should not, in my view, be discouraged by some of the studies that have come out thus far indicating that it's only X percent or Y percent, because as our tools get better, I am certain, I am absolutely convinced that they will be used increasingly by our generation, especially, to make good decisions.

The health care industry is evolving from delegating quality to the NCQA, URAQ, and other organizations, which has been the mode thus far to more direct timely and individual assessments, and I can see a day, through the leadership of groups like Leapfrog and others, that we will be making far more direct and individual assessments in the future and people will have even more detailed information on which to make decisions, and very importantly, our provider colleagues will have information -- will have their own road map on which they can -- which they can use in terms of improvement.

It cannot be overstated that the value of these tools is as much for the provider and the physician, the

hospital, as it is for the member, because no one wants to be in that bottom quartile, and virtually any provider who sees himself or herself in that quartile is going to try to improve.

Lastly, the health care industry should lead the changes by promoting the use of evidence-based medicine, sharing data and information for quality improvement, and then finally aligning financial incentives to reward clinical best practices and quality outcomes.

Thank you all very much.

(Applause.)

MR. BYE: Thanks, Woodrow.

Anthony Tirone will give the next presentation, and after that, we'll have a short break.

MR. TIRONE: Well, that sets us up nicely. As soon as I sit down, as soon as I be quiet, we can all go out and have a break. But that's okay.

Good afternoon. I am Anthony Tirone, the director of federal relations of the Joint Commission on Accreditation of Health Care Organizations. The Joint Commission does appreciate the opportunity to testify and to give you information today, information that hospitals can make available to consumers and that the Joint Commission is working to also make available.

We commend the Federal Trade Commission for holding these hearings, because information on the outcome and effectiveness of care is essential in achieving the improvements in health care delivery and quality of health care that we all believe our system is capable of achieving.

For those who may not be familiar with the Joint Commission, we are the nation's preeminent health care standard setting and accrediting body.

Our member organizations are the American College of Surgeons, the American Medical Association, American Hospital Association, American College of Physicians, American Society of Internal Medicine, the American Dental Association.

In addition to these organizations, our 28-member board includes representation of nurses as well as public members whose expertise covers a diverse area of ethics, public policy, health insurance, and so forth.

The Joint Commission accredits approximately 18,000 health care organizations, including a substantial majority of the hospitals in this country. I think we accredit about 80 percent of the hospitals, which represent about 90 percent of the hospital beds.

Our accreditation certification programs also provide quality oversight for home care, ambulatory care,

nursing homes, hospices, and other health care settings. We also have an active international accreditation program and do a considerable amount of consulting around the world on questions of safety and adequacy of care.

Today we've been asked to focus on the information consumers need from hospitals to assist them in making decisions. Historically, decisions on which hospital to use have not been based on information but have been based almost exclusively on what the patient's doctor has recommended or where that patient's doctor actually practices.

This does not seem to have changed very much, but it is changing very slowly as consumers become -- begin to have available to them more and more information on hospital performance and also begin to understand the significance of the information.

To a large degree, however, this change is being led by employers and by those who are paying for the health care, such as health insurance companies, and not necessarily by consumers or patients, which is probably along the line of, as was mentioned just briefly earlier, what Consumer Reports must have gone through somewhat as it generated people's interest in what they were doing with products. However, while performance information may not yet be a driving force or even a

consideration to many in the selection of a particular hospital, the vital importance of information and reporting systems for measuring and improving care is necessary and long been recognized by the Joint Commission and certainly by others.

Starting in 1986, which seems to be a long time ago in the world we live in, and was, with the agenda for change of the Joint Commission, the Joint Commission started a process of requiring accredited organizations to collect performance information and act on it.

Now, back in 1986, we had to start this journey by first acquainting organizations with what was meant by performance information and then encouraging the development of processes and systems within organizations and an infrastructure to actually go about the collection of that information.

We required, as part of the process, that hospitals have the ability to collect this information, that the information had to be collected in a systemic, valid, and auditable manner. Information was then to be used to identify areas where the hospital could improve care in the services it provided to patients. The organizations would work with measurement systems that had been approved by the Joint Commission. These systems were required to have valid measures and measure sets and

also the ability to compare an individual hospital's performance to not only itself over time but to other similar-type institutions, and that comparison was to provide the basis for identifying areas of improvement.

The process continued until 1997, when, as these systems matured, we were able to include this comparative data and this process as part of our survey process in the accreditation of facilities, and at that time, organizations were required to collect information four measure sets.

In 1999, we required that this information, for the first time, be reported electronically to the Joint Commission, and we commenced building a database, although this was not a database of comparable data. It was just a database on individual facilities.

In 2001, the Joint Commission announced the next step in what we've called our ORICS program, the next step on this journey, which was to come out with the use and require the use of core measures.

Core measures were a set of standardized performance measures that could be used to compare performance of institutions across accredited hospitals and across the country. Hospitals are required to select two of the core measure sets and report this information to the Joint Commission. Hospitals began collecting this

information in July of 2002 and report it quarterly to us.

The initial set of core measure sets include acute myocardial infarction, heart failure, community-acquired pneumonia, pregnancy, and related conditions. Hospitals are required to select two of those sets as it were relevant to their own practices.

As I noted, with the introduction of these core measures, comparison of individual organizations can now be made on a state and national basis.

In line with this data collection, if you would, the Joint Commission is collaborating with the AHA and others and the CMS in the hospital quality initiative that's been discussed this afternoon. In fact, the data that is being reported under that initiative is, in fact, a subset of the ORICS data collected by the Joint Commission, the data that we started collecting about a year ago.

Another area where the Joint Commission seeks to provide consumer information is what we refer to as quality check, and this is found on our Joint Commission web-site, jcahco.org.

Quality check provides the public information on individual accredited organizations, including the services they provide, accreditation status,

accreditation history, and a summary of the findings of the last survey.

I have to admit that we have been trying hard to make the site more consumer-friendly, with some limited success. We have currently underway a major revision and a significant redesign of that site.

We will be revising not only the presentation of the data but also the content of the information to be presented. For example, the Joint Commission this year, in 2003, inaugurated a series of national patient safety goals. These goals have been identified from information we received from our sentinel event reporting program. Each goal represents a very real, serious potential problem in the delivery of care. With these goals, we have required a proactive approach to resolving issues related to patient safety. That is, we have required that there be review and correction before actual errors occur, not retrospectively once you have had the error. We have adopted a process used in other high-risk engineering-based fields referred to as failure risk effect analysis. This analysis is required, as I noted, to identify problems in the systems of care before those problems turn into errors.

The goals under this requirement include: Number one is to improve the accuracy of patient

identification. Two is to improve the effectiveness of communication among care-givers. Three is to improve the safety of using high-alert medications. Four is eliminate wrong site, wrong patient, and wrong procedure surgery. Wrong site surgery, as it's affectionately called, is one of those areas where you think should never occur, and yet, we continue to have a shocking number of reports of that occurring. Additional goals include the safety of using infusion pumps and improve the effectiveness of clinical alarm systems.

These goals, while they seem quite clear and self-evident, do actually reflect documented areas of potential weakness in delivery of care; areas that have been documented as having caused sentinel events in other facilities across the country.

The Joint Commission is now reviewing the hospitals' performance against these goals as part of our survey accreditation process.

That information, as it's accumulated, will become part of that information that's available on our revised quality performance reports.

To enable us to get to our break sooner, I'll say that the challenge that's addressed here, the need for information, is awesome.

You ask if there is sufficient information

available today to allow consumers to make a choice. The answer, I believe, is clearly no. The information available today is not sufficient in and of itself to allow a consumer to decide, when given a choice -- remember, there are many, many times when consumers do not have a choice, either because of the emergency of the situation or, quite frankly, the lack of an alternative provider, but the information available to us today is perhaps best used as an indicator that should lead consumers or purchasers to ask additional questions of their doctor and of the hospital or both.

The state of art of performance measurement is arguably not yet to the point where it, in itself, should give definitive information to consumers or purchasers. This, however, should not detract from the need to continuously improve the ability to identify and collect this information, or from its use in improving the quality and safety of care.

When you ask why more information on hospital quality is not available, I think a significant factor is that there is a lack of real demand from consumers of this information. In addition, there is a lack of a clear consensus on what measures would be most meaningful in what situation and even how to present the information in a way that consumers would understand it, value it,

and not have it mislead them.

Another consideration which we would probably be remiss to not at least consider is cost. The cost of collecting this information, which is usually uncompensated, in the absence of an electronic medical record, is usually quite significant. What this has meant is that information needed for performance measurement is sometimes only available as a byproduct of other activity such as claims payment. As such, it may not result in the optimal measure in a particular case.

The work that is being done toward the development and implementation of a national health information infrastructure, we believe, should be encouraged and supported, as such an infrastructure would facilitate the adoption of the electronic health record. This record would not only facilitate treatment and reduce medical errors but would also make the collection and the identification of performance information easy and a byproduct of the records that are there.

Another issue on which we were asked to comment was how should compensation affect quality? It's interesting and quite exciting to hear how WellPoint and others are starting to try to compensate for quality of care and how CMS -- and we wish them all the luck in the world in getting their demonstration underway.

The Joint Commission, recently, in conjunction with the Agency for Health Care Research, held a public conference to discuss and identify the business case for quality. The general consensus of those present at that conference -- and they made up largely of hospital executives and others -- was that there is no business case for quality. The fact is that those that we ask to invest resources to improve the quality and safety of care are not those that benefit in terms of the return on investment. Simply put, the hospital that spends the money on its CPOE and so forth, if they are -- the more safe they are, the higher quality they give, in our current system, the less reimbursement, the less income they will have. The illogical extension of all this is that a really high-quality institution can, in effect, put itself out of business.

What this all really means is that we have a system that pays the same for high-quality care as it pays for less than high-quality care, must be revised if we're going to change the paradigm.

In conclusion, the Joint Commission remains steadfast in its belief that information and, in particular, information on the outcomes and effectiveness and safety of care is essential if we're going to achieve the care that our system and state of knowledge are

capable of delivering.

We also strongly support the underlying principle of these hearings that the competition based on quality and safety of care is not only achievable but desirable.

Thank you very much.

(Applause.)

MR. BYE: Thanks, Anthony.

We'll start back in about five minutes.

(A brief recess was taken.)

MR. BYE: Welcome back.

Arnold Milstein will be our next presenter.

MR. MILSTEIN: Thank you.

I am the medical director of the Pacific Business Group on Health, the largest of the regional employer health purchasing groups. I also head clinical consulting at Mercer.

My comments are -- really amplify on prior testimony at the FTC which I gave on February 27th, and they also incorporate some insights from work which I published in April of 2003 in Health Affairs.

The market for hospital services exhibits several features that imply the need for vigorously pro-competitive public policies. I will briefly outline these features and the pro-competitive policies that I

think might best address them.

First, approximately half of hospital admissions are under circumstances of perceived emergency in which ambulance personnel and/or personal physicians almost or wholly determine a consumer's hospital selection. Except in a few states with designated trauma centers, these two consumer agents -- that is, personal physicians and ambulance personnel -- have not successfully advocated for the performance reporting needed to assure that their selections on behalf of consumers would optimize consumers' health or financial outcomes.

In essence, consumers in need of emergency hospitalizations are relying upon agents who are not assuring the performance information flow which successful agency requires.

Second, those consumers requiring non-emergency hospitalization are typically either chronically ill or unfamiliar with hospital services. Chronically ill individuals suffer from a much higher incidence of depression, which commonly impairs the critical thinking capabilities that careful hospital selection requires. Both chronically ill and new consumers of hospital services also tend to experience hospitalization as stressful.

Irving Janis at Yale and other researchers have documented that such health care-induced stress -- such health care stress typically induces idealization of health care providers. Idealization of providers is the antithesis of the critical thinking required for consumers to transform available performance information into a hospital selection likely to generate their best health or financial outcome. This idealization is very well documented in the Blunden research which I referenced in my health affairs article.

In essence, what his research shows, which was published in December, is that if you ask a large random sample of American consumers how many people they think die due to preventable errors in hospitals, their average estimate is less than a tenth of the midpoint Institute of Medicine range. So, they're way off in gauging the safety or the dangerousness, in this case, of hospitals.

Third, as summarized in my article in Health Affairs, there are seven to eight other well-documented psychological barriers to accurate consumer perception of quality and reliability and to their successful navigation to hospitals likely to deliver better performance. Examples of these other barriers include something psychologists call the familiarity heuristic. What this means is that consumers, on average, tend to be

automatically inclined to associate familiarity, such as a hospital that they commonly see in their daily life, in their commute, or have previously used, to associate familiarity with trustworthiness and safety.

Secondly, a second psychological phenomenon is what's called optimistic bias, and especially in health care, 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 FTC and the Department of Justice. It implies that, if a hospital is familiar to a consumer, it may enjoy market power, especially among sicker consumers, who utilize much higher levels of hospital services, that substantially exceeds what is conveyed simply by a hospital's HHI.

These and other unique features of the market for hospital services imply the need in more concentrated markets, especially, either for aggressive regulation of hospital quality and efficiency or better enabling the market's invisible hand.

Since the market's enablement is the subject of today's hearings and aggressive regulation of hospital performance has never succeeded in the past, I will briefly recommend three illustrative enablements of the

market's invisible hand.

First, require hospitals to publicly disclose and to allow disclosure by payers, where payers have the information to disclose, readily comparable measures of quality and efficiency for specific diagnoses and treatments, for categorical service lines, such as surgery versus OB versus medicine, and for hospital performance overall.

Granularity of performance reporting is needed because research to date suggests that no hospital excels in treating all conditions. Aggregate performance reporting is also needed, because many consumers enter the hospital without knowing their diagnosis or likely required 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. Disclosure should also be keyed to performance measures requested by aggregations of customers, including payers, purchasers, and/or consumer organizations, who, together, a fiduciaries for a significant fraction of a hospital's patient mix.

This is no different than any other kind of purchasing that goes on in America. In general, any

group that represents a substantial source of customership for a given vendor, to put it in that generic term, usually has no trouble getting performance information, even custom performance information they need.

Should every individual customer, you know, every consumer, get any performance measures they want? No. But if we're to take the precedent that's been set in other industrial sectors, any big customer, anybody that's a significant customer of a supplier, should be able to get customized performance measures if they wish.

Third recommendation: Prohibit hospitals from restricting payer efforts to recognize and reward hospital excellence by assigning hospitals within multi-hospital organizations or by assigning service lines within a single hospital to different performance tiers, tiers that are made visible to consumers and/or subject to variable consumer out-of-pocket costs. Such tiering is the essence of how the market's invisible hand can be most feasibly enabled in all American health benefits plans. Freedom to tier hospitals 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, which I continue

to recommend for your consideration.

Significant efforts by the Leapfrog Group, as described by Suzanne, the consumer purchaser disclosure project, whose work I previously described, and by progressive insurers such as described by Woody Myers and others here today, have already -- are already promoting such transparency-based market solutions.

These efforts would benefit from support by the FTC and Justice Department.

America is spending almost 5 percent of its GDP for hospital services.

As clearly stated in the IOM's reports on American health care quality, the services which Americans are getting back for these internationally unprecedented levels of spending are, unfortunately, characterized by serious and widespread quality defects and economic waste. The FTC and Justice Department's competition policies can play a critical role in healing America's under-performing health care system.

Thank you.

(Applause.)

MR. BYE: Thanks, Arnold.

Cathy Stoddard is our final speaker today.

MS. STODDARD: Good afternoon. My name is Cathy Stoddard and I am a registered nurse. I practice

nursing at Allegheny General Hospital in Pittsburgh on a colo-rectal surgery and transplant unit. I am also a member of District 1199P SCIU.

I appreciate the opportunity to talk before this commission, and I am to talk about the importance of providing patients and their families with relevant, easy to use, easy to understand information regarding the quality of care in hospitals, and all of the panelists here have offered testimony that actually supports the position in mine.

Because I am a transplant nurse, I know the factors that affect transplant outcomes: the underlying health of the patient, the experience and teamwork in the operating room, the thorough and timely wound care and medication administration done by nurses, and the careful infection control policies and practices followed by everyone in the hospital, and finally, patients and their families must be given extensive education and preparation before discharge.

In theory, patients are given accurate information about the quality and price of hospital and physician services. They will choose the providers that offer the best value for them.

In Pennsylvania, for example, we have an excellent independent state agency, the Pennsylvania

Health Care Cost Containment Council, known as PHC4, which collects and publishes a large amount of price and quality data from Pennsylvania hospitals.

PHC4 adjusts the data for underlying patient risks and measures mortality rates for over two dozen procedures and is very successful in identifying outlier information, hospitals or procedures that stand out from their peers on these measures.

It has helped policy makers quantify the cost of manageable and preventable diseases such as diabetes. It has helped hospitals and physicians examine underlying reasons behind their performances on measures. But this data has limits.

It remains very difficult, for instance, to judge the relationship between cost, quality, and price. Small community hospitals and rural hospitals are worried that the data can be used by larger consolidated health care systems to eliminate competition. By the time the data is published, it is already a few years old and may not reflect the most current hospital conditions. Furthermore, information alone is not enough to encourage better price and quality competition among hospitals.

Health care, in general, and hospital care, in particular, are not like other services that we buy. We don't always have a large number of choices in hospital

care, and more and more, employers are offering limited number of health insurance choices to workers with different co-pays, deductibles, and other coverage limits.

More and more health insurance plans limit the number of hospitals or merged hospital systems that are in their network. Often, patients are limited to the hospital where their physician has admitting privileges.

In an emergency, of course, they might be taken to the nearest hospital without regard to the kind of grade or ranking a hospital may receive on a consumer report card. Once patients are admitted to the hospital, it becomes difficult for them to vote with their feet and be transferred to another hospital if they are not satisfied with their care.

Because of the limitations of information to improve hospital competition on the basis of quality and price, many nurses and nurse unions believe that we need stronger regulatory standards for hospitals. Specifically, we conclude that there is now strong research evidence to support minimum nurse-to-patient staffing requirements for acute care hospitals as an effective way to improve patient outcomes.

Much of the research that demonstrates the link between nurse staffing levels and patient outcomes has

been sponsored by the federal government.

I will summarize only a small part of the growing amount of information and evidence that links nurse staffing to patient outcomes.

Research funded by the federal agency for Health Care Research and Quality and carried out by Jack Needleman and Peter Buerhaus reveals that there is a strong indirect link between the RN staffing levels and time spent with patients and whether patients develop serious complications or die while they are in the hospitals.

Needleman and Burhouse and their colleagues found that low levels of RN staffing were associated with higher rates of complications such as pneumonia, upper gastrointestinal bleeding, shock, sepsis, and cardiac arrest, including deaths from all of these complications. These complications occurred 3 to 9 percent more often in hospitals with low RN staffing compared to levels where RN staffing was higher. Urinary tract infections were higher in hospitals with lower RN staffing patterns, and lengths of stay were also longer.

Last year, the Journal of American Medical Association reported results from the Linda Akin study and her colleagues showing that for each additional patient that is assigned to a nurse above four, that the

mortality rates needs to be adjusted by 7 percent. That means that, for every patient that I take care of over four, they have a 7 percent higher chance of dying. Failure to rescue patients with complication also rose by 7 percent. In addition, nurses working on units with short staffing had lower job satisfaction and higher rates of burn-out.

The Joint Commission on Accreditation and Health Care Organization recently reported that inadequate staffing levels were implicated in 24 percent of the sentinel events, unanticipated events that resulted in death, injury, or permanent loss of function it investigated through March 2002.

Other contributing factors in these sentinel events also implicated nursing problems. An expert panel convened by California Department of Health Services in 2002 reviewed research related to nurses, nursing, and patient outcomes. Using strict criteria, the panel reviewed 37 studies and concluded that nurse staffing is related to patient in-hospital mortality rates and several patient complications including pneumonia and nosocomial infections. They also concluded that fewer nurses were associated with longer patient lengths of stay.

The panel was convened to advise the California

Department of Health as it wrote regulations to carry out the state legislation enacted in 1999 to require nurse-patient ratios in all acute care hospitals.

Because of a clause in my collective bargaining agreement with the hospital at Allegheny General, we have a clause that says that we require high-quality patient care, and we have a commitment between the nurses on my unit and my nurse manager, who is incredibly progressive -- we began collecting data last year for six months, and the data included information about acuity of our patients. We broke the acuity down into the number of meds that a patient received, the number of diagnoses that the patient had, the volume of teaching that was required, their length of stay, any complications that developed, and their readmission rate. Our patient population of transplant patients and colo-rectal surgery and Crone's patients is a revisiting patient population, and we measured that. We lowered the patient ratios based on the information that we received on all three of the shifts that we work on, and we agreed for this trial to take place for eight weeks.

That was seven-and-a-half months ago, and we continue to maintain the trial, because one, the hospital wouldn't do it if it wasn't working, but the data also prove that infection rates have began to become very low

on our unit. The physician and nurse medication errors have been reduced, and I say physician and nurse because we have specific trials for our transplant patients depending on their age, their weight, the kind of kidney that they receive.

They are on specific medication trials, and we have physicians floating in and out, because we're a teaching hospital, and they make errors that we're able to catch because of our lower patient ratio, and fix.

Also, our readmission rates were lower, because we had the opportunity to sit with our patients and teach them the medications that they needed and the regime that they needed to follow at home. We didn't see them with complications that were corrected in the teaching in the first place. Our patient satisfaction and patient health improved, and the morale and the work processes on our unit also improved.

Minimum nurse staffing levels set by unit within hospitals would set a minimum safe standard and provide assurances for patients that they would receive a minimum level of quality of care regardless of the hospital that they were admitted to.

Of course, hospitals and nurses would also be encouraged to work together to tailor the staffing levels and the mix according to their patient acuity and special

factors affecting the hospital's situation and the setting that the nurses and the hospital are working with.

We think that state legislation as part of the state's authority to license hospitals is an important way for states to raise hospital quality. We also think that federal Medicare hospital conditions of participation should be updated to reflect the link between nurse staffing levels and patient outcomes.

We think that Medicare and other payers should begin to reward hospitals financially if they improve staffing levels and patient outcomes. We note that other respected health care experts such as the Institute of Medicine also reviewed and recommended new reimbursement approaches that pay hospitals for demonstrated higher-quality outcomes.

Since higher nurse staffing also has been linked to lower lengths of stay, there are likely to be significant economic benefits to payers in addition to quality improvements for patients. Because nurse staffing levels cut across all aspects of hospital care, they are an important measure that reflect quality.

Some critics of mandated nurse staffing levels may say that mandates limits the hospital's flexibility and won't accommodate for improvement in technology, but

setting minimum safe nurse staffing standards will not prevent hospitals from tailoring nurse staffing levels to meet the patient's need. Hospitals and nurses will also continue to be free to work together to design innovative staffing plans.

Nor will minimum safe staffing standards limit hospitals' ability to substitute new technology for nurses. Most technological improvements in health care lead to a greater need for nurses because of technology improvements and make it possible for sicker patients to receive procedures that they never would have been candidates for in the past, and just to give you an example for those who don't work in a hospital, transplant patients -- specifically, kidney recipients -- don't go to an ICU. They come to a unit where they may be in a mix of six to eight other patients. So they are no longer an ICU patient but have moved to a medical surgical setting.

This is one of the reasons behind the current nurse staffing crisis. Acuity of patients in a hospital setting has risen over the last decade as a result of direct technological improvements requiring more direct nursing care.

In conclusion, I would like to say that we support any policy that would improve providing patients

and their families with easy to use and understandable information about the quality of care in hospitals. We ask that you recognize the limitations of such information, primarily that patients, unlike consumers of other services, aren't always able to choose their hospital. As we say in Pittsburgh, we would really like to compete with the hospitals in the western region on the basis of quality of care and not on the bottom line.

We feel that it is vital for states to establish minimum safe staffing standards that must be followed by all hospitals. Reimbursement plans should reward those hospitals with better nurse staffing levels and subsequently better patient outcomes. These are policies that will ensure the quality of care for all patients regardless of their ability to make an informed choice. Only by ensuring sufficient numbers of registered nurses on the front lines can we ensure the quality of care for all patients in all hospitals.

Thank you.

(Applause.)

MR. BYE: Thanks very much, Cathy.

We'll briefly move to panel discussion. We only have 20 minutes remaining, but I'd like to throw out a couple of questions to the panelists.

The first one relates to incentives. Both

Woodrow and Stuart mentioned initiatives they're employing to encourage quality initiatives, and Suzanne also mentioned that Leapfrog was going to undertake some. I was wondering if you could first comment on what that is, and then if any of the other panelists wanted to make remarks, I would welcome that.

MS. DELBANCO: The Leapfrog Group advocates that its purchaser members use three different potential methods for rewarding hospitals, both for reporting information as well as for superior performance on the measures that we're focused on.

One method of reward is public recognition, which can be accomplished in a variety of ways, including recognition on our national web-site that a hospital has reported and has made significant progress or complete progress towards implementing a practice.

Another method is to reward the hospital with market share. In a variety of ways, we can encourage patients to seek care at particular institutions, whether it's through financial incentives to the patients or through intense education efforts or a variety of other benefit design and network design efforts.

And then third, the other kind of reward that I can't imagine any hospital would decline would be an increase in payment or an increase in unit price.

We have some examples of our members instituting programs like this. For example, in New York City, there are five major employers that are providing quarterly bonus payments to hospitals who have implemented the computerized physician order entry practice and intensivist staffing.

But while it's very nice that we advocate these high-level ideas, it's been important for us to help purchasers figure out how actually to operationalize doing this, because it's not easy, and over the last year, we've been working with a multi-stakeholder work group to figure out which incentive concepts are going to be palatable to all stakeholders but significant enough to actually impact provider behavior and to encourage more widespread adoption of the practices we're recommending.

And we have just launched four pilot projects where we will be trying different types of incentives and rewards and evaluating them, everything, again, from incentives to the patient to make certain choices to rewards to the hospital on a financial basis for the practices that they've implemented.

There's a variety of other demonstration projects that were mentioned here today, like the one that Woody's group is involved in, as part of the

Rewarding Results program, and many others, and I think, over the next couple of years, we'll see a big acceleration in purchasers trying these efforts and in our understanding of what approaches are effective.

MR. BYE: Does anyone else want to comment?

MS. FOSTER: I'll make a comment. It's Nancy Foster from the American Hospital Association.

I just want to remind the panel that, in addition to the exciting talk we've heard today about the potential for rewarding higher quality, which is something that should be considered and pursued, to date we've had a lot of difficulty identifying appropriate measures of quality, and we've talked a little bit today about some of the unintended consequences that come from measurement.

Every time you increase the reward or the punishment for performance in one way or another, you induce more of that behavior on the part of providers. That's the good news or that's what you're trying to do.

But if there are unintended consequences that have not been carefully considered, you're also inducing more of that, and we need to think through those very carefully before we proceed down a path that will result in fewer patients getting the CABG surgery they might need, or other kinds of things that we had talked about

earlier today.

MR. MILSTEIN: To sort of stimulate discussion, maybe to follow on to Nancy's prior comment, if one were to sort of say, well, you know, recognizing and rewarding hospitals for excellence in risk-adjusted CABG outcomes is good, but Nancy has pointed out, if one does not also measure the appropriateness of hospital decisions to decline or accept patients for treatment who meet indications, I mean how would American hospitals feel about expanding the dashboard so that all six Institute of Medicine aims, you know, were part of the dashboard so that it would not be possible for -- at least it would affect another dimension of a hospital's scorecard if it declined to provide surgery to a patient for whom it was clearly indicated as a way of improving their risk-adjusted CABG score.

MR. GUTERMAN: That's actually one thing -- we've done a lot of thinking about what measures to use, and I sort of alluded to it by referring to the increased comfort with process measures, because one of the problems with outcome measures is -- one of the problems with any measure is that if you pay people to -- according to that measure, what you're going to get is more people appearing to comply.

And depending on how you structure the measure,

you can, you know, comply with better outcomes by reducing your risk at the outset, whereas you know, more explicit process measures that you are sure lead to better outcomes, you know, sort of helps to circumvent that, like if you say -- if you make the criterion aspirin to 90 percent of MI patients, you know, that's more -- it's a little more difficult to game, although I'm sure if you pay enough, people will find a way, but it's also -- I'd be interested in what people, you know, think about this, because this isn't an agency position.

But it's occurred to me that -- you know, one of the problems we ran into in trying to pay for outcomes -- I mean there are basically three problems. One is the measure itself and risk-adjusting and sort of getting an accurate measure. Another is figuring out how to pay for it, because you have to put a price on it, and putting a price on a service is easier than putting a price on an outcome. And then the third is, you know, any gaming that you might get and sort of choosing who you decide to take because you're trying to avoid more difficult patients to treat, because it will hurt your outcome score.

MR. MYERS: We ought to, in my view, explore that a little bit further, because I think it's a significant issue that really has not had enough

discussion, and Arnie, I think, put the right name out for it. It's the issue of appropriateness of care. There's an old surgical adage that goes something like this. If you operate on healthy people, you get great results.

And it's true that there is an underlying assumption in many, many quality programs that everyone needed whatever it was that they got, and what we should look at is how well whatever it was was done, as opposed to the issue of whether they really did need it, whatever it is, or whether there were other alternatives that might have been less invasive and/or less expensive that could have accomplished the goal either without as much trauma and/or without as many potential complications and/or without as many dollars.

And so, I think this whole question, as the FTC explores the issues surrounding health care, of appropriateness from the consumer perspective really needs to be tackled.

You know, it's raised its ugly head in the investigation that's being done now by Medicare and the OIG, I believe, and some of the allegations that have been made about hospitals in California regarding unnecessary surgical procedures in the cardiac surgery arena, and it has raised its head in other places, as

well.

I don't think California is, clearly, the only place.

So, this whole question of how does a consumer judge appropriateness, how does a consumer participate in a more meaningful way in the question of therapeutic alternatives, is a real one that I think deserves more attention.

MS. FOSTER: Can I respond? Because I think there are lots of issues being discussed here.

The one of, you know, if you incent people to do something and there's already over-use of that procedure or a diagnostic process, then you're probably not accomplishing what you want to accomplish is an important one to think about, but Stuart suggested that, with process measures, you have less of a problem.

Well, the 10 measures that we've all selected to use in this quality initiative that includes CMS and the Joint Commission and others include measures of whether or not patients got aspirin and beta blockers at discharge after their heart attacks, important things to know, but for hospitals -- for small hospitals, particularly small rural hospitals that are within a reasonable distance of a large tertiary care center, their current practice is often to stabilize and treat

those patients. When they discharge them, they're discharging them to another hospital, not to home, but their measurement now would suggest that they're not delivering the right care, because they're not giving those patients aspirin and beta blockers at discharge. It would be inappropriate for them to do so. That's the responsibility of the next hospital. But you know, are we now going to induce hospitals to retain those patients and then give them the aspirin and beta blockers?

I mean it's that kind of very, you know, on-the-ground, how does this work in real life implementation issue that we need to work through, which is not to imply that we want to stop measurement. We don't. It's not to imply we don't want to get to a robust set of measures. We do. Whether it ends up being the dashboard the IOM laid out or something else that consumers tell us they want more is almost immaterial.

We want to make sure that we're giving people the information they need and want and will use, but getting there is a rough road. That was my only point.

MR. MYERS: Your particular example, if I just might comment -- maybe I'm missing something, but we used to call those transfers, not discharges. If you're going to another hospital, it should not be looked at in another light in terms of the discharge medication than

if you were going home, and so, I think there's a classification problem there that is solvable. You code differently, I think, depending upon what happens after the person leaves the -- what is intended to happen after the person leaves the facility.

I don't think that we can let anybody off the hook on any of these issues, but I'm particularly interested in how the hospitals and the associations that bring hospitals together view that question of what the responsibilities are with appropriateness, because you clearly have to have a medical staff structure, you clearly have to respond to outside authorities coming in to review your procedures and processes.

And given that this question of appropriateness has risen to, I think, a much higher level than ever before, it would seem to me that that requires a more direct response than ever before, and I just hope that the AHA and other organizations are looking at that separately and independently of the worthwhile study that's going to go on with the collaborators as you've outlined, because I think it's a big, big issue that is under-addressed.

MR. BYE: Arnold mentioned initiatives that the FTC and DOJ could undertake in this area. I was wondering if any other panelists have suggestions as to

things that the agencies could be doing in relation to health care and quality.

MR. GUTERMAN: This isn't exactly answering your question, but at least it's a response, and it will give other people a chance to think.

One thing that occurs to me is deciding sort of in whose eyes quality is to be evaluated. We've got a number of payers here and some providers and -- you know, and the title of the session is consumer information, but I think there's a real difference between what consumers may want and what payers may want.

And I think one of the things, in evaluating the impact of market structure on quality or any other kinds of sort of Federal action or action by payers, is who determines what quality is, because it's clear to me that patients may want, at any given time, something very different than what payers may want. And we have to sort of think about ways both to get information to consumers to help them make better choices but also to sort of get clear in our heads what we're trying to accomplish, because you know, there may be conflicts that come up between the different sort of people who are making the decision about what quality is.

MR. MYERS: Again, I'm not sure of all of the various things under the FTC jurisdiction, but if you

watch television, you're seeing increasingly health care facilities advertising themselves in some way or another based on quality or outcomes, and they're using those words, and I suspect that that trend will continue.

The question is, is there any limitation -- at least this is a question I would raise -- is there any limitation on what you can say about what you are doing or what you believe the results are of what you're doing to the public without some oversight from someone or some entity, government or otherwise, because I suspect that it's a trend that's not going to go away.

I think that health care is increasing its percentage of the total advertising budget in all media, and one would think that, given the competitive nature that many facilities have today, that this is going to be a problem that can be anticipated.

MS. DELBANCO: I will just add one thing to what Woody's saying, which is not really in answer to your question but maybe another sort of provocative question itself, which -- one of the things that fascinates me about trying to understand who it is that various government agencies service, such as CMS, for example, or the FTC or Department of Justice, in this case, is who is the customer?

Is it the individual patient who is trying to

make a health care decision or be able to gain access to health care in a way that's not inhibited by a lack of competition in some way, or is it the hospital industry, or is it individual providers? Is it health plans? Is it employers? And I think clarity of, you know, the answer to that question helps put a lot of the debate that we're having here in perspective.

MR. TIRONE: I don't know who your customer is. It seems to me that the FTC, at different times, has got everybody in that realm.

MS. STODDARD: I'd actually like to comment. From a patient perspective, being with them every day, you all are very educated folks that I'm sitting with, and while I do something much different than you, I'm with a patient every day, and the information that they receive at the moment, in my opinion, produces fear.

They come to the hospital. They have their family members with them. In Pennsylvania, one of the folks who ran for local office produced a booklet that said ask these questions.

If a patient began asking those questions in the middle of a health diagnosis when they're afraid that they may have cancer or their kidneys are failing or they need CABG surgery, I can't imagine the state that they would be in, and I know what state they're in when they

get to my hospital. Their family, their friends, every piece of information that they read says bring a family member with you and never let them leave the whole time that you're there, question everything.

So I think the first thing is that we do have to get information out there that says that hospitals in America are providing adequate, safe, and cost-efficient health care to patients. That, I think, they are missing the boat on. They aren't seeing it.

And then the second thing is, in a well setting, after they're healthy, I think that that information needs to be available, and frankly, I think, in my population in Pittsburgh, while there are many people across the socioeconomic status of life that I take care of, they're under-informed.

So I think that we do have a big job to do, but I think the thing that they want to know is that they're safe when they come into the hospital and that they're going to see the health care professional that they need to see when they're there.

So I think that we have a huge job to do, from my level at the bedside all the way to the government agencies that serve these people.

MR. MILSTEIN: I've started making a list for the FTC and the Justice Department.

I think one of the areas that would be worthwhile taking a look at is policies with respect to hospital retail prices.

I mean right now we have a circumstance in many markets in this country in which the difference between the negotiated price and the rack rate, the retail rate, is breathtaking and bears no resemblance to anything that would happen in virtually any other industry.

And I think when you link that up with one of the other unique characteristics of the hospital and, for that matter, you know, physician market, which is that there's a certain amount of un-selected or involuntary consumption -- I mean in emergency circumstances, there is -- you know, you're not, you know, in a position to buy right.

And I think that given the fact that -- you know, that a certain percentage of patients in a given health insurance plan will inevitably end up in a non-network hospital and there's nothing, really, that a consumer who's facing, you know, some big out-of-pocket exposures associated with that can do about it, I think it might be worthwhile for the Justice Department to sort of examine the reasonableness under that circumstance of involuntary consumption of current pricing -- retail pricing policies.

MR. BYE: Irene and then Nancy and then we might wrap up.

MS. FRASER: Actually, just to add to this, one other odd aspect of it is that you also have a lot of involuntary non-use, and when you have such a huge gap between the retail price and the negotiated price, the only people who pay retail are the uninsured.

And that's certainly a bizarre kind of market failure, and you know, in a sense, as the number of uninsured keeps increasing, we could end up in a situation where we're reinforcing the competitiveness of the market for those who are paying, but in the meantime, you have this peculiarity of people who cannot pay are using, you know, the wrong services, because they're receiving hospital care when they should have been receiving preventive care and making many of those admissions unnecessary.

I'm not sure what one does about it, but I guess the question is how do you expand the notion of competitiveness of markets to those who don't have the price of admission?

MS. FOSTER: Which is probably a really strange concept in most other industries. How do you expand the price of and fairly price vegetables for people who can't pay for any food at the grocery store, is not something

I've heard addressed before. But just to be clear on the issue, it is that the payments that are made to hospitals by most payers for services rendered are not related to the price list, if you will, for services rendered. They are calculated independently and are not related to it.

Most uninsured patients don't pay. We deliver an enormous amount of uncompensated care. So, they're not actually paying the retail price either.

But there are some strange things going on, and the one point I wanted to make is that, from our perspective FTC and DOJ should not do something independently thinking this is unplowed territory.

HHS has folks looking at the issues of pricing right now. There are other organizations that are engaged in all of these aspects that we've talked about here today, and the opportunity to add to confusion by doing something independently without recognizing what else is going on is enormous and would be detrimental to all of our efforts, I think.

MR. BYE: Thank you.

On that note, I'd like to thank all our panelists for their excellent presentations today. You've built a substantial record for us to go and look at over the coming months. And finally, I'd like to note that we recommence tomorrow at 9:15 a.m.

Thank you.

(Whereupon, at 5:13 p.m., the hearing was adjourned, to reconvene Friday, May 30, 2003, at 9:15 a.m.)

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C E R T I F I C A T I O N O F R E P O R T E R

DOCKET/FILE NUMBER: P022106

CASE TITLE: HEALTH CARE AND COMPETITION LAW AND POLICY

DATE: MAY 27, 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

LISA SIRARD

C E R T I F I C A T I O N O F P R O O F R E A D E R

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

SARA J. VANCE