

HOSPITAL PUBLIC REPORTING SUMMIT

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Summary of
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Hospital Public Reporting Summit

**The Link Between
Public Reporting
and
Quality Improvement**

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Hospital Public Reporting Summit: The Link Between Public Reporting and Quality Improvement

Summary of Conference Proceedings

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I. INTRODUCTION AND BACKGROUND

On May 25, 2005, the Centers for Medicare & Medicaid Services (CMS), the Delmarva Foundation for Medical Care (DFMC), and Mathematica Policy Research, Inc. (MPR) sponsored a one-day conference on the impact of hospitals' publicly reported quality measures on hospitals themselves. In addition to exploring the various avenues through which hospital public reporting has motivated quality improvement efforts, the conference goals were to explore how hospitals achieve quality improvements, leverage public reporting, and coordinate multiple stakeholders in pursuit of the shared goal of quality improvement.

Approximately 120 people, representing a broad range of constituencies, were invited to attend. Conferees included 6 hospital executives (Chief Executive Officers [CEOs] and Chief Operating Officers [COOs]); 23 hospital staff (Chief Medical Officers [CMOs]), physicians, nurses, and individuals involved in hospital quality management and quality improvement activities); 6 representatives of public reporting sites; 28 representatives of public agencies and affiliated groups (CMS, the Institute of Medicine [IOM], the National Quality Forum [NQF] and the Agency for Healthcare Research and Quality [AHRQ]); 21 individuals from national and state hospital associations and quality improvement organizations [QIOs]; 3 purchasers; and 33 academicians, researchers, consultants, and others.

The program included 13 speakers presenting in five areas:

- The hospital quality reporting environment and its effect on promoting organizational change.
- Participation of hospital CEOs, board members, managers, and physicians in quality improvement (QI) and public reporting.
- Public reporting programs' experiences with hospitals and their communities.
- Implications for federal, state, and private organizations as they design and implement public reporting programs, and implications for hospitals that respond to this new environment.
- CMS's perspective on the federal government's future directions for public reporting of hospital quality.

Many stakeholders accept that the U.S. health care delivery system can substantially improve the quality of the health care it delivers. One of several devices used by public and private organizations to try to improve care is to measure the quality of a health care provider's services and make the results available to consumers. The original basis for thinking that public reporting would improve health care quality was the notion that informed consumers would "vote with their feet" by patronizing high quality providers and avoiding low quality ones. This in turn would create competitive market pressure on the low-performing providers to improve care. Additional stimulants for public reporting now include the belief that consumers also impact quality by bringing concerns about hospital quality to their personal physicians, and that

public accountability can drive quality improvement through public image and reputation effects on hospitals. These concepts together motivated CMS's development of the Hospital Compare Web site (<http://www.hospitalcompare.hhs.gov>). In addition, about 50 state agencies and private organizations publish quality metrics for hospitals (see, for example, http://www.delmarvafoundation.org/html/public_reporting_summit_052604/WebSummariesFinal9.2.04.pdf, which will be updated and available on Delmarva's website by the end of August 2005).

This is the third in a series of conferences on public reporting of hospital quality measures in which the public debate over the practice has evolved. *The National Forum on Public Reporting of Hospital Performance Data*—November 15, 2002, sponsored by AHRQ—focused on the need for public reporting of hospital quality metrics. *Hospital Public Reporting: A Summit on Messages and Communication Strategies*—May 26, 2004, sponsored by CMS, AHRQ, the Joint Commission on Accreditation of Health Care Organizations (JCAHO), and DFMC—focused on techniques for communicating hospital quality measures to health care consumers. This third conference, *Hospital Public Reporting Summit: The Link Between Public Reporting and Quality Improvement*, focused on the direct impact of public reporting on hospitals themselves.

Section II of this report addresses several themes that cut across the conference presentations. Section III summarizes each speaker's key points. The conference agenda and slides of the conference speakers are available at http://www.delmarvafoundation.org/html/3_state_hospital_pilot/index.html.

II. CONFERENCE THEMES

Although the stakeholders at the conference—hospital medical directors, QI officers, hospital board members, CEOs, academic researchers, executives from state and business purchasing coalitions, health information vendors, and CMS staff—presented diverse views, several common themes emerged.

- ***Most stakeholders accept that the quality of U.S. health care needs improvement.*** The watershed study by McGlynn et al. (2003), and numerous other studies referenced in the 2001 IOM report, *Crossing the Quality Chasm: A New Health System for the 21st Century*, provided unambiguous evidence of that need, which is now accepted as fact by most hospitals and payers and by many providers and consumers. Solving the quality problem is essential for the long-term viability of Medicare and Medicaid.
- ***Achieving substantial improvements in health care quality requires transformational, rather than incremental, change that involves providers, consumers, and payers.*** Permanent, comprehensive, broad-based improvement cannot be limited to a few individual projects sponsored by a hospital's QI department. It requires changes to a hospital's organizational culture, involving all levels of governance, management, and staff.
- ***Transformational change requires more improvement of delivery systems than of individuals' performance.*** Systems include, but are not limited to, health information technology designed to support decisions made at the point of care and redesign of clinical processes.
- ***Public reporting of health care quality indicators is now widely accepted as a necessary to improve the quality of health care.*** The public debate is no longer whether to have public reporting, but how best to design it. In the past couple of years, there has been unprecedented cooperation and dialog among health care stakeholders, and opportunities continue for CMS to exercise leadership in public reporting.
- ***Hospitals are responsive to public reporting, even if consumers are not.*** There is little evidence that consumers have altered their behavior in response to publicly reported quality measures, although increasing evidence shows that hospitals and other providers respond in substantive and positive ways to public reporting. Continual refinement of the content and format of information displayed in public reports that allow all audiences to more easily understand and evaluate the information should lead to more impact in the future on both consumers and providers.
- ***Current public reporting measures may not be well suited for some components of transformational change.*** Current hospital- and physician-level quality reporting programs do not reinforce clinicians working in teams and focusing on chronic and complex conditions. Nearly all quality measures are designed around existing health care "silos" that do not facilitate patient-centered continuity of care.
- ***Transformational change requires active participation and commitment from all hospital leadership and staff.*** Even well designed quality reporting efforts will not

succeed if staff committed to them is limited to that of hospital QI departments. Clinicians, in particular, need to be committed to making the necessary system and clinical-process changes.

- ***Hospital executives and many boards of trustees or directors are paying attention to public reporting and pay-for-performance programs.*** Although public reporting activities have led to increased attention of boards and top management of hospitals to QI, that attention is still often limited. Having QI champions in top management and on governing boards increases the likelihood that a hospital will implement and sustain these efforts. Hospital management is also instituting or considering pay-for-performance incentives for hospital leadership, physicians, and all levels of hospital staff as one way to catalyze action on publicly reported measures.
- ***Hospital leadership and staff go through several stages of accepting and using quality reporting.*** The typical cycle of acceptance is first, shock and disbelief; second, anger and finger pointing; third, bargaining; and finally, acceptance and proactive use. Hospitals are currently at different stages of this cycle, but most seem to be at or near the bargaining stage. This is a major step forward, even from a year ago.
- ***Hospitals tend to allocate their fixed QI budget to clinical areas whose quality is measured.*** Hospital QI resources are fixed in the short term, shifting toward measured activities and away from unmeasured ones. Choosing which measures to further develop should take this into account by assessing which quality indicators in clinical areas need these resources most.
- ***Aligning the many current reporting programs frees hospital QI resources to report on additional measures.*** Managing the burden of quality reporting requires consolidating the many existing quality measurement and pay-for-performance programs by standardizing measure definitions. CMS has a key leadership role to play in doing so.

III. OPENING REMARKS: WELCOME AND PREVIEW

1. Roxanne Rodgers, P.M.P., R.N.

Public Reporting and Special Projects Leader, Delmarva Foundation, Easton, Maryland

Ms. Rodgers opened the conference by welcoming attendees on behalf of the Hospital Public Reporting Summit conference team: Myles Maxfield, Mathematica Policy Research; Anna Shearer, JCAHO; Mark Legnini, The Health Care Decisions Group; Janet Gadow, Delmarva Foundation; Mark Koepke, CMS Government Task Leader for the Three-State Pilot Project; and David Miranda, CMS Coordinator for the Assessment of HQA and Related Hospital Quality Public Reporting Activities Project.

2. Michael T. Rapp, M.D., J.D.

Director, Quality Measurement and Health Assessment Group (QMHAG), Centers for Medicare & Medicaid Services, Baltimore, Maryland

Dr. Rapp's opening remarks included a brief preview of conference topics. He first noted there have been substantial advances in public reporting of hospital quality measures since last year's CMS conference focused on messages and communications strategies. However, he also observed that public reporting is still in its relative infancy and faces many challenges. Solutions that will bring about transformational change require broad involvement, as the number and mix of conference attendees shows. Dr. Rapp suggested that perhaps the ultimate consumer of hospital quality public reporting is the hospital itself: hospitals not only collect the data to produce the measures, they analyze the results and compare their performance with that of other hospitals, ultimately benefiting in many ways. The conference's primary intent, then, is to help hospitals with this process by better understanding the issues surrounding hospital quality improvement and enhancing public reporting as a tool to improve patient care.

Dr. Rapp briefly described CMS's new Measures Management System. Soon to be implemented, it will focus on standardized development of new quality of care measures, maintenance of current ones, and retirement of old ones. Dr. Rapp also introduced Jean Moody-Williams, CMS's new Director of the Division of Quality Evaluation and Health Outcomes for the Medicaid program, who will lead the agency's work on Medicaid quality measurement.

IV. PANELS AND PRESENTATIONS

A. QUALITY REPORTING AND ITS EFFECT ON PROMOTING ORGANIZATIONAL CHANGE

1. Gregg S. Meyer, M.D., M.Sc.

Medical Director, Massachusetts General Physicians Organization, Massachusetts General Hospital, Boston, Massachusetts

Dr. Meyer, former director for Quality Improvement and Patient Safety at AHRQ, emphasized that as the cost of health care keeps rising, purchasers increasingly want to ensure that they are receiving good value for their money. Providing such information, however, presents several problems. First, although medical chart data are the most accurate for constructing valid quality measures, obtaining that data is very costly. As a result, many quality measures depend on administrative claims data, but they may not be credible enough to use for constructing valid indicators. Second, current physician group-level quality measures are not sensitive to heterogeneity among physicians within a group, nor are they consistent with the current team approach to providing health care. Third, low standardization among the public and private organizations that provide hospital ratings results in inconsistent hospital ratings. A hospital that ranks high using one rating system may rank much lower using another. Even ratings based on a single system have been unstable over time. These inconsistencies might also obscure longer-term trends in overall hospital quality improvement. Moreover, rating systems may not always control for case mix among hospitals, making a referral hospital, for example, seem worse than it would if it were not focused on more severe cases.

Finally, Dr. Meyer noted, it is still not clear how to best present quality ratings to consumers or purchasers to ensure they interpret the ratings correctly. In fact, he observed, public reporting of hospital quality indicators has not noticeably affected consumer or purchaser behavior, nor has it significantly altered provider referral patterns. This does not mean that public reporting is unimportant or has had no impact. Rather, it is having a major impact on hospital quality because hospital management and boards have responded to public reporting.

To ensure even greater attention to hospital quality measures, Dr. Meyer said that quality measurement or rating systems should be transparent, stable over time, credible, actionable, and parsimonious; make sense to providers; and meaningfully discriminate performance among providers. These properties indicate the great need to develop rational criteria for selecting which measures to publicly report. In developing such criteria, he emphasized the importance of recognizing that hospital resources shift toward measured activities and away from unmeasured ones.

To really achieve transformational improvement, Dr. Meyer called for adherence to what he calls “the iron laws of improvement.” The first is that “B teams with A systems always beat A teams with B systems.” The major task is to invest in improving hospital systems rather than that of individual providers. The second law is that “It’s not the seed; it’s the soil.” Even well designed quality reporting efforts will not succeed if all relevant players are not prepared and committed to making necessary changes.

If structured correctly, pay-for-performance systems can contribute to enforcing both laws. Pay-for-performance should be designed to reimburse hospitals for their investments in quality improvement systems. Currently, there is a strong business case for measuring and improving quality from the perspectives of CMS and the public, but the business case is not as strong from a hospital's viewpoint. The benefits from hospital investments often accrue to other organizations. Pay-for-performance should be designed to ensure that individual hospital staff, management, and board members see how they benefit from committing to a quality reporting effort. But preparing the soil for the seed also requires significant time and experimentation with financial and non-financial incentives.

2. Questions and Answers

Responding to a question about comparing cardiac surgery outcomes in states that have publicly reported on this measure with those that have not, Dr. Meyer said research has shown a long-term national trend toward improvement, but his review of the research seems to indicate that states with public reporting are moving faster. He noted, however, that cardiac surgery might not be the best example for demonstrating the impact of public reporting because the Society of Thoracic Surgeons has persuaded nearly all U.S. cardiac surgeons to participate in reporting data on these measures.

Regarding a question about board involvement in public reporting efforts at Massachusetts General Hospital, Dr. Meyer said he is given as much time in board meetings to discuss quality and safety issues as the CFOs are given to discuss financial performance. In general, boards would rather hear about poor performance from the hospital's leadership than learn of it from the news. They do not want public reporting to portray the hospital unfavorably.

Concerning nursing-staff involvement in QI, Dr. Meyer said Massachusetts General, which is a magnet hospital, has tremendous interaction with its nurses, who are substantially involved in day-to-day quality-measurement activities.

B. HOSPITAL LEADERSHIP AND SURVEY RESULTS

1. Thomas Vaughn, Ph.D., and Eugene Kroch, Ph.D.

Dr. Vaughn: Associate Professor, Department of Health Management and Policy, College of Public Health, University of Iowa, Iowa City

Dr. Kroch: Vice President of Research, CareScience, Philadelphia, Pennsylvania

The University of Iowa College of Public Health coordinated the administration of a Hospital Quality Improvement and Leadership Short Survey to CEOs and senior quality executives from a sample of hospitals in eight states. The specific purpose of the Short Survey was to identify characteristics that are most likely to strengthen quality improvement activities within hospitals. The Short Survey was a collaborative project coordinated by the University of Iowa and supported by in-kind contributions from CareScience, ActiveStrategy, and the National Committee for Quality Health Care (NCQHC).

The 18-question web survey was completed by hospital CEOs or their designees in Arizona, Colorado, Illinois, Iowa, New Jersey, New York, Pennsylvania, and Wisconsin. The survey

results, based on 413 responses that represented a 33 percent response rate, were linked to American Hospital Association (AHA) data to capture hospital characteristics. The data were also linked to a CareScience risk-adjusted outcomes-based hospital quality index that incorporates mortality, morbidity, and complications measures.

Dr. Vaughn and Dr. Kroch presented preliminary results from the survey. First, their findings indicate that hospital boards are paying attention to quality measures. In fact, 80 percent of responding hospitals reported that they use a formal quality performance measurement method for reporting to their boards. However, other survey statistics, such as those on board interaction with medical staff and the amount of board time spent on quality issues, indicate that many boards are engaged in QI efforts in a still limited way. These findings are enhanced by the researchers' detection of a systematic positive correlation between hospital quality index scores and the level of attention paid by hospital leadership to quality (measured five different ways).

The researchers also found an association between higher index scores and hospitals that said government, regulatory, or accrediting organizations have a high level of influence on their QI activities. However, hospitals also said that multiple reporting requirements from different organizations create impediments to quality improvement. Additionally, their research detected a link between hospital public reporting and better outcomes, especially in Pennsylvania, which is among the states with the longest public reporting history.

Although 94 percent of survey respondents said that changing the reimbursement system to focus on quality would have a high-to-medium impact on improving patient care, executive base compensation is not tied to quality improvement in most hospitals. However, approximately two-thirds of respondents base some portion of executive compensation on measurable quality improvements, and almost as many use quality metrics for executive performance reviews.

Responses to the survey question, "What single change would lead to the most significant quality improvement in your hospital," reveal differences between CEOs and hospital medical staff. Health information technology (IT) ranked highest among quality improvement executives and CMOs, but less so among CEOs, perhaps because the former are closer to IT and see its value. Among CEO respondents, engagement of physicians ranked highest, with this issue being cited three times more frequently by CEOs than by CMOs and medical staff. Other changes reported by respondents include improved payment alignment between hospitals and physicians, access to resources, and staff education.

As part of the Hospital Leadership and QI Survey project, the University of Iowa is also examining templates of hospital board performance reports/scorecards for 230 hospitals in the eight survey states. These scorecards are being compared according to the balance and composition of indicators, report structure and format, benchmarks cited, and software programs used. The presenters plan to publish their complete findings in summer 2005.

C. PANEL: HOW HOSPITAL LEADERSHIP RESPONDS TO PUBLICLY REPORTED INFORMATION

Lawrence Prybil, Ph.D., FACHE—Professor and Associate Dean at the University of Iowa's College of Public Health, and Vice Chair of the Board of Directors for the Sisters of Charity of Leavenworth Health Systems—facilitated the panel presentation. Panelists were asked to address

three issues: (1) the previous two presentations; (2) how hospitals in general and their peer group hospitals, in particular, view public reporting of quality and cost information; and (3) how hospitals, working together with federal and state agencies and with purchasers, can make public reporting more useful to consumers. The four panelists—a chief medical officer, a chief quality improvement officer, a chief executive officer, and a lead board member for a quality committee—presented four different perspectives on these topics.

1. Richard T. Lopes, M.D.

Chief Clinical Transformation Officer, Sisters of Charity of Leavenworth Health System, Lenexa, Kansas

Dr. Lopes described the Sisters of Charity System as a moderate size system with nine hospitals of diverse size in diverse regions that rely on organized medical staffs. He said the hospitals decided to participate in the Premier Hospital Quality Incentive Demonstration in order to introduce their providers to public reporting on quality measures and to begin benchmarking their performance.

The complexity of the delivery of health care, juxtaposed with actual delivery of care in a one-on-one, intimate relationship between a provider and patient, he said, partly explains the ineffectiveness of motivating patients to choose a provider based on quality measures. Public reporting has done a good job of measuring the outcomes and outputs of a complex system of delivery, he said, but it has been less effective in attributing many of the outcomes directly to individual physician behavior. Another problem is that many physician do not understand the need for, and therefore do not accept, efforts to redesign clinical processes. Dr. Lopes agreed with Dr. Meyer that although information technology and other system solutions may be necessary in the longer term, the “creation of favorable soil” is more important at the clinician level for short-term improvement.

Dr. Lopes made several suggestions for improving individual physicians’ accountability and acceptance of system changes. They include reporting physician-specific quality measures, linking inpatient and outpatient quality measures, engaging the help of specialty medical societies, increasing the transparency of public reporting goals, providing the appropriate IT infrastructure, conducting physician-specific profiling, and incorporating financial incentives into individual provider compensation packages. He asserted that purchasers will play an important and continuing role in achieving a higher level of individual accountability through pay-for-performance and other provider-contracting incentive systems. He also emphasized the importance of ensuring that system changes encourage individual providers to “default” to best practices and enhance provider efficiency. Another important factor in promoting acceptance by individual providers is to present system changes and redesign of clinical processes so as to win their trust. Engaging physicians in system changes and redesigning processes will help such efforts.

Something not often talked about, a better case for the potentially detrimental clinical impacts of over-utilizing health care services should be presented, Dr. Lopes suggested—for example, the increasing use of CAT scans or imaging studies. Most measures of outcome and process in the public domain currently focus on under-utilization.

2. Jolene Goedken, M.S., B.S.N.

Vice President of Medical Services and Quality Improvement Officer, Sisters of Mercy Health System, Chesterfield, Missouri

The Sisters of Mercy Health System includes 18 hospitals in Oklahoma, Kansas, Missouri, and Arkansas. Ms. Goedken noted that each hospital has unique cultural aspects because of differences in medical staff culture, facility sizes, and locations in urban versus rural settings. The System's quality efforts began several years ago, with interviews of hospital leadership about quality and priorities for improving it, she said. The System then developed a physician leadership council of CMOs and vice presidents of medical affairs, who became the primary authors and drivers of their QI efforts. Currently, those efforts encompass three key tenets—care that is customer-centered, knowledge-based, and collaborative-minded—all designed to increase the likelihood of desired patient health outcomes. The tenets recognize that in today's environment, collaboration at all levels and excellent team performance are required to achieve the best possible health outcomes.

To translate its goals into day-to-day practice, the System first incorporated them into its strategic initiatives, each led by a team of CEOs, physician leaders, nurse leaders, corporate-office vice presidents, and subject matter experts. The Clinical Quality strategic initiative focuses on six areas, one of which is Outcomes Measurement and Reporting. The associated leadership team, Ms. Goedken said, is developing internal and external Web sites to disseminate information about quality, publicly report outcome performance measures, and share "lessons learned" across their health system. External Web site design and development has drawn extensively from community focus groups. She noted that the System has adopted the strongest form of transparency and has linked outcome measures to assigned targets; she displayed one of the System's simple outcome-measures reports, which quickly shows viewers whether each hospital is above or below the System's-defined target.

Ms. Goedken echoed Dr. Meyer's observation about an acceptance cycle of internal hospital quality reports:

- "Shock and disbelief"—for example, providers wanting to see and validate the underlying figures before they are submitted to CMS, multiple attempts to explain their performance, citing lack of documentation of their actual provision of target services, arguments that it is too early to set targets without understanding the data better
- "Anger and finger-pointing"—for instance, there are too many measures, the target measures are not important to quality, collecting paper records is too burdensome, shortcomings are someone else's fault, other providers or nurses are not documenting outcomes, the CEO's focus is on financial instead of outcome measures
- "Bargaining"—citing a need to improve adjustments for severity, questioning whether internal quality reports are really worth the effort, and how much can process measures accomplish in the face of patient noncompliance
- "Acceptance"—openness to sharing data, sharing best practices across the system, willingness to constantly improve.

She believes that several, but not all, of the System's facilities are transitioning to this last stage.

Ms. Goedken suggested the following next steps for the Sisters of Mercy Health System and other hospitals: first and foremost, all relevant players need to collaborate to standardize and prioritize hospital quality measures; second, they need to scrutinize whether pay-for-performance guidelines can be applied effectively by standardizing and simplifying incentive structures among both public and private purchasers; third, consider whether federal legislation is necessary to accommodate HIPAA confidentiality requirements; and fourth, provide rewards and incentives for investment in health information systems (particularly to the many hospitals that cannot afford such investments) and design these systems to produce useful information.

Steps she has found particularly helpful in encouraging private-practice physicians to engage in system reform, she replied in answer to a question, include articulating the compelling need for physicians to pay attention to the measures and to the benefits they will accrue by embracing changes; bringing consistency to messages directed at improving service, quality, and safety for patients; and ensuring that any changes reduce, or at least do not increase, physician workload.

3. David Bernd, M.H.A., F.A.C.H.E.

Chief Executive Officer, Sentara Healthcare, Norfolk, Virginia

Mr. Bernd, a former chair of the AHA board, presented the AHA's views on clinical quality and public reporting and efforts to help hospitals improve clinical quality. He described the AHA's goals as: (1) building awareness of the need for AHA and member hospitals to be involved in clinical quality improvement and public information; (2) creating a public policy environment that facilitates improvement for the industry; (3) promoting expectations of field performance to determine areas that AHA hospitals can concentrate on to improve health care; and (4) providing a central location for strategies and solutions. To meet these goals, the AHA developed the Quality Center, which will be a clearinghouse for quality improvement ideas and access to best practices. Partners in the Quality Center consist of the Hospital Quality Alliance (HQA) organizations, which, in addition to the AHA, include the AFL/CIO, CMS, the Federation of American Hospitals, the Association of American Medical Colleges, NQF, and AHRQ. HQA's primary goals are to help hospitals assess QI products, services, and market strategies and to help adopt standardized, properly incentive-aligned measures of hospital quality.

Turning to Sentara, Mr. Bernd said Sentara may have instituted systemic changes more easily than the two hospitals previously discussed because, as a regional health care provider, it provides a unified environment that facilitates information sharing among different care venues. Sentara has \$2 billion in revenue, integrated physicians, and six acute care hospitals located between Williamsburg, Virginia, and northeast North Carolina. Its providers believe that the quest for quality benefits them substantially in several ways: (1) strategic market differentiation increases its market competitiveness; (2) QI efforts reduce costly problems and mistakes; (3) QI improves patient safety; and (4) improvements in quality induce superior financial performance.

Historically, bottom-line-oriented hospital administrators have spent most of their time trying to improve infrastructure and billing, materials management, and other business structure components because these areas are often easier to deal with and to understand than improving

clinical quality. The most profitable hospitals, however, almost uniformly focus on quality improvement from a clinical-process basis, use quality to differentiate themselves from other hospitals, and view quality as being key to their long-term financial success.

Mr. Bernd described how Sentara arrived at its current stage of QI efforts. Ten years ago, its initial steps included collecting basic quality measurements of customer satisfaction, average length of stay, and cost per discharge. To understand clinical effectiveness, it also began profiling physicians and using clinical protocols. The key to success, it found, was to find and involve crucial champions within a facility. Sentara also found that clinicians are data-driven and competitive; they want to know how to improve to match their peers' performance. Quality data that are used for improvement, not for economic credentialing or threatening physicians, can dramatically improve clinical quality among medical and clinical staff. In Phase II, Sentara identified 10 critical areas for improvement, focusing on community health needs and on acute and chronic care in its institutions. Sentara then concentrated on improving critical processes and applying evidence-based medicine in these 10 areas.

The current Phase III aims to establish strategic and annual goals and to track progress in a monthly "red light, green light" report. In 2004, the report included 27 measures of quality and patient safety addressing the continuum of care. The board of directors is very engaged in quality reports, and Sentara has built quality-improvement-based incentives into all job descriptions and performance expectations. An example is an annual monetary award for improving quality and financial performance, given to teams across functional areas or care venues. Compensation for the CMO and the CFO is subject to the same clinical quality goals, which include short-term and long-term financial incentives. There is also an employee gain-sharing program based on clinical quality and financial targets. Sentara's more recent efforts appear to have substantially reduced "red lights" on reports, and they may be responsible for a significant decline in malpractice claims in the past 18 months.

Mr. Bernd agreed with the previous speakers that continued transparency in developing measures is very important, that quality-measurement targets and financial incentives for physicians should be used positively and not punitively, and that purchasers and providers are increasingly demanding standardization of quality measures. Transparency and public disclosure are not likely to change consumers' behavior in the near future, but it will probably raise the general quality of care nationwide as health care providers are forced to examine and improve their own performance. Mr. Bernd believes the future will bring stronger links between provider payments and performance, as well as shifting more focus to quality than to productivity.

4. Doriane Miller, M.D.

Section Head, General Internal Medicine, Rush Medical College, Chicago, Illinois, and Chair of Board Quality Committee, Ascension Health, St. Louis, Missouri

Dr. Miller discussed the role of hospital boards in quality improvement. A recent NQF forum on achieving the six QI aims contained in IOM's 2001 report recommended that hospital boards provide adequate resources, assess the financial impact of allocated resources, and ensure quality health care partly through performance measurement. NQF stressed that this requires not just data and data review, but also adequate staffing dedicated to QI activities, clearly delineated QI leadership roles, and shared QI responsibilities among several staff members. Also important are making QI

educational resources available to staff, understanding and analyzing organizational design, budgetary and resource alignment, and board endorsement of pay-for-performance initiatives for all staff levels.

She emphasized the importance of composing hospital boards that understand the many hospital processes that might need to be reformed for QI efforts to be effective. Boards should include physicians, nurses, pharmacy staff, consumers, and representatives from the fields of industrial and systems engineering, health care administration, and risk management. She noted that effective boards also spend adequate time discussing quality issues. Holding boards and staff accountable for establishing QI measures during periodic performance reviews can also positively impact hospital quality. Additionally, Dr. Miller stressed the importance of improving the quality-literacy of boards through education to help them understand how performance data can be practically translated into QI activities. Additionally, consumer representatives on boards should be very active in every aspect of the boards' involvement in QI efforts. The NQF conference, Dr. Miller reported, also emphasized the necessity of board members' extensive leadership and participation to sustain and broaden hospitals' QI activities. Furthermore, the conference noted the importance of informing boards about the negative financial consequences of poor performance and adverse outcomes.

Ascension Health has worked to incorporate many of these principles through its "call to action," which has established specific, measurable, and timely objectives. Several specific steps it has taken include: composing a board of both trustees and non-trustee experts who understand the connection between health care financing and quality; developing multi-disciplinary clinical-excellence teams of physicians, nursing staff, and administrative, financial, and risk assessment staff; focusing on reducing non-comfort care mortality; and becoming a partner and national champion in the Institute for Health Care Improvement's (IHI) 100,000 Lives Campaign.

Recalling Dr. Meyer's comments about "preparing the soil," Dr. Miller said Ascension Health has been examining the safety culture and the safety climate within its individual health ministries to find ways to work better with medical staff to promote these concepts.

5. Questions and Answers

Panelists were asked how to improve aspects of care that are not measured or publicly reported. In response, the panelists described several QI initiatives in their hospitals that are not driven by publicly reported measures, but rather by concerns about patient safety, internal assessments of areas that need improvement, or new evidence-based guidelines for effective care.

Panelists also responded to a question about how to ensure that publicly reported measures encompass all patient subgroups. They cited a clear need for more efforts devoted to examining health care disparities at both a system and a local level. One way, they said, is to encourage local hospital leadership to adopt AHRQ's guidelines for addressing health care disparities. Another is to analyze data at the most local level possible. Panelists also indicated that hospitals probably do a better job of serving all patient subgroups in emergency rooms, but the biggest challenges are to provide good follow-up care after patients are discharged.

Another question sought panelists' comments on federal government activities that could help support QI efforts. The ideas panelists offered included: (1) by example, encourage performance measurement and linking pay-for-performance, particularly because private-sector purchasers often follow CMS's lead; (2) create incentives and measurement tools that reward team behavior and, in

particular, encourage physicians to accept team care; (3) design non-punitive incentive systems that encourage poorer performers to improve along with better-performing providers; (4) standardize the definitions of quality measures; and 5) keep communication channels open among the public and private sectors.

Panelists also addressed the challenge of ensuring that clinical QI activities and incentives do not drive a wedge between administrative staff and medical staff. Among their suggestions:

- Create a strong partnership between institutions and physicians and other clinicians.
- Provide incentives that save clinicians time while improving care.
- Reimburse physicians for the time they invest in QI activities.

In a related vein, panelists said it is critical to include nursing staff in QI and public reporting efforts. The relationship and cooperation between the nursing and physician staffs often lay the foundation for promoting a QI culture. Nurses are important as clinical partners, providing unique knowledge and expertise in the quality realm that is sometimes overlooked. Additionally, particularly in rural hospitals, nursing staff delivers a substantial amount of care.

D. STATE AND BUSINESS COALITION QUALITY REPORTS: HOW HOSPITALS HAVE RESPONDED

1. Jerry W. Burgess, M.B.A.

President and Chief Executive Officer, HealthCare 21 Business Coalition, Knoxville, Tennessee

The HealthCare 21 Business Coalition is a non-profit purchaser organization that is committed to improving the quality of health care for east and mid-Tennessee. Mr. Burgess said its three core strategies are: (1) improving the health care purchasing process; (2) developing reliable, standardized measures at the local, state, and national levels to quantify provider value; and (3) improving communities' health by involving consumers in all aspects of purchasing. Purchasers, he said, facilitate improved transactions between providers and consumers by establishing appropriate incentives and providing information on health care cost and quality.

Financial incentives and information should be supplied to both providers and consumers in health care transactions, Mr. Burgess said, adding that HealthCare 21 has done so through its design of health insurance benefits, consumer-driven health plans, and consumer guides that report provider cost and quality—such as its “Heart Health” guide based on Leapfrog measures. He said the coalition’s informal research indicates that its purchaser involvement and consumer guides distribution has led to faster improvement in several areas of the state (as evidenced through the Heart Health guide’s ratings) than would have occurred otherwise. The coalition tries to balance consumer and provider interests by, for example, including some language the hospitals wanted in its Heart Health guide but still keeping the guide user-friendly. Hospital and physician response to this consumer guide has been mixed, accompanied by the common friction in any buyer/supplier relationship.

While purchaser/provider collaboration across its markets varies over time and by concentration of purchaser presence and assertiveness in the process, HealthCare 21 believes that

in general, cooperation with most providers has improved dramatically over the past nine years. Collaboration now includes meetings between purchasers and providers with open discussion about the weaknesses and strengths of different measures and their use in pay-for-performance initiatives. Mr. Burgess believes HealthCare 21's commitment to the national agenda of quality measurement, rather than developing its own local standards, has been partly responsible for provider acceptance.

Other signs of HealthCare 21's impact on quality include QI projects initiated by providers. For example, he cited a recent initiative among all Knoxville-area hospitals to reduce ventilator-associated pneumonia in ICUs. The hospitals worked together to develop and adopt a common clinical protocol. Indicators showing that this initiative improved care have been accompanied by purchaser-sponsored recognition activities. Hospitals are now extending this momentum to the development of rapid response teams for IHI's 100,000 Lives Campaign.

Mr. Burgess said that achieving continuing QI success includes staying focused on the goal of patient safety over the long term, finding key people within an organization to champion change and quality initiatives, fostering open communication between purchasers and providers, giving "black marks" to providers who choose not to participate in public reporting, carefully validating data while acknowledging their limitations without letting "the perfect be the enemy of the good," and creating a long-term vision.

2. Paula Bussard, M.S.

Senior Vice President, Policy and Regulatory Services, The Hospital and HealthSystem Association of Pennsylvania (HHAP), Harrisburg, Pennsylvania

HHAP represents more than 200 hospitals and health systems in Pennsylvania, Ms. Bussard said, noting that the state's hospitals have been publicly reporting for almost 20 years—as required by the Pennsylvania Health Care Cost Containment Council (PHC4) and, more recently, by other organizations. The state is unique in also having a patient-safety reporting system. The board of PHC4, she said, resembles a purchasing-coalition structure more than most state agency boards. Even though Pennsylvania hospitals have been publicly reporting for two decades with broad hospital staff support, she claimed, some newspapers and aggressive consumer advocacy groups have portrayed hospitals as unwilling to accept public reporting, placing their efforts in the "bargaining" rather than "acceptance" phase of QI efforts.

Pennsylvania has initiated a more recent reporting effort under the Patient Safety Authority (PSA), created in 2002. All Pennsylvania hospitals, in addition to reporting serious events, now are required to have a patient safety officer, a patient safety committee with two community members, and a patient safety plan. They also must report "near miss" incidents and give patients or their designees written disclosure of serious events. The PSA is non-regulatory and non-punitive, designed to provide "a culture of learning." It releases a public annual report with aggregated, non-hospital-specific data.

Ms. Bussard said Pennsylvania hospitals first and foremost believe in transparency for providers, public and private purchasers, and insurance companies. Good data can help foster such transparency. The hospitals also believe that clinicians should provide most QI leadership and that all public-reporting processes must be collaborative and deliberative, which most often occurs in the

“bargaining” phase. Other principles, she said, include ensuring that whatever measures are collected and reported are actionable by clinicians and designed to improve care in whatever setting the care is provided. The ultimate goal of public reporting should be to help providers respond better to patient needs and to help consumers make better decisions, to empower them in their interactions with providers, and ultimately to increase their satisfaction with the health care system.

3. Questions and Answers

In response to a question about major insurance carriers’ involvement in HealthCare 21’s quality initiatives, Mr. Burgess said health plans have a seat on its board, are members of its purchasing coalition, and provide valuable input about how they use quality measures. Regarding recognition of hospitals that refuse to voluntarily report data publicly, he said that a hospital’s refusal is noted in the HealthCare 21 consumer guide, but that coalition members still contract with the hospital. However, he explained, under a new HealthCare 21 consumer benefit initiative to be launched this fall referred to as “tier and steer,” consumers will pay more for choosing a low-performing hospital.

The two panelists said that to use the media effectively, hospitals must constantly educate reporters and emphasize how the publicly reported data can be useful even if they are not perfect. Addressing how to improve the support of QIOs for hospital QI, the panelists said QIOs should be included in all of the hospital’s collaborative QI initiatives. One panelist also suggested that improving QIOs’ political savvy and communication skills would increase their support.

Another audience member asked the panelists how to standardize quality measures to reduce what is called “measurement madness.” Mr. Burgess suggested that coalescing around the NQF, which involves both the private and public sectors, is the best way to certify measures and methodologies. He also indicated that purchasers are likely to gravitate toward Leapfrog Group measures, which are based on a comprehensive methodology and on NQF methodologies and measures.

The panelists also discussed whether pay-for-performance initiatives that reward top performers and penalize bottom performers discourages people from helping their colleagues at other institutions. Mr. Burgess said HealthCare 21 would design initiatives to steer consumers away from only “the worst of the worst” and perhaps eventually to drop such hospitals from its network. He said such hospitals should be dropped if they do not provide good value, because they may be doing more harm than good. Ms. Bussard said health care is more like education, where some people receive services without paying for them (e.g. in public schools), and that hospitals serving vulnerable populations should be supported.

E. PANEL: IMPLICATIONS FOR HOSPITALS AND FOR REPORTING PROGRAMS

The final conference panel, moderated by Mark Legnini, Dr.PH., of the Health Care Decisions Group in Washington, D.C., focused on implications for reporting programs, hospitals, and other organizations as they implement and respond to public reports of hospital quality.

1. Michael Lundberg, B.S.

Executive Director, Virginia Health Information (VHI), Richmond

VHI is a public-private partnership that produces health care information, consumer guides, databases, and analytical systems. Mr. Lundberg said that VHI collects, analyzes, and disseminates Virginia health care data under contract with the Virginia State Health Commission. The VHI board includes representatives of hospitals, physicians, nursing facilities, business, consumers, health insurers, and state agencies.

The effectiveness of hospital data reporting, VHI has learned, can be enhanced by involving hospitals in all aspects of the public reporting process, from designing the measures to designing severity adjustments in response to challenges to the reporting model. Hospital executives have said VHI's public reports have led them to start monitoring low-risk patients with higher than expected mortality rates, or using admission tools to better identify high-risk patients in order to improve their hospitals' care management processes. Some have also said they changed internal policies to improve reporting of secondary diagnoses and revised their coding process to better represent patient mortality risk and severity of illness. Some have even contracted with different coding companies because of their existing contractors' poor coding.

VHI's current activities include an expansion of cardiac-care information for 14-day readmissions, consideration of including 30-day post-hospitalization mortality rates from death certificate records, and independent evaluation of the AHRQ quality indicators for potential inclusion in VHI's public reporting activities. VHI values the national information and the standardization that would be available from adopting the AHRQ indicators; it is already using AHRQ's prevention quality indicators for local health department monitoring of chronic disease.

Commenting on the conference's previous presentations, Mr. Lundberg believes that both administrative data and medical record extraction data are valuable for deriving publicly reported health measures. Patient-level data from administrative records is more readily available, he said, but could be strengthened by adding clinical indicators such as "present upon admission" information to the UB92 hospital claim form. He also asserted that part of the reason public reporting is not having a stronger impact on consumer choice is that it is not being disseminated or promoted adequately. The best way to improve both, he said, will take collaboration among business coalitions, hospital associations, government agencies, and others. Finally, he noted the importance of collecting and reporting health quality data that is amenable to consumer decision-making and choice, such as focusing more information on elective surgery or services (for example, obstetric care) than on non-elective treatments such as AMI process measures.

2. Sheila Roman, M.D., M.P.H.

Senior Medical Officer, Quality Measurement and Health Assessment Group (QMHAG), Centers for Medicare & Medicaid Services, Baltimore, Maryland

Dr. Roman provided CMS's perspective on hospital public reporting based on HQA and the Premier Hospital Quality Incentive (HQI) Demonstration project. Her experience as a faculty member at Johns Hopkins has shown that public reporting creates urgency for hospitals to review their data, to be data-driven, and to systematically consider their quality measurement and

improvement processes. HQA's efforts have been successful largely, she posited, because of the alliance's collaborative nature and commitment among public and private organizations and U.S. hospitals, which has enabled standardization of measures between JCAHO and CMS. She did note, however, that CMS believes that so far, the project has targeted "low-hanging fruit" and is now moving into a much more difficult phase of quality improvement: standardizing measures nationwide while maintaining their usefulness to multiple stakeholders.

Hospital Compare reporting has made it clear that hospitals consider more than financial returns in choosing to publicly report. About 40 percent of hospitals that currently report on the Web site voluntarily report the additional seven HQA measures that are not tied to Medicare payment updates. In addition, many critical access hospitals are reporting data even though they have no financial incentive to do so. Dr. Roman said it is too early to analyze movement in HQA scores because the number of hospitals differs among the several quarters reported to date. Although CMS agrees that consumers are not yet involved in public reporting as much as the agency would like, it still believes that consumers should have provider choice and need information to make good choices. Hospital Compare experienced about a half-million hits in its first few days online and currently gets about 150,000 hits per day. CMS expects this number to increase substantially as baby boomers age, and it believes that public reporting will increasingly affect consumers' health care choices.

Turning to the HQI project—the first national Medicare project to pay for quality—Dr. Roman said that very preliminary, non-validated data from the demonstration indicate there has been improvement in composite quality scores for all hospitals (not just the top-tier ones), between the fourth quarter of 2003 and the third quarter of 2004.

Dr. Roman summarized CMS's view of public reporting's success and challenges. Transparency and accountability have increased at the national level, largely because of the alignment of CMS and JCAHO hospital measures. CMS's experiences have also highlighted the need for data to identify clinical opportunities, and they have helped many hospitals begin to build a culture of quality.

Many challenges remain, she said: selecting measures that do not significantly increase hospitals' burden but divert resources to QI; considering whether to use the same measures for pay-for-performance efforts as for public reporting or for supporting QI efforts; maintaining the measures' stability and consistency while ensuring that they can respond quickly to the changing health care environment; providing timely feedback to hospitals; and finally, proof of effectiveness and analysis of results, such as understanding the correlation between process measure scores and outcomes.

Dr. Roman said the next frontiers of public reporting include better understanding of how to actively engage clinicians and respond to the reported data; considering other dimensions of quality such as cross-cutting, patient-centered measures; advancing the adoption of pay-for-performance; standardizing scoring methods; increasing understanding of health information technology's role in promoting quality; and, finally, creating an environment of transformational change throughout the health care system to support needed changes.

3. Stephen Horner, M.B.A.

Assistant Vice President, Outcomes Measurement, Hospital Corporation of America (HCA), Nashville, Tennessee

HCA is a for-profit health care company with 190 hospitals across the United States, mostly in the South and the West. Mr. Horner said it also has hospitals in the United Kingdom and Switzerland, which are applying lessons learned from U.S. hospitals, asserting that Europe tends to be 10-15 years behind this country in QI activities. HCA has a unique perspective on hospital quality measurement because it is both a health care provider and its own vendor of JCAHO and HCA data collection and submission.

When deciding whether to participate in the HCA, the company made two key decisions. First, its board felt “it was the right thing to do for the patient”—that is, it did not use a cost/benefit analysis in its final participation decision. Second, HCA believed that participation was too important to let individual local hospitals decide, instead mandating it for all its member hospitals. Mr. Horner noted that these decisions were made before the financial reporting incentives were added to the 2003 Medicare Modernization Act.

HCA has faced a number of challenges, however, since deciding to participate, such as the burden of collecting additional data because some of its hospitals use measures not required by JCAHO. That burden includes the need for more nursing staff to collect the data, the complexity and detail of data definitions, and issues such as deciding who will document the data (physicians or nurses—or both) and where to keep these data within their information system. Other challenges Mr. Horner cited involve the increasing number of measures being used not just within the HCA, but also through JCAHO, other vendors, myriad payers, and professional societies, many of which use disparate measures or descriptions of them. The multiple reporting programs require more complex and expensive health information technology and systems. Finding the right skill mix within HCA staff to conduct root-cause analysis is another challenge, as are individual hospitals’ instability of scores over time, making it difficult to conduct root-cause analysis or develop best practices; uneven QI leadership among HCA hospitals; and clinicians’ lack of acceptance that the measures and methodologies are valid.

Among the positive impacts of the company’s HCA public reporting are improved inter-departmental and inter-staff communications and more attention to QI issues from leadership and boards. In fact, HCA has incorporated the HCA results (along with AHRQ measures) into its “clinical dashboards” for all its hospitals, which are used as an incentive compensation base for many of its CEOs. The company has also incorporated the HCA measures into its internal measures used in its centers-of-excellence program. HCA hospitals that achieve a center-of-excellence rating receive \$1 million in capital to invest in their programs the following year. Another positive effect has been collaboration among multiple HCA hospitals in a single geographical area to collectively improve heart failure and AMI results by sharing best practices. HCA’s analysis has also indicated a positive link between its hospitals’ performance on the HCA heart failure, pneumonia, and AMI process measures with lower rates of complications and mortality for those conditions.

Mr. Horner said that moving hospital QI efforts forward requires addressing several issues: (1) establishment of a central data warehouse or clearinghouse to reduce or eliminate the

disparity of measure definitions and data-collection requirements among public and private payers, accreditors, and regulators; (2) development of composite scores for health conditions or treatments, such as a single measure for heart failure, to help consumers make better choices among hospitals; (3) more payer incentives to motivate consumers to choose the best hospitals; (4) greater alignment of physician and hospital incentives for QI; and (5) increased payer support for developing health-information technology systems in hospitals.

V. CLOSING REMARKS: WHAT HAVE WE LEARNED, AND WHERE ARE WE HEADED?

1. Stephen F. Jencks, M.D., M.P.H.

Director, Quality Improvement Coordination, Office of Clinical Standards & Quality (OCSQ), Centers for Medicare & Medicaid Services, Baltimore, Maryland

Dr. Jencks summarized the key messages from the conference, discussed next steps and priorities for CMS, and described important messages he believed were not highlighted during the conference.

Key Conference Messages

Dr. Jencks said one of the most interesting messages from the conference is that people are no longer talking about *whether* to publicly report hospital quality measures, but rather *how* and *when* to do it. Although public reporting so far appears to have had little impact on consumer choice or physician referral patterns, there is abundant evidence that it has catalyzed hospital organizations to make internal changes and implement QI efforts.

Conference presenters discussed mostly transformational system changes, he said, rather than small, incremental ones focused on a few individual providers or staff or on reporting a few selected QI measures. Still, he noted, presenters emphasized that a systems orientation has not yet been reconciled with current reporting measures and rankings, which tend to focus on individual providers instead of clinical teams.

Dr. Jencks summarized the factors that presenters said seem important for transformational system change: (1) greater adoption and financing of health information technology, (2) increased executive leadership and board competence regarding QI efforts, (3) aligning financial incentives for QI across many different providers (particularly hospitals and physicians) and within clinical teams, and (4) preparing physicians to accept and embrace system change. Physicians often do not understand the need for change, are too busy to facilitate or adopt changes, or overestimate their readiness and ability to change.

Presenters also said that to incorporate system changes, it is necessary to understand the local hospital and medical culture, but there are no tools for assessing local culture and matching interventions to it. Regarding the purchaser's role in QI, speakers called for direct financial returns to the entity that finances an investment, such as information technology. Moreover, on the whole, U.S. purchasers have paid providers to deliver *more* services instead of *appropriate* services.

Despite these system shortcomings, however, a unique opportunity exists to transform the health care system. First, Medicare and other purchasers have data that indicates whether some health care services do or do not enhance quality. Second, the hospital industry has developed effective strategies to implement transformational change. Third, U.S. health care will become steadily worse and more complex if we do not invest in QI. Fourth, important groups have become more willing to collaborate on QI, and they are asking government to lead the transformation—a change from the past, when many were concerned that government leadership

would lead to command and control. The government is increasingly seen as the best entity to establish consistency and standards. Finally, transformational change to solve the quality problems is essential for the continued viability of Medicare, Medicaid, and the State Children's Health Insurance Program (SCHIP).

Advice to CMS

Dr. Jencks summarized presenters' main advice to CMS:

- Keep the pressure on for QI, but do not leave weaker institutions behind.
- Standardize quality measures, methodologies, and public reporting requirements.
- Align multiple public reporting programs.
- Keep communications open and do not set up QI programs or incentives that drive a wedge between physicians and hospitals.
- Emphasize the need for systems of care and systemic changes to improve the quality of care in all parts of the health care system.

He also cited the conference's two main implications for the future. The first is the need for a clear vision of the U.S. health care system 10 years from now and the quality measures that will drive the system toward that vision. This vision needs to recognize that the massive IT adoption likely in the next three to seven years will completely change the number and kinds of collectible measures, as well as the breadth and types of care that can be monitored. The second implication is that, although current published measures are fairly imperfect on several levels, we need to continue to collect and publish measures in order to make progress.

CMS's Role

CMS can influence performance in the health care system by several means, Dr. Jencks said:

1. **Provide leadership.** This includes developing a vision of the future health care system, credibly conveying it and how to achieve it, and advising all stakeholders how to make reaching it a good experience rather than a bad one.
2. **Standardize methods.** Develop and promote standardized measures, information-system standards, clinical guidelines, and other uniform processes to achieve the vision.
3. **Promote and create partnerships.** Collaboration can be very powerful in bringing people together and influencing change.
4. **Provide technical assistance.** Regarding Medicare, this work has been done mostly by the QIOs, but many other organizations have provided, and can continue to provide, technical assistance to help effect transformational change.
5. **Public reporting.** Providing public information is very important, but it is only one tool in the kit for quality improvement.

6. **Patient-centered care**. Make coverage and payment decisions, as well as rewards for performance, based on patient-centered care services. Although we do not know how to do this yet, many people are working toward that vision.
7. **Motivate providers to embrace system change**. Measuring improvement is relatively easy compared to motivating it. Moreover, motivating systems change is much harder than motivating improvement, but it must be done.
8. **Create and use effectiveness data**. This is one of CMS's strategies for improving the U.S. health care system. CMS may alter or clarify benefit-coverage decisions as new effectiveness data are accumulated.

2. Questions and Answers

Regarding how to ensure that all health care providers can make the necessary capital investment in IT, Dr. Jencks suggested that loan programs are likely to be more politically viable than a grant program similar to that for hospital construction under the Hill-Burton Act.

As to how much provider income should be subjected to pay-for-performance to affect QI, Dr. Jencks indicated that, although there is no definitive answer, relatively small amounts of money seemed to have motivated hospitals to sign up for the Premier Demonstration, perhaps anticipating the growing trend toward pay-for-performance. He also argued for keeping the amounts low in this stage of measurement development because of imperfect measures and data integrity issues.

In response to a final question, Dr. Jencks discussed CMS's plans to bring Medicaid in line with Medicare's QI efforts by helping states to develop measurement methodologies and data capabilities.

REFERENCES

McGlynn, E., S. Asch, J. Adams, J. Keeseey, J. Hicks, A. DeCristofaro, and E. Kerr, "The Quality of Health Care Delivered to Adults in the United States," *The New England Journal of Medicine*, Vol. 348(26): 2635-2645, June 26, 2003.

Institute of Medicine. *Crossing the Quality Chasm: A New Health System for the 21st Century*. Washington, DC: Committee on Quality of Health Care in America, Institute of Medicine, March 1, 2001.