

**What Other Nations Can Teach Us About
A More Patient-Centered Health Care System
Welcome and Panel 1
November 4, 2005**

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ED HOWARD: Good morning. My name is Ed Howard. I am with the Alliance for Health Reform. We are pleased to be partnering with the Commonwealth Fund on this final day of this wonderful conference. Many of you may not be familiar with the Alliance. We have been in business a startlingly long time in my lifetime—15 years almost.

We are a nonpartisan or bipartisan—or both—group whose mission is to help members of Congress and their staff and other opinion leaders here in Washington mostly to understand better the challenges and tradeoffs that you have been talking about for the last two and a half days that can lead us to a health care system that delivers quality affordable health care to everybody in this country, which is our preoccupation.

Today, we are going to anticipate a bit more of a dialogue, a two-way conversation between this wonderful international array of experts and officials, and some key policy staff from the U.S. Congress about the issues that have been on the table.

There seem to me to be something in the Harris Interactive Cathy Shane [misspelled?] article survey to offend everybody. There is plenty of work for all of us to do and I think Don Berwick illustrated dramatically last night that one institution can achieve well beyond even the target for an improvement in a particular jurisdiction, so we know that there

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are tools available to help us to get to that improvement.

This morning we are going to explore ways to learn from each other how to improve quality and safety, what is being tried, how well it is working, how it might be transplanted to other settings, and I am very pleased to be able to be part of that and the Alliance staff is here, including me, to help you get through this morning. If you have any questions or any problems or some situation you want to deal with, just see one of us, including the folks at the registration desk, and we will be delighted to try to help you with it.

I want to introduce now Robin Osborn. Most of you know, she is the vice president of the Commonwealth Fund and the moving force behind this entire conference. Robin, would you like to address us now?

ROBIN OSBORN, MBA: Thank you Ed. Good morning. On behalf of the Commonwealth Fund, I am delighted to welcome you and to thank you for joining us to the Commonwealth Fund's eighth international symposium on health care policy. I know I am speaking on behalf of Karen Davis, president of the Fund, whom you will hear from later today, when I say how pleased we are to be able to conduct this morning's session here on Capitol Hill.

This is an innovation for us that we introduced last year in order to be able to include in the program a broad audience of congressional staff and Washington policy makers.

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We are particularly grateful to the Alliance for Health Reform and Ed Howard and staff for their collaboration in arranging this morning's program, and to John Iglehart of *Health Affairs* for their partnership in organizing this annual event.

For those of you who are joining us this morning, the Fund's annual international symposium brings together health ministers, senior government officials and leading international policy experts to share strategies and spark creative policy thinking in response to pressing health care issues that are common across our health care systems. The Commonwealth Fund has, since 1918, conducted research and sponsored service delivery innovations, helping to address many of the most urgent health policy problems in the United States, recognizing that many of the issues of greatest concern to the Fund, access to adequate preventive and primary care, quality of care and responsiveness to patients concerns and needs, reducing barriers to health care for vulnerable populations, long-term care for the elderly, and ensuring value for money in health care, are matters of concern in other industrialized countries. The fund established an international program in health policy and practice.

The program is premised on the belief that while health care systems may be financed and organized differently and operate in different political and cultural contexts, it is valuable nonetheless for the policy makers, researchers and

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journalists to look beyond their own borders at the policies and innovations of other countries.

I think there is often a conventional wisdom here in Washington—and it operates similarly in other countries—for each to believe that it has the best health care system in the world. Our aim is not to dispute that, mostly because what we have learned from the work that we've done is that no country is the best or the worst, each performs well on some measures and has room for improvement on others. But what we hope to do through cross-national comparisons and exchange, such as this morning, is to share country policy experiences and results, highlight innovations and identify where country approaches may offer lessons to be learned.

The core countries of the Fund's international program are Australia, Canada, New Zealand, the UK and the United States, and we have been particularly pleased, beginning last year, to have been able to expand the program to include senior government officials and experts from Germany and the Netherlands. I would also add that all of our international work is strengthened and enriched by strong partnerships with other foundations who are here today: Ridelfial [misspelled?] Trust, the Health Foundation, Bertelsmann Foundation, Canadian Health Services Research Foundation as well as the OECD.

Uwe Reinhardt, professor of political economy at Princeton University, an internationally recognized health

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economist, whom we are privileged to have on the panel later this morning, chairs our international coordinating committee. Yesterday morning we presented the findings from the Commonwealth Fund's 2005 international health policy survey of sicker adults in six countries, which were simultaneously released as the Health Affairs web exclusive and there is some great coverage in today's Washington Post, which I hope everyone has seen.

The survey findings and *Health Affairs* article, which are in your meeting packs, highlight the experiences of sicker adults, people who are very dependent on their health care systems, very high users, having intense medical experiences. And the survey tries to bring out what those experiences are about in terms of access, medical errors, coordination of care, pharmaceuticals and management of their chronic illnesses.

For this morning's program, we are focused on examples of country innovations that we think are particularly relevant to the United States and relate to common issues, challenges that happen to be prominent at this time on the U.S. health policy agenda. We will hear about a major initiative for hospital benchmarking in Germany. The UK is very ambitious, patient safety agenda, and how physician performance and financial incentives are being linked to improve quality of care in the UK.

I'd like to thank our country experts this morning for

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joining us and for the thoughtful background papers that they have prepared. And I would especially like to thank Gail Wilensky, senior fellow at Project Hope and a member of our International Advisory Committee since 1998, for chairing what promises to be a terrific luncheon roundtable session. And last, but not least, to thank the congressional staff whom we are thrilled to have join us on the program, who are working on these particular issues and have generously agreed to provide firsthand reactions to the models and approaches that will be presented this morning.

I expect that we will have a very, very rich day. But before I turn the program over to Ann Montgomery and to Ed Howard, I just want to provide some context for this morning's discussion, particularly for those who have joined us and haven't been with us for the past two days, in terms of how the US and other countries compare on some very broad measures. My thanks to Jerry Anderson and his team at Johns Hopkins for much of the data that I will be showing this morning, which has also just been published by the Fund and is available on our website at www.cmwf.org.

With this data, each country has a story to tell, but since this morning is about the United States looking abroad, I am only going to be speaking from the U.S. perspective and I only have about five minutes, which is the other reason why. So it is not to neglect the other stories, but there is only

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going to be time to do one country and zip through these pretty fast.

When it comes to health care spending, looking at health care spending as a percent of GDP, the United States is clearly an outlier spending almost twice the OECD average. Similarly, the United States, while many of these countries in the OECD, despite having universal coverage, there may be some cost sharing and there may be services that aren't covered, where there is out-of-pocket spending. But here again, the United States is something of an outlier in terms of the magnitude or out-of-pocket spending.

What we think of the U.S. health care system is being predominantly employer-driven health insurance coverage, private, I think you can see from this slide that the public spending on health care in the US is actually comparable to the other countries, in addition to having very large private sector. The United States stands out typically when we look at how much we spend for services in health care and the United States is at the upper end of the spectrum when it comes to spending for a hospital discharge, hospital episode. Similarly spending for physician services, also for pharmaceuticals.

Utilization, the United States ends up usually at the other end of the spectrum. We have low rates of admissions to hospitals, our average length of stay is short compared to other OECD countries, average number of physician visits, also

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low compared to other OECD countries. Where we've had to stand out, again, is when it comes to some of the very high-tech procedures, the expensive complicated procedures, and there the US tends to be one of the top consumers.

On access to care, the United States stands out in terms of financial barriers. And this is data that comes from our 2005 survey of sicker adults, where one in two sicker adults reported that they had to forego some form of care—doctor visit, filling a prescription, other follow-up treatment—because of financial barriers.

Where the United States invariably looks very, very good is when it comes to not having waiting lists. And this was from our 2003 survey, which was hospital chief executives, where we asked about waiting times—waiting times for breast biopsy, waiting time for a hip replacement—and the United States had virtually no waiting times compared to other countries.

Quality of care—this data will come from the Fund's international working group on quality indicators, and that work is transitioned to the OECD and it is a much bigger project now in 21 countries, many more indicators. But the quality of care story was very mixed for countries, and what we found clearly was that every country did the best on some of the measures, and every country performed at the bottom of the spectrum on others.

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Here, for example, you can see five-year transplant survival rates. The U.S. performance is at the low end, versus breast cancer five-year survival rates, where the United States performs extremely well. The United States has also, in our recent surveys, done very well on preventive care and has a very good profile in terms of percentage of people getting recommended preventive care.

Patient safety—this is a composite slide—these are the sicker adults in our survey that was released yesterday, where we asked if they had in the past two years experienced a medical error, medication error or error in terms of getting lab test results. And here you can see the United States does not do as well as the other countries, and some of that may well be due to the fragmentation from the health care system.

Patient experiences with health care—we have thousands of slides on those and I don't have time to show you. I'm just quickly going to show you what are two. This is on choice, and we asked patients who had had surgery in our sicker adult survey if they were satisfied with the amount of choice they had in selecting a surgeon and the United States shows high satisfaction rates on choice, which is very much built into our system. But when we asked overall how they rated the quality of care they had received, overall patients in the US tended to be more negative about the quality.

I think just a couple fast message—takeaway messages—

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that the industrialized countries that we were looking at are all facing very similar challenges. No country's performance is perfect. There are wide variations in health system performance and we see those as opportunities for cross-national learning.

In many cases however, we are concerned because the US performs at the bottom range on quality and access, despite spending more, and that raises some important questions about value for money. But the good news is many of the issues that we are looking at are amenable to policy action and that is what we are going to hear a bit more about today. Thank you very much, and I am delighted to turn the program over to Ann. [Applause]

ANN MONTGOMERY: Thank you Robin. Good morning to you all. I am Ann Montgomery at the Alliance for Health Reform. I am very pleased to be here and thank you so much to the Commonwealth Fund for hosting this.

It is a real pleasure to be here this morning to discuss and compare key health quality developments that are taking place in the United Kingdom, in Germany, in the United States and elsewhere. Some of these initiatives are concentrated in the public sector, while others emphasize the role and the potential of the private sector, and all of them are multifaceted and evolving rapidly.

So it is particularly fortunate, as Ed and Robin have

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mentioned, that we have an outstanding lineup of speakers and discussants here today, who will explore and explain some of the more compelling recent initiatives and what they aim to do and what they have achieved.

Our first speaker today is Dr. Christof Veit. Dr. Veit manages QUANT GMBH in Hamburg, Germany, in which capacity he oversees quality-benchmarking programs for health care facilities in 13 of Germany's 16 regions. And these programs aim to continuously improve patient care. If I have understood this correctly, QUANT evolved out of a project that was pioneered in the Hamburg region by the company EQS. Dr. Veit will give us an overview this morning of Germany's groundbreaking national quality benchmarking project, including a bit about its history and how the findings are used. Dr. Veit?

CHRISTOF VEIT, M.D.: Thanks for the welcome. It is a terrific experience to be here, and when I say thank you to the Commonwealth Fund, it is not politeness—it comes from the heart.

I want to tell you on the national benchmarking project on quality benchmarking with all German hospitals, which is a project we routinely run now. I would say in the fourth generation of the project. It all started in '88 when surgeons had sort of a more supportive approach to who is the best surgeon in Hamburg and they compared their complication rates.

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Since then, we have changed three times the organizational part, the methodology, and the culture of the project. We are now running the project as I show it to you today for two years now, and we are already working on the next generation. So it really is something that is an evolving project. It is not perfect now. We have a lot to do, but it is moving and it shows results, which we are very happy about.

The principle is very basic; the details are more elaborate. The principle is define good quality in health care, measure and improve it in all hospitals involved nationwide. There are two things I want to point out. The first thing is define good quality in health care. We learned that we should start our projects, defining our standards. In the beginning, we were just collecting data, look what the variance is and then say this should be our standard.

Now, we learned it is much better when you have the experts who come from the hospital, sit down, view the literature, view the evidence, write down what the standard should be, giving them the sentence, "Good quality and the care for patient with hip replacement is..." and then the definitions come. Then you pile up the literature, what outcomes should be, what treatments should be done. And then we go to the hospital scene and say, "Look, these are our standards. We can discuss it."

If someone stands up and says, "This quality indicator

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is nonsense," we say, "Here is our evidence. Do you have a better ones?" If yes, we learn. If no, "Please join us." The culture-first define your standards was a lot of effort, but it pays with the acceptance of the hospital's participating.

The second is that we started as a culture of voluntary projects. With quality management, we want to be friendly people, we want to be consensus-based, we want to moderate the participants, which is true. No project can run when people are not motivated. But after awhile, running these projects on that basis, people were frustrated that there still were the refuses, which you always have. And at one point, we decided we want to improve quality for all the patients in Hamburg, for all the patients in Germany; therefore, we must have those hospitals get involved. And you can involve them early with penalties.

We found that we have to have two cultures in one project. The one is, do get the enthusiastic ones involved. They have the ideas. They do the pilot projects. They are the first ones to help you. Then you have the mass of the neutral ones, who hesitate, who just wait what will happen, they are not reluctant, but they are not sort of stepping forward. Inform them and make it attractive. Have the idea. If you want a quality improvement project, your project is for the service of the hospital. It is not that they have to serve your system, but you serve the hospital to improve their

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quality. So you have to make it attractive for the hospital.

And then you have the critical ones. You have a meeting, you want to advertise your project and someone stands up and says, "This is nonsense. This does not work. This is not good enough" and it is very, very important. The project is your child and you tend to be very mild with your child and forgive them. And these people, who are intelligent, you really show the problems you have with [inaudible] force you to become better.

So always be happy that there are the critiques—there—use them to become better, they force you to become better and this has been very helpful, not to resist them, but just pick up their good points. And then with the refusing ones, you just have to make it unattractive for them to refuse to participate. The measures we have are financial. If they do not report their patient treatments to the state and national data pool, they have to pay 150 Euro per patient, which if they have a thousand patients in a project, it brings it up to \$150 in Euro penalty, which is quite painful. And we have on the Internet, the rates with how they participate in our project. So it is very publicly known who participates and who not.

In the area of Hamburg, we have 100 percent participation now. And the thing we have to learn was, we feared, starting with voluntary projects, that the hospital wished to do—the anesthetist came up to us and said, "We want

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to do a project." The urologist came up and said, "We want to do a project." And then introducing [inaudible], we thought that the morale would go down because now it was sort of a top-down approach, but it did not.

The acceptance raised because people felt that we are serious about the goal to improve quality for all the patients in our region and that we were really serious to go along with that, still having the quality management culture of trying to do it together, of making it clear you have no chance to refuse, and acceptance raised.

At the moment, we have more than 2,000 German hospitals participating, which is more than 98 percent, and by this year, we will have 100 percent because of the penalty. We have more than 5,000 medical departments involved and milo [misspelled?] is not a [inaudible]; it is the German abbreviation for million, we have more than three million cases in 2004, which more than 20 percent of hospital cases in Germany that are in the database in one or another way.

In Hamburg, we have a project where we do surveys of the cubital all system, all the patients, so we have more than 300,000 cases there; more than 300 quality indicators in 26 areas of care. There are more than 800 experts involved of a national or regional level, which are experts that come from the hospitals. That is something where the hospital can find themselves, where they can influence what are the indicators,

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where they can influence how it is evaluated. And later you may ask me with how many people we've run these projects. It is huge, but to be huge does not necessarily mean it is good.

The first thing I said—define the standards of medical and nursing care, make them available to everyone. Document the processes, risks and results. You have to have integrated documentation tools for the hospital so that they can do it. One important step was that we would give the software industry a standardized database every year for the update of the software, where you have all the fields, the plausibility rules and whatever you need, in a way that they can automatically integrate that into their special computer software surrounding. So we have more than 60 software vendors. We just import this every year and can update easily on the project. They are happy to have this national standard.

Measure and visualize variation, as variation is the strongest power to move quality. If you tell the hospitals where they are compared to the others, it is like comparing countries, but even more, hospitals. They will be not happy when they find themselves to be somewhere where you should not be and it is the strongest strive. But pride on their own work is the strongest strive to improve quality.

Then we define levels of acceptance, where we say, this range of results we accept as being one-fourth, and this range of results we do not accept, we go into dialogue with the

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hospitals, why do you have this result? And then we analyze the variants within the structure dialogue, where we have special ways of analyzing indicators, whether they are process indicators or outcome indicators, whether they are referred to only a few cases or to a lot of cases. So we have special ways of asking the hospital, "Please, why do you have this outlying result and let's analyze what we can do about it."

And then start improvement processes and check whether you really get better. This is sort of the rough structure. We are questioning indication where we think indication is a problem. We've really tried to be problem focused. That means in the cardio catheters, we are not so much troubled by how it is done, we are more troubled by the indication. So we have a lot of questions for the indication of cardio catheters.

With hip fracture of course, indication is not the question, but whether they get postoperative physiotherapy, whether they are able to walk after one week or whatsoever. We address in each field specifically whether indication or diagnostic procedures or the way the treatment is done or outcome is the thing we are worried about—variants that shouldn't be there. And this is also used to bring national guidelines into practice because asking the doctors and nurses, "Have you done this and this and this and this?" They are reminded everyday whether they follow the national guideline.

I was reported one day from an anesthetist, cardio

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anesthetist—because do a project there as well—that their surgeon, the cardio surgeon is going in the morning through the operation theatre, so where he can see someone doing a coronary bypass, you will ask him, “Do you use the internal lameri [misspelled?] artery?” because they ask for it.

Evidence so far couldn't make him move from why he was treating an operating patient, but that we asked him, “Did you use this because this is the national standard?” he will go around and say, “Okay, they asked for it, so we better do it.” On the other hand, the data pool we have now is very precious for those who continue to develop the guidelines. They come to us and say, “What's happening in obstetrics? Should we change anything?” For example, with sterility treatment, we could show that we have an increase in multiple births. And these neonates, they were very ill because they were early neonates. So we could tell them, “You have to change the standards of your sterility treatment.” And then we could find when they did this then the multiple births went down again. So you can really follow what is happening.

From the structures, we have the fertile joint committee, which has some political responsibility. We have a national institute; we have national expert groups in the national database. We have the same thing on the regional level and there, the hospital center data to this database, they have the structure dialogue with the state project office.

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The data events for the national database, and we have a close cooperation between the national institute and the state project offices. And we have some of the project around on the national level because, for example, Hopschwantz, France [misspelled?], patient centers are not that often in Germany.

So this is the structure and I just happen to be responsible for Hamburg, the state project office. We run 13 out of 16 state databases—the national database and I am on the federal committee there.

The major responsibility on the national level is the financing rules. We have patient representatives involved, which now really influence the culture of the project a lot and we really like it. We can perhaps discuss that later. Whereas, on the regional level, we have the structure dialogue.

The hospital sends the data mostly by Internet to the data service and the project office gets protocols, statistics and data. This is rich material to work with the hospital, give them feedback. When they send in through the Internet, their data, within five minutes, they have a feedback on their data, the quality of their data. When the hospitals get their statistics, you might find that two of the hospitals are numerical outliers. Then you start the structure dialogue. You ask them why does this happen? At this point, we do not say, "You have a quality problem," because there might be a very good reason why someone is not in the result, within the

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acceptance range.

For example, we had the indicator that you shouldn't do hysterectomies on patients who are under 35 years of age. We had one hospital having 63 percent of their patients being under 35 for hysterectomies and we had another one with 27 percent. We asked them, "What is going on there?" And the one with the 64 percent, they wrote to us, "We are specialized in treating transsexual people, so they come as women and we transform them, so hysterectomy is a very normal procedure." It is okay. So we learn. We have to improve our indicator.

The other one said, "They are mostly young women from Turkey who have finished with the family planning," and these are just the prejudices we have to fight because being a lady from Turkey is not an indication for hysterectomy, neither is it that you have finished your family planning at the age of 35. And we say, "We are not tolerating that." We have two hospitals: One having very good reason—and we learned from their answer—and the other one, where we say, "No, we are not tolerating that." So there, do correct and check it.

The results are discussed in the expert groups anonymously. And then when there are repeatedly outliers, then they are opened up. And our expert group just recently has judged one of the members of the expert group to be a qualitative outlier. They are very just. They said, "You are excused. We do not accept. You have to do something for your

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quality."

We do give a structured report for the steering committee and the state because they have to see whether politically they have to act on the results here. And we give reports, standardized records, to the national committee and national expert groups so they learn for further development of the project. We also have regional meetings that are very, very important.

The hospitals of Hamburg come together to discuss the variants of their results, even more now that we put the statistics on the Internet for the public so they can look into that. And here they learn what is their variation, what is best practice, some would stand up and say, "We have a problem. How do you solve it?" Someone else will say, "Well we were working with that life data and therefore we have better results." Improve, check and learn. This is the culture where I think this is really precious for them, to have a learning environment from the data where they are. We have a huge variety of projects, like pneumonia, coronary catheters, obstetrics and so on.

Questions—where we have to work on this data validity, risk adjustment of our indicators, working with confidentiality, where will we open up? And hospitals are forced now to do a quality report on the Internet every other year, and how much of that becomes part of the benchmarking

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project as well?

One important thing is that we work for improvement instead of [inaudible]. It doesn't make sense that we tell the Hamburg population, "Surgeon 'X' and surgeons that are the best ones." What are we going to tell those patients who cannot get an appointment with these two surgeons? We want to have that we raise the quality of all the surgeons who offer an operation to the same level if possible, and the others who cannot achieve that, to step out. Rather than telling, "This is number one and this is number two," we would draw the line to tell them, "These are class A or class B hospitals and these are the ones who do not offer that."

This is how the results are presented. Here you have every hospital is a column. Here is the one that is evaluated. Here is the range of not acceptable results. This is from perineal too. And the standard is less than 2.7 percent. This is okay. It is represented to them like this, in a long report. We can visit hospitals for advice. We identify continuous quality problems. We have these regional conferences.

Do we have results? Yes we do. We have the incidence of this disputable [inaudible] since 1994 until 2004 in Hamburg hospitals, and we have about 200,000 cases per year. And we could lower it from something like 1.9 percent to below 0.8 percent. And this is not for just a few hospitals, this is for

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200,000 cases per year. This is for the Hamburg population because we have all hospitals in there.

Antibiotic prophylaxis in hip replacement, going up from something like 92 percent to 98 percent. And if you look at the variants we had—and 2003 is still there—we had hospitals being as low as something like 55 percent. They increased their percentage of antibiotic treatment, but as they were given the feedback only in the middle of 2003, they did not have the opportunity to change for all the years. So the results now are even better. But we still work with these who have non-tolerable results. One infection really could be shown that it went down.

Just the last thing—the question is, do these results improve because medicine anyway improved, or is it the project? And my friends from the state of Hassy [misspelled?] they did a wonderful study. They have a huge area of Hassy with Frankfurt here and they do regional conferences. This is about antibiotic prophylaxis and hysterectomy. They did a regional meeting that there should be more prophylaxis. And after the regional meeting, they got better. They looked at the results of the non-attenders of that meeting, and you can see, they did not react. No one can say, "Okay, the attendants are always those who are interested in quality and the non-attendants are not interested, so they are different anyway." But they looked at the rest of Hassy, where you have the motivated one and the

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non-motivated one, and this was the result of those of other regions who did not have a regional meeting. And you see the attendants were even worse than the rest of Hassay. So you could really show that the regional meetings do change the behavior of hospitals and you do get results that improve quality.

In the future, we are looking at more general indicators like the decubitus ulcers, falls, pain treatment. We are much interested to get long-term outcomes and to find followups after one year, after two years, which we already do, for example, in heart surgery. Benchmarking of hospitals and ambulatory care together—these are some of the gains. We try to be more interactive through the Internet, and getting a more problem focused, more public information. This is where we work.

Just to answer the question of the national institute, where 25 people to run this, and to run the national database and 13 of the 13 state databases, we have 15 people with 1,400 hospitals reporting that to us because we've highly automatized the project and we think we have to be slim. We don't have a lot of scientism. Would it be wonderful? But the other question—if it would have had a hundred or two hundred people, would improvement have been faster? Thank you very much.

[Applause]

ANN MONTGOMERY: Thank you Dr. Veit. That was really

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interesting. And before we turn to our open discussion session—and please use the mics to join in and to press the button—first we will hear from two senior congressional staffers as discussants. First, Ken Serafin from the republican staff of the House Ways and Means Committee and Diana Birkett from the democratic staff of the Senate Finance Committee.

Ken is an attorney and a staff member of the Health Subcommittee of Ways and Means, where he has primary responsibility for Medicare Part A issues. Previously, he worked for the Pennsylvania Insurance Department and has expertise in medical malpractice issues, having served as chief counsel for the state's Medical Malpractice Compensation Fund.

Diana is health policy advisor for the Senate Finance Committee and she has focused a substantial part of her work on health care quality, pay-for-performance and health information technology.

So Ken, if you would like to start off and offer some comments on Dr. Veit's presentation and bring us up to date on what the Ways and Means Committee has been doing in this area, that would be terrific.

KEN SERAFIN: Thanks Ann. It is a pleasure to be here. I just want to start off and say the comments are my own and off-the-record. I thought Dr. Veit's presentation was very interesting in a number of respects. First of all, the

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participation of all hospitals is impressive. And comments regarding voluntary participation and then how they went to the participation of all hospitals through encouraging participation through financial penalties, that is something that is very interesting in telling. The publication also of results is something that is very crucial.

With respect to what we are doing on the committee and our perception of pay-for-performance measures, we noted the lack of consistent measures and the lack of reporting over the past few years than with the Medicare Modernization Act in 2003. With respect to the hospital realm, it imposed reporting requirements in 10 conditions. And following implementation of that, if a hospital did not report, they would be subject to a financial penalty—I think it's market basket -0.4 percent.

Through that legislation and that reporting requirement, I believe CMS had about a 98 or 99 percent response rate on those 10 reporting measures, which I think is suggestives and indicative of the fact that incentives do work and it is something that should be explored in the future. What has been happening since, through various demonstrations, including the premiere demonstration, which involves about 270 hospitals, it is a demonstration that seeks to provide standards and quality reporting measures; it seeks to compel the hospitals to report if they don't meet certain criteria and efficiency levels and performance levels, they are subject to

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financial penalty. If they excel, they will get a bonus. And I think the preliminary results from what I've heard so far are encouraging and have resulted in quality improvements. I think that starts to be the next step as to where we want to go, depending ultimately on how that works out.

Other initiatives include physician group practice demonstration. CMS is conducting a variety of demonstrations, all of which we are monitoring and we are very interested in how they turn out. But we are interested in pay-for-performance. We want to move from a pay-for-reporting system into a more pay-for-outcomes and actual improvements in quality. And we are very interested in the public initiatives and the public-private partnerships to get to that point.

Our position is, we would like to see continued progress. We would like to improve the transparency. We would like to improve upon the Medicare Modernization Act and benefits that that's provided so far, but we are very early on in the process it seems and we have to get some coordination and some consensus on what appropriate standards are, what appropriate reporting requirements are, the difficulties that hospitals may experience in reporting, and those problems have to be worked through intelligently. And that is what we are trying to do now.

With respect to specific initiatives in the House, there have been a couple bills proposed fairly recently within

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the last couple months by Chairman Johnson of the Health Subcommittee. She was working on health information technology issues, promoting interoperability, the use of electronic health records, exemptions from the Stark Law requirements to permit hospitals and physicians to work together to get to the point where they could start using health information technology more efficiently. And she has also worked on a Physician Payment Bill, which also included pay-for-performance mechanisms.

But again, these pay-for-performance initiatives require the consensus and the willingness of the participants and the providers to work together toward really improving quality of care. And everybody understands what best practice is and understands that we are not quite there yet. And there has to be a willingness, and to the extent that the German model can provide some sort of instruction as to how to organize—define the measures, organize a reporting structure and promote reporting and quality improvement, that is something we are very interested in doing and something we are going to be working very hard on in the future. Thank you.

ANN MONTGOMERY: Thanks so much Ken. And now we will turn to Diana and we would love to have your thoughts on what some of the recent quality initiatives are that we've seen in Medicare, some of which Ken discussed, and what is still left to do, and what parallels or similarities you see to what

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Germany is doing.

DIANA BIRKETT: Certainly. First, I would also like to echo Ken and just say that my comments are off-the-record and are my own. And I would also like to thank the Commonwealth Fund and *Health Affairs* and the Alliance because I am always very anxious when new data comes out on health spending and quality and comparing different countries because it is definitely the resource that we look to, and I am very grateful that that resource exists.

Just to start, what strikes me about the German project is that they are facing a lot of the same problems that we are in terms of things that they struggle with: The risk adjustment issues, the data validity issues, and issues about confidentiality are all things that we've wrestled with, as on the Finance Committee, we are looking at both following up on things that CMS is currently doing in terms of hospital and physician quality and reporting, but also as we are looking farther down the road to things like pay-for-performance.

Some of the things that I think are particularly interesting about the project are, as Ken said, the fact that they have encouraged so many hospitals to participate and that there has been, seemingly, a willingness to do so and to accept the sort of stick model, as opposed to providers in the US I think are still sort of hoping that the carrot model will prevail and that we will be putting new money into these

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initiatives.

Also, the way that they are stratifying providers—they are doing public reporting on a stratified basis rather than just sort of exactly numerically how hospitals rank as opposed to one another I think is an important thing and something that we've been talking with physicians about in the US. Because of course, here there is particularly a concern about malpractice and liability, especially if inevitably somebody is going to be that last person on a list and that is never going to look good and also going to potentially be problematic in terms of liability. That is an interesting approach that I think we can learn from.

The other thing that I think we can learn from is the collaborative and learning model. I work most directly for Senator Baucus, who is the ranking member on the Finance Committee and he is from Montana. In Montana, we have a fairly collaborative health care industry. There is usually, in many of the small towns, one critical access hospital and so all these different critical access hospitals tend to collaborate to drive quality improvement. It is a very different model than in other places around the country—Boston for example—where there are huge health care providers that are competing against one another quite vehemently. And so the collaborative approach I think is one that we can work on cultivating. We see the benefits of it in Montana and I think that perhaps we

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can work on that around the country.

Some things that we are doing here—Ken mentioned several of them and I will just add a couple—the new physician reporting project that CMS is implementing that they just announced last Friday, they are going to provide “an opportunity” for physicians to begin reporting quality data on a select array of quality measures, beginning January 1, 2006. It will be interesting to see how that plays out. I think that doing it in a completely voluntary way up front poses both some benefits and some detriments.

The benefits could be that people sort of have an opportunity truly to have a trial run and get used to reporting, see what it is like, we can work out some of the kinks up front. The detriment would be that since it is completely voluntary, nobody might do it. Ultimately we might need to have some sort of a financial incentive or penalty.

We are also seeing the development of a patient safety survey for hospitals that will soon go into effect and there has been a fairly rigorous cost benefit analysis done on that. The patient safety survey has gone through some ups and downs. It definitely poses a threat to the vendor industry in the United States that has been fairly successful, keeping a business of providing a patient satisfaction survey to hospitals, so we do have to deal with that. But I think that it will provide some valuable information not only about—we

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already have the information about hospital process and some about outcomes, but now also having the patient safety aspect.

Just in terms of what the Senate and the Finance Committee in particular is doing—we actually have some quite recent news. The last several days have seen the Budget Reconciliation Bill on the floor of the Senate and it finally went to final passage last night. That bill actually includes language that was quite almost identical to a bill that Senators Grassley and Baucus introduced earlier in the summer to begin paying for performance across all of Medicare. So not just hospitals, but other providers under Medicare and moving from a reporting phase into a second phase, which would be the actual paying for quality rather than quantity, which is how we do it today.

That bill was incorporated into the Senate Reconciliation Bill. It went through a couple of changes and passed the Senate last night. The complication here of course is that the House has gone through their own reconciliation process and has not put Medicare on the table in terms of addressing Medicare cuts or spending in their reconciliation package. So we are going into a conference process where the Senate has some fairly aggressive, moves forward in terms of quality and Medicare and the House has nothing and they will have to come to some sort of agreement about what they will keep and what they will throw out. And that is sort of a black

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box at this point. We don't know how that will pan out, but hopefully we will find out in the next several weeks or months and be able to move forward on some of these issues.

I think we have a lot to learn from each other. I think that we should be inspired by the success in Germany and be perhaps shamed into getting going on our own turf and really emulating some of the things that they had done over there. Thanks.

ANN MONTGOMERY: All right. Now it is your turn. Thanks to our three panelists for some really cogent presentations and observations. Please use the mics and press the button and you will see the red light, that will indicate it is active and raise your hand and I will try and recognize you and remind us of who you are. So now it is your turn. Who has a question? Okay.

VERA KERLANSICK: Hi. I am Vera Kerlansick [misspelled?] from American Association on Health and Disability. I have a question about how all of these systems, the proposed systems in the states and the existing system in Germany—how their development goes along with the development of how information technology and Christof—Dr. Veit—mentioned the cost of the penalty for the hospitals. I didn't know if there was any cost to the hospitals in if they had to develop any new information structure or if that already existed. And how will that play out for the United States as we try to move

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forward?

ANN MONTGOMERY: Great questions.

CHRISTOF VEIT, M.D.: Well, quality benchmarking came up when a fixed price payment system was introduced and the politicians felt we should follow quality closely when we have a fixed price payment system. With that, all the hospitals had to have quite a good IT system within their hospitals. So we have some basic structure there.

And the second thing was that using this standardized way to have the medical quality data put into the system integrating, that helped the [inaudible] awareness a lot to have the standardized database where they could automatically integrate it into their system. So it was not too expensive. The hospitals, now they get something like between 5,000 and 25,000 Euro a year for the documentation effort, which is not really covering. But they say, "Okay, it is a little tribute to what you are doing."

Certainly, we try to use more and more information technology to keep costs low. Because of course, everyone's asking why don't you put this money into patient care rather than into the [inaudible] thing. Therefore, we really can't stop flow and everything. And it helps us. We do this structure by a log from the next year on the Internet. It is easier for the hospitals. It is easier for us. It is easier for the experts.

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ANN MONTGOMERY: Diana, really quickly does the bill that you were referencing that went in the reconciliation package in the Senate include new money for HIT?

DIANA BIRKETT: No, it doesn't. It just addresses pay-for-performance and quality. There is a separate package that is a bill that combined a bill that Senators Kennedy [inaudible] Grassley and Baucus put together with one by Senators Frist and Clinton. It was cast out of the Help Committee back in July and we are trying to get it through before the end of the year—that would not put a lot of new money toward health IT—because we are struggling with the budget as it is, but it would include a small grants and revolving loan program for the people who are really struggling. It is definitely an important consideration.

ANN MONTGOMERY: Go ahead.

JOHN GREEN: John Green from the National Association of Health Underwriters. To followup on that last question, are you able to measure—since you are getting improved performance—are you able to estimate savings to the hospitals that sort of serves as an offset since you are not able to fully subsidize the cost of implementation of the program?

CHRISTOF VEIT, M.D.: We have no calculations so far; it is on the way. But the hospitals report that they are happy when they can reduce one infection grade to things like that obviously. On the other hand, it is rather discussed in

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Germany as a political issue because we have a fixed budget for the hospital that cannot be raised. So the hospital has to pay anyway for it. But they say politically we cannot tell the society that we get something like 3,000-4,000 Euro for treating an appendicitis and we cannot have complication statistics. How can we tell society?

If we want to discuss with society how much money for health care, we have to have numbers. If we can show that under lowering the budget, the quality gets less, we are very powerful, but for that we have to have numbers. So to follow what is happening in our health care system, it is within the interest of the hospitals. And therefore, they were willingly to say, "Okay, we follow this project because it gives us also political data to discuss with society."

ANN MONTGOMERY: Yes sir?

JAMES MELFORD: James Melford [misspelled?], I am one of the Commonwealth Fund's [inaudible] fellows from the UK. I thought it was absolutely fascinating and I think the speed with which it seems to have been rolled out and the level of automation is fantastic. I am just trying to put it into the context of the talk that we had from Don Berwick last night about how maybe the way that we define quality today is in the wrong space and it is not about moving along a normal curve, it is about shifting that curve along. The example he gave was the target for acute [inaudible] infarction of nine percent and

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the hospitals that can achieve mortality is below three.

So I am just wondering whether you see any risk in the approach that you've taken towards maybe stifling innovation or other methods that would be game changing towards quality improvement?

CHRISTOF VEIT, M.D.: The novelty of things are taken up very quickly. So for example, when the national guidelines change, we have I think a much higher speed that they are really spread within the medical community that it was in earlier times because from the next year, they will be asked in the questionnaire, "Did you follow the new guidelines?" Certainly we do have points where the Hamburg obstetricians or the Hamburg radiologists say we do no longer accept that and that results. We must have a jump in improvement, not just a little bit better.

There we had some initiatives focusing on problems, which really showed a much quicker way of quality. So I think we really are within the philosophy of [inaudible] as well. But sometimes we want to move it quicker, but at least we have what we have.

ANN MONTGOMERY: I think we have time for one more question.

MALE SPEAKER: This is a very impressive account of physician recorded quality improvement in Germany. Has Germany also considered collecting patient reported outcomes of the

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health experiences?

CHRISTOF VEIT, M.D.: We do not have it in our project. But what we do as a quality management office for Hamburg for example, we do patient questionnaires and we do ask what all your experience is within the hospitals. This is one where it comes in. And the other is, as I showed to you, we have more and more patients being in the expert groups. And they are sometimes not happy with the project, where the doctors are. And they put really force into it, which we love, because it forces us to look still at a different angle there. And as this was already intruded in 2004, they are there. They have moved a lot, but I think the cultural change just started.

ANN MONTGOMERY: Great. Ken, if you have any closing thoughts and then I think we are running into our coffee hour.

KEN SERAFIN: I won't keep you from your coffee hour.

ANN MONTGOMERY: Thanks to you all for a terrific panel. [Applause]

[END RECORDING]