# THE WHITE HOUSE

Domestic Policy Council

DATE:________

FACSIMILE FOR: Pamela Johnson

PHONE: ( ) - FAX: ( ) -

FACSIMILE FROM: Sarah Bianchi

PHONE: ( ) - FAX: ( ) - 632 0390

NUMBER OF PAGES (INCLUDING COVER):________

[ ] FOR YOUR REVIEW
[ ] PER MY E-MAIL OR VOICE-MAIL MESSAGE TO YOU
[ ] PER YOUR REQUEST

COMMENTS: Few more slight changes on memo
Thank — SB.

WILLIAM M.
**MERCER**

May 8, 1998

Mr. Christopher C. Jennings
Special Assistant to the President for Health Policy Development
Domestic Policy Council
Old Executive Office Building, Room 212
17th St. & Pennsylvania Avenue, NW
Washington, DC 20502

Dear Mr. Jennings;

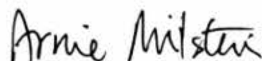
I would like to be considered as a *purchasers' clinical representative* for the Vice-President's Blue Ribbon Panel on Quality of Care and for the subsequent Forum. I would bring following qualifications:

1. Described in May 1998 *New England Journal of Medicine* article on employer managed health care as "a pioneer" in employer advocacy of quality of care.
2. Medical Director of the largest American employer health purchasers coalition. (Pacific Business Group on Health - with over 3 million covered lives) and architect of its nationally distinguished quality advancement program.
3. Head of clinical consulting of largest employee benefits consulting firm in U.S. (William M. Mercer, Incorporated).
4. Sole consulting industry representative selected for national quality of care measures development committees of both NCQA and FACCT.
5. Invited to speak on behalf of U.S. purchasers at the Institute of Medicine's 1998 Rosenthal lecture series on the state-of-the-art in health care performance measurement.
6. Selected to testify on exemplary private sector health quality initiatives at March 3, 1998 hearing of Bipartisan Congressional Task Force on Health Care Quality.
7. Selected to review 1998 Institute of Medicine Roundtable Statements on Quality of Care.
8. Board certified physician (in Utilization Management/Quality Assurance and Psychiatry)
9. Associate Clinical Professor at University of California, San Francisco with more than 30 published articles and book chapters on performance measurement and management in health care.
10. Selected as one of 20 people "who have made a difference over the last 20 years" in employee benefits management by Business Insurance Magazine.

I have attached my CV and my recent Congressional testimony.

Please contact me if I can be of further help. I would be honored to serve.

Yours truly,



Arnold Milstein MD, MPH

cc: Ms. Sarah Bianchi

William M. Mercer, Incorporated
3 Embarcadero Center, Suite 1500
Box 7440 / 94120
San Francisco, CA 94111-4015

Phone 415 743 8700
Fax 415 743 8950

California Insurance License 0510400

# MOBILIZING EMPLOYER PURCHASING POWER TO ADVANCE QUALITY OF CARE IN CALIFORNIA

TESTIMONY BY ARNOLD MILSTEIN MD, MPH TO
THE BI-PARTISAN CONGRESSIONAL TASK FORCE ON HEALTH CARE QUALITY
MARCH 3, 1998

## Introduction

I am the Medical Director of the Pacific Business Group on Health (PBGH), the country's largest employer health purchasers coalition. I am also a physician consultant at William M. Mercer, specializing in reengineering clinical services and quality of care management. The former role is a window on employers' quality of care objectives; the latter role is a window on physician uptake of opportunities to improve health care quality and affordability.

Today I will focus on PBGH and its quality advancement efforts.

PBGH is a nine-year-old coalition comprising 34 large private and public California employers and employer groups who collectively purchase on behalf of roughly three million Americans and spend in excess of $3 billion on health care. PBGH includes Fortune 500 employers such as Bank of America and General Electric; we also encompass small employers which are part of CalPERS and the HIPC, California's small employer purchasing pool.

## Overarching Value Focus

Our coalition's central focus is on obtaining more quality and customer service per dollar. While PBGH is perhaps best known for its early success in negotiating lower HMO premiums, the lion's share of its budget and effort has been dedicated to advancing quality of care and customer service.

## Primary PBGH Quality-Advancement Activities

### 1. Counting Quality and Making it Count

PBGH's quality of care advocacy has focused on two activities: **counting quality of care** and **making quality count in the market.**

Counting quality of care means taking the best-groomed quality measures from NCQA and nationally distinguished health service research centers; and then using our purchasing power to ask California's health plans, hospitals and physician groups to apply these measures and report them publicly. We have made significant progress on all three levels.

In measuring the quality of health plans, we manage a multi-lateral California partnership, the California Cooperative Healthcare Reporting Initiative (CCHRI). CCHRI applies and publicly reports the HEDIS 3.0 quality and enrollee satisfaction measures annually (see Attachment A) and is expanding into other

quality advancement activities. In measuring the quality of hospitals, we co-lead with the State of California a program to measure and publicly report risk-adjusted hospital mortality from coronary artery bypass graft surgery and will seek to expand this to other measures of hospital quality. In measuring the quality of physician groups, we co-lead with The Medical Quality Commission, a program to measure and publicly report patient satisfaction and quality of care for more than 58 physician groups in California, as well as Oregon and Washington (see Attachment B).

It is important to note that, while in 20 years our measures will be judged to be crude and non-comprehensive, they already constitute a solid starting point. They encompass **technical quality** (such as providing retinal exams to diabetics), as well as **customer service** (such as waiting times for a physician appointment); **processes of care** (such as whether children are getting immunized) as well as **outcomes** (such as whether high blood pressure is being successfully reduced); **preventive care** as well as **illness care**; and **narrow** performance measures as well as **broad** performance measures. With respect to broad measures of outcome, within 24 months, California's purchasers and consumers will be able to access publicly reported, risk-adjusted performance measures for health plans *and* physician groups in maintaining the longitudinal health status of seniors and of working age populations, respectively.

Making quality count means using market incentives to reward reporting, improvement or superiority in quality. PBGH is pursuing this by two types of incentives: incentives to reward quality by greater patient volume and by greater unit prices. We create patient volume incentives by explicitly tying **purchaser choice** of health plans to comparative quality ratings and by sharing with consumers comparative quality ratings to support quality-based **consumer choice** of health plans, hospitals and physician groups. Consumer choice is supported via posting of comparative quality scores at a public internet site (www.healthscope.org) and by 1-800 number access to a printed version available in English or Spanish (see Attachment C). In addition, many PBGH employers provide comparative quality scores with open enrollment material, and then pro-actively track and manage continuous improvement in its use by their employees. Finally, PBGH annually selects and publicly acknowledges the California HMO achieving the most favorable combination of quality, affordability, information systems advance, and customer partnership.

Thus far, unit price incentives to reward quality have been applied to health plans which are required to rebate up to 2% of premium to PBGH's HMO Negotiating Alliance, if pre-negotiated annual improvements in quality of care and customer service scores are not achieved. While there have been failures to reach improvement targets, in the majority the targets have been met and quality as well as customer service are steadily advancing. PBGH is now in the process of collaborating with its health plans and providers to extend unit price rewards for quality to physician groups and hospitals. In broad brush, via multiple methods, we are aiming to create a **quality-sensitive demand curve** for health care in California.

## 2. Advancing Electronic Health Information Systems

Another critical element in our quality of care advocacy is our program to advance health information systems (IS). Our efforts are rooted in recognition that improved quality accountability and quality management depend on IS advance. In pursuing this initiative, we have acknowledged that advances are required of employers in their enrollment and disability systems in addition to advances by plans, hospitals, other providers and, most critically, of physician offices. The road will be challenging. We are moving in partnership with our plans, our providers and the California Health Care Foundation. Our initiative is managed by a doctorate level, full-time PBGH health informatics specialist, propelled by purchaser demand, and aligned with NCQA's excellent Roadmap for Health Information Systems.

## 3. Partner Relations

In advancing quality, we start with the core assumption that our target is quality improvement, not our suppliers. Accordingly, all that we have accomplished has been by collaboration with our plans, our providers, CCHRI, health industry organizations, accreditors, the State of California and visionary foundations.

## Focusing on the Forest not the Trees

Underlying PBGH's quality advancement efforts has been the central awareness that America's biggest quality problem is not the debatable gap between managed care and unmanaged care. Our biggest quality problem is the gap between best American quality and average American quality. As documented by multiple American researchers, the latter gap is wide, comprising a silent ongoing national calamity.

Dr. Lucien Leape has shown that deviation from best clinical practice results in avoidable death or disability in 3 of every 100 American hospitalizations. Dr. Robert Brook has shown that deviation from best clinical practice avoidably impairs 11 of every 100 Americans with common chronic diseases. In contrast, Drs. Robert Miller and Harold Luft's analysis of available scientific evidence found no clear differences in quality between managed and unmanaged care. Average American care, managed or unmanaged, is today unsafe at any price.

Clinicians, like other humans, do not embrace change. However, scientific review of evidence on clinician behavior change by Drs. Peter Greco and John Eisenberg concludes that economic incentives can be effective. PBGH quality advancement activities are using this principle to build for PBGH suppliers a business case for quality, both directly as purchasers as well as by supporting quality-informed consumerism. My reengineering work with delivery systems continuously validates the conclusion that a strong business case will be a prerequisite for the health industry's integration of industrial-strength quality management into the mainstream of its daily operations.

In using market incentives to advance quality, PBGH is at the front edge of an innovation adoption curve. But PBGH and other innovative, quality-focused purchasers cannot close America's big quality of care gap alone. The pace of quality advancement will depend on the level of help from regulators, accreditors, the health industry, the media, and the weight of many more purchasers. There is much that each of these stakeholders can do.

The key is focusing on the forest, which is the gap between best and average American care, and on the highest leverage points for closing this gap. These high leverage points do not include what may be popular, narrow mandates with equivocal evidence bases, such as minimum lengths of maternity stay. They do not include shotgun attacks on the managed care industry as a whole. They do include stretching our managed care industry to be as effective in improving quality as it has been in improving affordability.

Thank you for the opportunity to speak with you.

**ARNOLD MILSTEIN MD, MPH**

--------------

**BIOGRAPHICAL SUMMARY**

Arnie directs the national clinical consulting practice at William M. Mercer Inc. and is the Medical Director of the Pacific Business Group on Health. His work focuses on improving managed care programs for providers, large purchasers, insurers and government.

His 30 book chapters and published articles have centered on managed care program design. Dow Jones' and McGraw-Hill's reference texts on managed care contain his chapter on utilization management. His articles, which have encompassed quality measurement, behavioral health and workers compensation performance evaluations, have been published in Barron's, HMO Magazine and the New England Journal of Medicine.

A member of NCQA's national committee to develop HEDIS 3.0 and the FACCT Measures Council, he also served on the National Academy of Science's Committees on Utilization Management and Children's Health Insurance. Business Insurance magazine selected him as "one of the 20 people who has made a difference in employee benefits management in the past 20 years."

Arnie was educated at Harvard (BA-Economics), Tufts (MD) and UC-Berkeley (MPH-Health Services Planning). He is an associate clinical professor at the University of California-San Francisco Medical Center and a Worldwide Partner at Mercer.

Three Embarcadero Center, Suite 1250
San Francisco, California 94111
(415) 393-5657

CURRICULUM VITAE

# Arnold Milstein, MD, MPH

January 1998

## General Information


| | |
|---|---|
| Address: | Three Embarcadero Center, Suite 1500<br>San Francisco, California 94111 |
| Telephone: | (415) 743-8803 |
| E-mail: | arnold_milstein@mercer.com |


| | |
|---|---|
| Date of Birth: | January 4, 1946 |
| Marital Status: | Married |

## Education

| | | | |
|---|---|---|---|
| B.A. (cum laude) | Harvard University | Economics | 1967 |
| M.D. | Tufts University | General Medicine | 1971 |
| Internship | UCSF Mount Zion Hospital | Medicine and Psychiatry | 1972 |
| Residency | UCSF Mount Zion Hospital | Psychiatry | 1974 |
| M.P.H. | Univ. of California, Berkeley | Health Administration and Planning | 1975 |

## Professional Certification

| | | | |
|---|---|---|---|
| Licensed Physician | California Board of Medical Quality Assurance | Medicine | 1974 |
| Board Certification | American Board of Psychiatry and Neurology | Psychiatry | 1981 |
| Board Certification (with honors) | American Board of Utilization Review and Quality Assurance | UR and Quality Assurance | 1986 |

## Employment

Managing Director and Worldwide Partner, William M. Mercer, Inc., a Marsh & McLennan Company, August 1986 to present.

President, National Medical Audit, a Mercer consulting group specializing in the design and evaluation of innovations in managed health care, December 1984 to present.

Chief Medical Advisor, Health Care Financing Administration, Region IX, January 1982 to December 1984.

Director, Division of Professional Standards Review, Health Care Financing Administration, Region IX, January 1977 to December 1981.

Regional Program Consultant for HSA Development, U.S. Public Health Service, Region IX, February 1976 to December 1976.

Private medical practice in hospital, intermediate psychiatric facility, and outpatient settings, 1974 to 1988.

Research Assistant, Department of Economics, Harvard University, Cambridge, Massachusetts, June 1965 to July 1967.

## Honors and Awards

Rosenthal Lecturer, Institute of Medicine, National Academy of Sciences ..........................1998
"Using Purchasing Power to Advance Health Care Quality"

Selected by Business Insurance as ........................................................................... 1987
"...one of the 20 people who made a difference over the last 20 years
in employee benefit management in America..."

U.S. Public Health Service Commendation Medal for ............................................................ 1981
"...leadership, initiative and creativity, leading to extraordinary benefits
to the federal government..."

U.S. Public Health Service Plaque for ........................................................................... 1980
"...an exceptional record in providing intelligent and perceptive leadership..."

Mount Zion Hospital Mark Berke Prize for ........................................................................ 1974
"The House Officer Best Exemplifying the Qualities of the Compleat Physician."

National Institute of Mental Health Career Development Fellowship ......................................... 1972

Honorary Harvard College Scholarship ........................................................................... 1964

**Consultation and Professional Activities**

Member, Institute of Medicine Committee on Children's Health Insurance, National Academy of Science, 1997 to present.

Advisory Committee, UCSF Center for Health Professions, 1997 to present.

Member, University of California Commission on the Future of Medical Education, 1996 to present.

Board Member, The Medical Quality Commission, 1996 to present.

Member, National Measures Council, Foundation for Accountability (FACCT), 1996 to present.

Member, NCQA HEDIS 3.0 Committee on Performance Measurement, 1995 to present.

Trustee, University of California-Mount Zion Campus, 1994 to present.

Trustee, San Francisco University High School, 1994 to present.

Advisor, White House Health Care Reform Task Force, 1993.

Editorial Board, Medical Outcomes and Guidelines, Faulkner & Gray, 1993 to present.

Member, Institute of Medicine Committee on Utilization Management, National Academy of Sciences, 1988 to 1990.

Medical Director, Pacific Business Group on Health, 1988 to present.

Medical Director, Department of Defense CHAMPUS prepaid psychiatric quality monitoring project, May 1987 to 1993.

Associate Clinical Professor, University of California at San Francisco, July 1986 to present.

Editor, "Review Decisions," a bi-monthly UR case analysis published in Medical Utilization Review, McGraw-Hill Publications, April 1986 to 1990.

Medical Director, National SuperPRO project, July 1985 to 1992.

Member, California Chamber of Commerce Task Force on Preferred Provider Organizations and Utilization Review Programs, 1983.

Assistant Clinical Professor, University of California at San Francisco, December 1980 to 1986.

Chairman, Skilled Nursing Facility Subcommittee, California State Psychiatric Association, September 1976 to 1979.

Consultant, Planning Task Force, California Conference of Local Mental Health Directors, September 1975 to December 1976.

Consultant in clinical program evaluation, Rand Corporation, July 1974 to 1977.

## Publications and Papers

1. "Hospitalists and Pursuit of Value," Annuls of Internal Medicine, (in review) Spring, 1998.
2. "Bringing Outcome-Based Quality Differentiation to the Physician Group Market," Medical Outcomes Trust Monitor, January, 1998.
3. "Better Managing Utilization Management" Health Affairs, Spring 1997.
4. "Health Education and Patient Satisfaction," with H. Schauffler and T. Rodiguez, The Journal of Family Practice, January 1996.
5. "Industry in Transition: Central Engines, Blooming Flowers, Batting Averages and Re-Invention," Viewpoint, Fall 1994.
6. "Evaluating Psychiatric and Substance Abuse Case Management Organizations," with M. Henderson, J. Berlant and D. Anderson, Managed Behavioral Health Care, S. Shueman, W. Troy and S. Mayhugh, eds., Charles C. Thomas Publisher, 1994.
7. "UR Liability: A Continuing Question," HMO Magazine, January/February, 1993.
8. "Increased Costs and Rates of Use in the California Workers' Compensation System As a Result of Self-Referral by Physicians," with A. Swedlow, G. Johnson and N. Smithline, The New England Journal of Medicine, November 19, 1992.
9. "Utilization Management Lessons," HMO Magazine, March/April, 1992.
10. "Ambulatory Care Utilization Review," with T. Mayer, Ambulatory Care Management and Practice, A. Barnett, ed., Aspen Publishers, 1992.
11. "Evaluating Indemnity Plan Managed Care," Managing Employee Health Costs: Assuring Quality and Value, J. Harris, H. Belk and L. Wood, eds., OEM Press, 1992.

12. "Excellence in Programs to Manage Workers' Compensation Costs," Viewpoint, Summer 1991.

13. "Mirror, Mirror on the Wall, Is My UR Program Best of All?", Medical Interface, July, 1990.

14. "Managing the Medical Cost of Hospital Workers' Compensation Claims," Handbook of Health Care Human Resources Management, Norman Metzger, ed., Aspen Publishers, Inc., 1990.

15. "In Pursuit of Value; Fifteen Years of American Utilization Management," Making Managed Health Care Work, P. Boland, ed., McGraw Hill, 1990.

16. "Controlling Workers' Compensation Medical Costs--California Style," Risk Management, September, 1988.

17. "Second Generation Perspectives on Employer Medical Cost Controls," Barron's, June 27, 1988.

18. "Controlling Medical Costs in Workers' Compensation," Business and Health, March, 1988.

19. "Enhancing Utilization Review Program Results," with M. Martin, Health Cost Management, March/April 1988.

20. "The Future of Utilization Review," Business Insurance, October, 1987 (invited paper for 20th Anniversary Issue).

21. "Gauging the Performance of UR Programs via Medical Record Audit," Business and Health, February, 1987.

22. "Auditing the Quality of Care--an Employer Based Approach," Business and Health, July/August 1986.

23. "Controlling Utilization through Preferred Provider Arrangements," The New Health Care Market, Peter Boland, ed., Dow-Jones Irwin, 1985.

24. An Employer's Guide to Utilization Review, with Jack Bush, published by the California Chamber of Commerce, February, 1984.

25. An Employer's Guide to PPOs, with Dr. Joan Trauner, published by the California Chamber of Commerce, February, 1984.

26. "Factors Associated With Successful Physician Peer Review," with Dr. Nancy E. Adler, American Journal of Public Health, October, 1983.

27. "Psychological Dimensions of Health Planning," (with N.E. Adler), Health Psychology, G. Stone, F. Cohen and N. Adler, eds., Jossey-Bass Publishers, June, 1979.

28. "Opportunities for Improving Mental Health Services at the Interface between PSROs and HSAs," (invited paper), Special Session on Mental Planning, American Psychiatric Association Annual Meeting, May, 1978.

29. "Effects of the National Health Planning Act on the Use of Data Processing Hardware in Health Care Institutions," Journal of Clinical Computing, Spring, 1977.

30. "Public Law 93-641 and Its Implications for the Diffusion of Ultrasonic Medical Instrumentation," Proceedings of the First Meeting of the World Federation of Ultrasound in Medicine and Biology, August, 1976.

31. "Anticipating the Impact of Public Law 93-641 on Mental Health Services," American Journal of Psychiatry, June, 1976.

From : 301 567-2409 FT WASH MD USA Apr. 22. 1998 02:03 PM P04

File Sarah's Minority/tobacco

# Summit Health Coalition

1424 K Street, N.W., Suite 500
Washington, D.C. 20005
(202) 371-0277 • Fax (202) 508-3826

note to Sarah

**Board of Directors**
American Cancer Society
Association of Black Cardiologists, Inc.
Black Caucus of Health Workers
City of Opa-locka, Florida
Congressional Black Caucus Foundation, Inc.
Medical Care Management Company
Meharry Medical College
Morehouse School of Medicine
National Alliance of Community Based Care
National Association for the Advancement of Colored People
National Association of Black County Officials
National Association of Black Social Workers, Inc.
National Association of Health Services Executives
National Black Caucus of State Legislators
National Black Leadership Commission on AIDS
National Black Nurses Association
National Caucus and Center on Black Aged, Inc.
National Conference of Black Mayors, Inc.
National Dental Association
National Education Association
National Medical Association
National Pharmaceutical Association
National Urban League, Inc.
Presbyterian Church (USA), Washington Office
Tennessee Managed Care Network
The Congress of National Black Churches, Inc.
United Church Board for Homeland Ministries
Vermont Avenue Baptist Church

**Executive Committee**

**President**
Richard O. Butcher, M.D.

**Vice President**
Ramona McCarthy Hawkins

**Secretary**
Hazel J. Harper, D.D.S.

**Treasurer**
Samuel J. Simmons

**Board Members at Large**
Rev. Bernadine Grant McRipley
Cheryl A. Townsel

**Executive Director**
Ruth T. Perot

**Coalition Partners**
African American Healthlink
Health Management Resources, Inc.
Healthy Solutions, Inc.
Hines Family Care Center, Inc.
Howard University Hospital
Illinois Chapter, Summit Health Coalition
Lomax Health Systems, Inc.
Medical Billing Incorporated
National Coalition of 100 Black Women, Manhattan Chapter
Prairie State Medical Society
Saint John Baptist Church
Student National Dental Association
The Greater Maryland Coalition for Health Assurance, Inc.
Tennessee Black Health Care Commission
Total Care Home Health System, Inc.
Tristate Center of the National Podiatric Medical Association

**ector, NY State Project**
eila L. Thorne

**TESTIMONY OF**

**SUMMIT HEALTH COALITION**

**VIEWS FROM THE PUBLIC**

**ON**

**COMPREHENSIVE TOBACCO CONTROL LEGISLATION**

**BEFORE THE**

**UNITED STATES HOUSE OF REPRESENTATIVES**

**HOUSE COMMERCE COMMITTEE**

**SUBCOMMITTEE ON HEALTH AND THE ENVIRONMENT**

**WASHINGTON, DC 20515**

**March 19, 1998**

"Networking to ensure meaningful health care reform"

**Testimony of**

**Summit Health Coalition**

**Before the**

**United States House of Representatives**
**House Commerce Committee**
**Subcommittee on Health and the Environment**

**March 19, 1998**

## Introduction

Summit Health Coalition, the nation's largest network of organizations focused on health policies as they affect African Americans, welcomes this opportunity to communicate with the Subcommittee on Health and the Environment of the House Commerce Committee. We are aware of the critical role this subcommittee will play in developing comprehensive, bipartisan legislation addressing the issue of tobacco control. We are appreciative of your leadership.

Summit Health Coalition is a national public health advocate for minorities and underserved populations. It encompasses the key minority health professional organizations in the United States, including the National Medical Association, the Association of Black Cardiologists, the National Dental Association, the National Black Nurses Association, the National Pharmaceutical Association, the National Association of Health Services Executives and the Black Caucus of Health Workers.

Historically black colleges and universities are also members of Summit, along with major civil rights and consumer organizations, associations representing elected officials, religious groups and health care businesses. At present, fifty national, state and community based institutions and organizations comprise Summit Health Coalition.

Summit also works cooperatively with coalitions and organizations that represent other communities of color and public health groups with respect to tobacco control and other health policy issues. Regarding tobacco, we are committed to three priority goals: 1) preventing the use of tobacco products by minority and other youth and adults; 2) helping minorities stop smoking; and 3) improving the health of minorities and other vulnerable, underserved populations.

With this testimony we seek to convey three messages.

1. By passing comprehensive tobacco control legislation, the Congress can make a major contribution to eliminating disparities in health status among racial and ethnic groups in the United States - disparities that limit the productivity and potential of far too many Americans.

2. By passing comprehensive tobacco control legislation, the Congress can reverse the negative health effects of decades of targeting by the tobacco industry.

3. By passing comprehensive tobacco control legislation, the Congress can strengthen the capacity of individuals and organizations throughout the nation to assume responsibility as partners with health providers for promoting health and preventing tobacco-related diseases.

**The Impact of the Tobacco Industry's Targeting of African Americans**

It is very appropriate that the Subcommittee on Health and the Environment is hearing testimony today from representatives of both youth and minority organizations. The tobacco industry by its own admission has targeted both of these groups - with devastating effects. For example, at a time when African Americans comprised approximately ten percent of the population, almost twenty percent of the advertising budget for Kool cigarettes was dedicated to marketing to African Americans. The result - African Americans made up not twenty, but thirty percent of the Kool market.1/

What has been the impact of this deliberate targeting? Consider these statistics.

- Overall cancer mortality rates among African Americans are higher than those among other racial or ethnic populations in the United States. Mortality rates for African American men are about 50% higher than those for white men. Rates for African American women are about 20% higher than those for white women.2/

- African Americans have higher overall cancer incidence rates than any other racial or ethnic group in the United States.3/

- Lung cancer is the cause of 32% of all deaths attributed to cancer among African American men and is the leading cause of cancer deaths among black men and women.4/

- Between 1950 and 1985, the occurrence of lung cancer increased 86% among white men while increasing 220% among African American men.5/

- Cancer incidence rates for African American women increased 21% from 1973 to 1992, a period coinciding with intensified targeted marketing. These increases have been attributed to increasing rates of lung and breast cancer.6/

- It is estimated that smoking causes 87% of all cases of lung cancer.7/

- African Americans have the second highest smoking rate (27.2%) of all racial and ethnic groups, following American Indians (42.2%).8/

- Smoking among African American high school boys nearly doubled between 1991 and 1995, from 14.1% to 24.8%, Frequent smoking among this group nearly doubled as well.9/

- Estimates are that 76% of all African American smokers smoke menthol cigarettes as compared to 23% of all white smokers.10/

- African Americans tend to start smoking at a later age, are more likely to attempt to quit smoking, are less likely to succeed that their white counterparts.11/

- An estimated 47,000 African Americans die each year from smoking-related diseases.

These statistics clearly suggest that a substantial reduction in smoking rates among African Americans and other minorities would lead to a significant decrease in their mortality and morbidity rates. Such an outcome would lead to the accomplishment of the principal goal of Healthy People 2010 and other government initiatives to eliminate health disparities among racial and ethnic groups.

## Appropriate Responses to Minority Targeting

1. Countertargeting is Necessary.

   In formulating its essential positions on national tobacco control policy, Summit Health Coalition has proceeded from the premise that the tobacco industry has had a disproportionate impact on minorities. This impact is evidenced by these groups' disproportionate rates of tobacco use, addition, morbidity and mortality. Resources required to counter the effects and undo the damage of the industry's targeting should be made available, at minimum in proportion to the incidence of minorities in the smoking population.

2. Significant Reductions in Tobacco Use Require Well-Financed, Community- Wide Participation

   For most of this century, the tobacco industry has spent billions to promote its message. Undoing the damage from this propaganda barrage requires the engagement of all levels of government, the private sector, non-profits, colleges and universities, essential community and other health providers, schools, faith and community-based organizations. National tobacco control policy, backed by adequate resources, must serve to strengthen and equip these partners to do battle. A strong federal role is a prerequisite for success if national goals are to be met.

3. Diversity Is Essential to Effective Tobacco Control Policy.

   There are significant differences among racial and ethnic groups with respect to mortality and morbidity rates, smoking use and patterns. The tobacco industry's marketing strategies illustrate that a "one size fits all" approach is ineffective. Counter-advertising, research, prevention and cessation programs must be culturally sensitive and appropriate. They should be implemented by minority institutions and organizations with a history of service to and involvement with the racial and ethnic groups to be served.

4. Public Health Must Be A Funding Priority

A substantial portion of tobacco control resources will be raised from smokers, many of whom have low incomes and are members of minority groups. Fairness dictates that most of the funds received from smokers or the tobacco industry be reinvested, in the communities in which these smokers reside, for the support of regulation, prevention, cessation and related programs.

**Summit Health Coalition's Essential Positions on National Tobacco Control Policy**

1. Summit Health Coalition urges Congress and the President to ensure that tobacco control legislation will prohibit targeted marketing of tobacco products to children and youth, African Americans, women and other at-risk populations. At the same time, such legislation must require that targeted anti-tobacco marketing be aimed at these vulnerable groups with adequate funding.

2. Funds must be allocated for demographic, physiological and behavioral research to foster better understanding of such phenomena as differing tobacco consumption and use patterns, incidence, morbidity and mortality rates among African Americans and other vulnerable populations. This research should involve historically black colleges and universities (HCBUs) and other minority health professions schools, as well as other African American institutions involved in health care delivery and research, professional associations, non-profit organizations and individual African American researchers.

3. Funds derived from penalties on the tobacco industry, increased excise taxes and other sources must be allocated in relation to tobacco-related mortality and morbidity rates among various population groups, as well as past targeted marketing practices by the tobacco industry. These funds should be used for culturally relevant and appropriate programs to support prevention, cessation, treatment and rehabilitation efforts aimed at reducing and eliminating tobacco addiction among African Americans and other vulnerable, at-risk groups.

4. In recognition of the impact that anti-tobacco legislation and regulations will have on certain communities and geographic areas, legislation should be enacted to protect these communities by means of economic development services and targeted resources. These services may include job retraining, small business loans, support for community redevelopment planning and program implementation, expansion or creation of empowerment zones.

5. The Food and Drug Administration (FDA) must have full jurisdiction over all tobacco products (i.e., cigarettes, cigars and smokeless tobacco) and nicotine delivery devices immediately upon enactment of legislation. Congress must affirm through legislation the FDA's authority to regulate the tobacco industry's marketing practices to prevent targeting of children, youth, women, African Americans and other people of color, and must provide the requisite funding for FDA's strengthening and expansion so as to fulfill these responsibilities.

6. We urge the passage of legislation that will require all health insurers, health benefit plans, managed care organizations and other entities providing health services to emphasize prevention and health promotion and provide information to enrollees, beneficiaries and patients to help them prevent and decrease smoking and improve their quality of life.

7. The federal government should support international tobacco control initiatives through legislation, regulation, Executive Orders, funding and other means, as well as through the dissemination of information on effective models and strategies for tobacco use prevention and control.

8. National tobacco control legislation must provide for a substantial and immediate increase in the price of tobacco products to support public health initiatives and to discourage tobacco consumption. An increase in the federal excise tax of at least $2.00 per cigarette pack is recommended.

## Summit Legislative Proposals

Summit offers the following proposals, which serve to operationalize the foregoing principles and positions, for incorporation in comprehensive tobacco control legislation. The list is not exhaustive, and we would welcome an opportunity to meet with members of the subcommittee and staff to offer other proposals and relevant information.

1. Funding of public health research, education, cessation and counter-advertising programs should be distributed to the Department of Health and Human Services and its constituent agencies with the understanding that an appropriate percentage of those funds should be targeted to address the needs of underserved and vulnerable racial and ethnic groups. Said percentage to be determined on the basis of such factors as: the prevalence of racial and ethnic groups within the youth and adult smoking population; or the proportion of racial and ethnic groups within the general population (nationally or by state).

2. In addition, the Office of Minority Health (OMH) should be charged with the responsibilities of oversight, coordination, monitoring and reporting with respect to Department-wide tobacco control activities on behalf of minorities. It should have expanded grant-making authority and should be funded at a level commensurate with its expanded responsibilities, including oversight, coordination, monitoring and reporting with respect to state offices of minority health. An Advisory Committee should be created and appointed by the Secretary to provide guidance to the Department on the development of goals and program activities undertaken by OMH, as well as on minority-focused activities undertaken by other HHS agencies.

3. There should be full participation of historically black colleges and universities and other minority institutions and organizations with a history of service to or involvement with the group to be served in the implementation of public health research, prevention, cessation and counter-advertising programs at federal and state levels, in proportion to minority smoking prevalence rates (or in accordance with other appropriate standards).

4. Comprehensive legislation should provide for the conduct of surveys on adult and youth tobacco use, with data to be collected by race, ethnicity, gender and age.

5. "Look-back" targets for youth should be established by gender, race and ethnicity.

## Conclusion

Tobacco claims the lives of 420,000 people in the United States each year. There is no time to spare. We pledge our full support to any effort that will put an end to the needless ill health, death and addiction for which tobacco is responsible.

We urge you therefore to seize this unprecedented opportunity and enact comprehensive legislation that will attain that goal. We would welcome an opportunity to work with you in the days and weeks ahead.

**National Committee**
**for Quality Assurance**

NCQA

**Margaret E. O'Kane**
President

2000 L Street, N.W.
Suite 500
Washington, D.C. 20036
202/955-3500 FAX 202/955-3599
www.ncqa.org
Direct Dial 202/955-5100
email: okane@ncqa.org

**National Committee**
**for Quality Assurance**

NCQA

**Stephen N. Lamb**
Assistant Vice President for
Public Policy

2000 L Street, N.W.
Suite 500
Washington, D.C. 20036
202/955-3500 FAX 202/955-3599
www.ncqa.org
Direct Dial 202/955-5102
email: lamb@ncqa.org

**FOR IMMEDIATE RELEASE**

**FOR MORE INFORMATION:**

AMAP -- Robert Mills 312-464-5970
JCAHO -- Cathy Barry-Ipema 630-792-5630
Janet McIntyre 630-792-5175
NCQA -- Barry Scholl 202-955-5197
Brian Schilling 202-955-5104

File Quality Forum Ntbk

# NATION'S THREE LEADING HEALTH CARE QUALITY OVERSIGHT BODIES TO COORDINATE MEASUREMENT ACTIVITIES

*Landmark collaboration among AMAP, JCAHO, and NCQA will help ensure efficient collection of comprehensive performance information across all levels of the health care system*

WASHINGTON - The nation's preeminent health care accrediting organizations -- the American Medical Accreditation Program[SM] (AMAP[SM]), the Joint Commission on Accreditation of Healthcare Organizations (JCAHO), and the National Committee for Quality Assurance (NCQA) -- today announced a collaborative effort designed to coordinate performance measurement activities across the entire health care system. The agreement establishes the Performance Measurement Coordinating Council (PMCC), a 15-member group that will work to ensure that measurement driven assessment processes are efficient, consistent and useful for the many parties that rely on them to help make important decisions about health care.

"Independently, our organizations are working aggressively to develop rigorous performance measurement programs for different levels of the health care system," said NCQA President Margaret E. O'Kane. "Working together, we can make performance measurement not only much less burdensome, but also more meaningful to consumers, employers and health care professionals."

"The work of the PMCC will start a positive chain reaction," said Randolph D. Smoak, Jr., M.D., Chair AMAP Governing Body, and Vice Chair of the American Medical Association (AMA) Board of Trustees. "More efficient measurement will lead to broader participation in accreditation programs, which will lead to quality improvement, which will lead to better care and service. Ultimately, patients and the public are the real winners."

Formation of the PMCC dovetails with the recent recommendation from President Clinton's Advisory Commission on Consumer Protection and Quality in the Health Care Industry urging greater coordination in health care performance measurement efforts. In a related executive order, President Clinton has directed Vice President Gore to organize a "Forum for Health Care Quality Measurement and Reporting" that will seek to incorporate existing private sector efforts. The PMCC expects to work through the Forum to help shape measurement priorities and approaches that serve the needs of the American public.

The PMCC's efforts will build on a consensus statement, *"Principles for Performance Measurement in Health Care,"* developed by the group's sponsoring organizations. The document briefly outlines:

- the rationale behind performance measurement efforts;
- appropriate uses of performance data;
- specific areas on which measures should focus;
- guidelines for using performance data for comparative purposes;
- general requirements for cost effective measurement;
- and specific opportunities for collaboration.

"This is an exciting opportunity to pool and collectively expand our quality measurement expertise in service of the public interest," said Dennis S. O'Leary, M.D.,

President, JCAHO. "Good measures and good data will eventually provide good information to drive improvement in health care services and to better inform consumer decision making."

Currently, AMAP, JCAHO and NCQA each define performance measurement at different levels of the health care system. AMAP focuses on standards of quality for the individual physician. JCAHO accredits a range of health care facilities, including organizations providing acute care, ambulatory care, behavioral health care, home care, clinical laboratory services, long term care and managed care. In addition, JCAHO has begun integrating performance measurement into the accreditation process.

The focus of NCQA Accreditation and performance measurement program (HEDIS®) is on systems of care for defined populations, such as HMOs and point-of-service plans. More than 90 percent of the nation's managed health care plans already use HEDIS to track and report their performance. NCQA recently announced a new accreditation program that will base accreditation decisions in part on a health plan's performance on key HEDIS measures such as member satisfaction, immunization rates, and mammography screening.

Each organization is committed to developing and advancing rigorous, dynamic measurement programs to improve care and help consumers and purchasers make important health care coverage decisions. The accreditation programs developed by JCAHO and NCQA already enjoy broad participation across the health care industry, and have consistently drawn upon the input of various constituencies. The new AMAP initiative, similarly, is gaining rapid acceptance from physicians, hospitals, health plans and health care purchasers.

Performance measures currently vary from one level of the health care system to the next, but there is overlap. For example, member satisfaction, immunization rates and cervical cancer screening rates have been used to assess providers, facilities and plans alike. Other broadly applied performance measures include cesarean section rates, mammography screening rates, measures of the accessibility of care, cost measures, utilization rates (e.g., coronary artery bypass graft surgeries per 1,000 members) and average office wait times.

A common criticism of performance measurement activities -- even from those who appreciate their importance to quality improvement -- is that costs for data collection and reporting can be high. The PMCC's efforts will help to reduce those costs by:

- coordinating identification and/or development of groups of 'universal' measures (i.e., measures that could be used to assess performance of physicians, facilities or health plans in the same ways)
- standardizing data requirements for different measurement systems;
- devising means of coordinating measurement activities among physicians, organizational providers, facilities and health plans;
- establishing more efficient verification and data quality assurance systems;
- and developing guidelines for the appropriate use of performance data.

"This collaborative effort represents a significant step forward toward improving the delivery of health care in this country," said David B. Pryor, M.D., Chair of JCAHO's Advisory Council on Performance Measurement and System Vice President for Information Services, Allina Health System.

The PMCC will also address other important issues such as standardization of risk adjustment techniques (adjusting for differences in the health of covered populations or patients) which is a key issue for measuring performance at the physician, facility and health plan levels. Ultimately the group expects to articulate principles to deal with risk adjustment that will help the science of performance measurement move forward.

The PMCC will begin work on these issues at its first meeting this summer. The group will meet three to four times per year. Work groups addressing specific issues will meet in person and via conference call more frequently.

# # #

The American Medical Association is the voice of the American medical profession. The AMA is a partnership of physicians and their professional associations dedicated to promoting the art and science of medicine and betterment of public health. AMAP - sponsored by the American Medical Association - is designed to enhance the health of the public by setting standards and improving the performance of individual physicians, while replacing the current duplicative and fragmented patchwork of existing physician review and assessment programs.

Founded in 1951, the Joint Commission on Accreditation of Healthcare Organizations' mission is to improve the quality of care provided to the public through the provision of health care accreditation and related services that support performance improvement in health care organizations. The Joint Commission evaluates and accredits over 18,000 health care organizations and programs, including hospitals, integrated delivery networks, and organizations that provide home care, long term care, behavioral health care, laboratory and ambulatory care services. The Joint Commission also accredits health plans, integrated delivery networks, and other managed care entities. An independent, not-for-profit organization, the Joint Commission is the nation's oldest and largest standards-setting and accrediting body in health care.

A non-profit watchdog organization, the National Committee for Quality Assurance (NCQA) is widely recognized as the leader in the effort to assess, measure and report on the quality of care provided by the nation's managed care organizations. More than three quarters of Americans enrolled in HMOs are in plans that have been reviewed by NCQA.

National Committee
for Quality Assurance

2000 L Street, N.W.
Suite 500
Washington, D.C. 20036

Main: 202/955-3500
FAX: 202/955-3599
http://www.ncqa.org

EMBARGOED UNTIL:
March 31, 1998

FOR MORE INFORMATION:
Barry Scholl or Brian Schilling
(202) 955-5197 or 955-5104

# NCQA REDEFINES ACCREDITATION WITH HEALTH PLAN STANDARDS THAT FOCUS ON RESULTS

*Draft requirements will provide more complete information to guide choice; program will require health plans to report independently audited results*

WASHINGTON – The National Committee for Quality Assurance (NCQA) today released for comment new accreditation standards for HMOs and other health plans which expand the scope of the nation's leading health care accreditation program to emphasize results across a range of important care and service dimensions. The standards include selected performance measures from NCQA's Health Plan Employer Data and Information Set (HEDIS®), making *Accreditation '99* the nation's first true performance-based accreditation program. As a result, consumers and employers will soon receive more complete, easier-to-use information about health plan quality than ever before.

"With *Accreditation '99*, results count," said NCQA President Margaret E. O'Kane. "*Accreditation '99* uses three approaches to evaluating health plan quality – rigorous standards, objective measures, and customer satisfaction. That comprehensive assessment gives consumers and employers more information with which to make informed health care coverage decisions."

NCQA's HEDIS, the nation's premier performance measurement tool for health plans, is a set of measures related to such issues as immunization rates, mammography rates, member satisfaction, access, service and other areas of public concern. Many health plans already use HEDIS to comply with accreditation requirements which require them to demonstrate improvement over time.

"*Accreditation '99* is the best health plan assessment program yet. Basing accreditation decisions on actual performance – using standardized measures – is a critical step towards moving the industry from prevailing practices to best practices," said Robert Galvin, M.D., Director of Healthcare, GE. "That's what the quality movement is all about. *Accreditation '99* will help us work with our employees to reward those plans that are doing thing right."

Other employers have expressed similar support for the program. "Working with health plans that have achieved the highest level of NCQA Accreditation is good business – it helps ensure that our employees and their families get top quality care and service," said Kathleen Angel, Vice President, World Wide Benefits and Work Life Solutions, Digital Equipment Corp. "*Accreditation '99* and its emphasis on consumer information raises the bar on performance measurement and improves our ability to select the best plans for our employees."

HEDIS results will initially count for 25 percent of a plan's accreditation score. (See page 6 for the list of measures and survey results plans will report.) The remaining 75 percent will be based on a plan's degree of compliance with NCQA's standards. In the future, NCQA anticipates increasing the proportion of the accreditation score based on a health plan's performance. HEDIS results will initially be evaluated relative to national and regional averages, and national benchmarks.

"Accreditation should provide easy-to-understand information about a plan's strengths and weaknesses; it should speak to the consumer and help make the decision about what plan to choose easier," said Andrew Webber, Senior Associate, Consumer Coalition for Quality Health Care. "*Accreditation '99* does that. This represents a big step forward in the national effort to promote quality in managed care."

To make accreditation outcomes more intuitively understandable for consumers, NCQA renamed and redefined the different accreditation designations. Under *Accreditation '99*, plans will earn one of the following accreditation levels:

- Excellent
- Commendable
- Acceptable
- Denied.

"The distinction between the higher levels of accreditation will be based on results," said Cary Sennett, M.D., Ph.D., NCQA Executive Vice President. "Only those plans that demonstrate excellence both in terms of their quality improvement and consumer protection systems, and on important measures of care and service, will achieve the highest levels of accreditation."

To help consumers and others better understand each health plan's strengths and weaknesses, reports based on *Accreditation '99* surveys will indicate plan performance in five new categories, each of which reflects performance on several measures and standards. The new reporting categories are:

- Access and Service
- Qualified Providers
- Staying Healthy
- Getting Better
- Living With Illness.

NCQA worked with the Foundation for Accountability (FACCT) and others to develop and test these categories, to ensure that they address consumers' concerns. NCQA will continue to work with FACCT and others to refine these categories in the coming weeks.

"For a health plan that can demonstrate excellent care and service, *Accreditation '99* represents an opportunity to achieve greater distinction in the market," said Linda Winslow, Director of Purchaser Relations and Accreditation, Harvard Pilgrim Health Care. "This program validates all the hard work we've put into improving our results over the years."

To aid consumers, NCQA will include a separate entry on its Accreditation Status List for each "product type" a health plan offers. Many health plans offer HMO, point-of-service and other plan options, and also offer separate plans for commercial, Medicare and Medicaid beneficiaries. NCQA's Accreditation Status List will distinguish between these various product types to ensure that consumers know whether their plan has been accredited.

*Accreditation '99* also introduces new standards that help protect consumers by:

- prohibiting health plans from using financial incentives to encourage case managers to limit or deny care
- requiring health plans to have a process for approving exceptions to restricted drug formularies
- evaluating whether health plans unduly limit access to emergency room care
- requiring health plans to coordinate medical and behavioral health care.

To ensure that quality and performance are maintained between on-site surveys (which occur at least every three years), plans will be required to submit independently audited HEDIS results to NCQA annually. Should these results, or other factors such as regulatory action, suggest a lapse in quality, NCQA may elect to resurvey the health plan sooner. NCQA will also resurvey a plan sooner if its initial compliance with NCQA standards is low.

*Accreditation '99* also confronts head on the critical need to improve the state of health plan information systems. At present, most health plan information systems fall far short of the ideal and cannot easily or routinely provide important data to employers, consumers or care managers. New "advisory" standards specify the capabilities health plan information systems must have in the future. Acquiring these capabilities will mean better care and service for health plan members and improved coordination between providers.

Specifically, the new Information System standards will require managed care organizations to be able to: ensure the security and confidentiality of members' data and information; link data from different sources and databases; ensure the accuracy and

reliability of data; use data to help manage care and improve performance; and monitor internal and external data needs on an ongoing basis.

The standards have been mailed to approximately 2,500 business coalitions, employers, health plans, medical groups, associations, regulatory bodies, and other groups to encourage broad comment. The full text of the standards is also available for download from NCQA's Web site (www.ncqa.org/99draft.htm). The comment period runs through May 15, 1998. NCQA will accept written comments via regular mail or e-mail (mcodraft@ncqa.org). The final standards will be released in August 1998. Health plan reviews against NCQA's 1999 MCO Accreditation requirements will commence July 1, 1999.

A non-profit watchdog organization, NCQA is widely recognized as the leader in the effort to assess, measure and report on the quality of care provided by the nation's managed care organizations. More than three quarters of Americans enrolled in HMOs are in plans that have been reviewed by NCQA.

# # #

# The Following HEDIS® and Consumer Survey Measures are Required Under *Accreditation '99*

**Effectiveness of Care**

- Childhood Immunization Status*
- Adolescent Immunization Status*
- Breast Cancer Screening
- Cervical Cancer Screening
- Prenatal Care in the First Trimester*
- Advising Smokers to Quit
- Beta-Blocker Treatment After a Heart Attack
- Eye Exams for People with Diabetes
- Check-Ups After Delivery*
- Follow-Up After Hospitalization for Mental Illness
- Flu Shots for the Elderly**

* Measures relevant to and required for commercial and Medicaid products, but not Medicare products.
** Measure relevant to and required for Medicare products only.

**Consumer Survey Results**

- Getting Care Quickly
- Doctors Who Communicate
- Courteous and Helpful Office Staff
- Easy to Find a Personal Doctor or Nurse
- Getting Needed Care
- Claims Processing
- Customer Service
- Rating of Personal Doctor or Nurse
- Rating of Specialist Seen Most Often
- Rating of Health Care in the Past 12 Months
- Rating of Experience With Health Plan

File Quality
Forw Ntbk.

**D**aniel N. Mendelson

05/21/98 05:01:23 PM

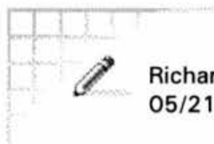
Record Type: Record

To: Christopher C. Jennings/OPD/EOP, Sarah A. Bianchi/OPD/EOP

cc:
Subject: HHS Report on Targeting Efforts on Asthma

Here is another disease that can be targeted in a discussion of outcomes and effectiveness research. AHCPR research creates algorithms to target potentially vulnerable kids (often minorities in low income areas), treat them appropriately, and save money by keeping them out of the ER.

---------------------- Forwarded by Daniel N. Mendelson/OMB/EOP on 05/21/98 04:59 PM ---------------------------



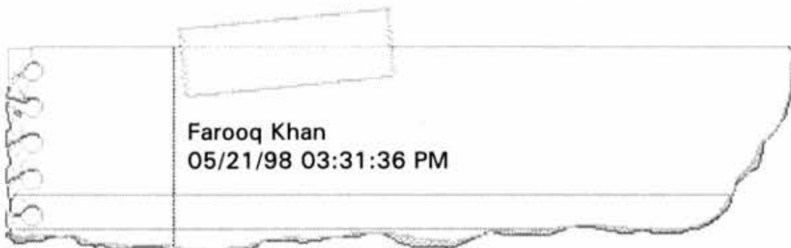
Richard J. Turman
05/21/98 03:39:37 PM

Record Type: Record

To: Daniel N. Mendelson/OMB/EOP@EOP

cc: Barry T. Clendenin/OMB/EOP@EOP, Mark E. Miller/OMB/EOP@EOP
Subject: HHS Report on Targeting Efforts on Asthma

---------------------- Forwarded by Richard J. Turman/OMB/EOP on 05/21/98 03:39 PM ---------------------------



Farooq Khan
05/21/98 03:31:36 PM

Record Type: Record

To: See the distribution list at the bottom of this message

cc:
Subject: HHS Report on Targeting Efforts on Asthma

bHHS Report on Targeting Efforts on Asthma

To: National Desk, Health Writer
Contact: U.S. Department of Health and Human Services

Press Office, 202-690-6343

WASHINGTON, May 21 /U.S. Newswire/ -- The following was released today by the U.S. Department of Health and Human Services

HHS TARGETS EFFORTS ON ASTHMA

Overview: Asthma is a major public health problem in the United States, with prevalence increasing rapidly in recent decades, especially among children. More than 15 million Americans are affected, some 5 million of whom are under the age of 18. Between 1980 and 1994, the percentage of Americans with asthma increased 75 percent, and the percentage of preschool-age children with asthma increased 160 percent.

HHS efforts to combat asthma will exceed $100 million in discretionary funding for the first time this year, up about 70 percent from 1993. HHS agencies support a wide range of activities to better understand this disease and its increasing prevalence, and to help patients and physicians better recognize and treat it:

-- Basic research into asthma's underlying causes and mechanisms, the triggers that bring on asthma symptoms, and other issues surrounding the disease.

-- Treatment studies to evaluate the effects of different medications on various populations.

-- Epidemiology to more precisely identify populations at risk for the disease and the factors that put them at risk in order to better understand and control it.

-- Prevention efforts to prevent asthma onset and to reduce asthma symptoms, hospitalizations and deaths.

-- Guidance and education for physicians, patients and their families, and the general public to increase asthma awareness and knowledge.

The Medicare and Medicaid programs pay for asthma treatment for low-income, elderly and disabled Americans.

In addition to ongoing HHS efforts, Secretary Donna E. Shalala and Environmental Protection Agency Administrator Carol Browner are also making asthma a special focus of the Interagency Task Force on Children's Environmental Health and Safety, created by President Clinton in April 1997.

Today, Secretary Shalala announced that a new National Heart, Lung, and Blood Institute initiative will be launched this summer to better understand the role of respiratory infections in childhood asthma. NHLBI will support $2.5 million per year for five years of research projects to study asthma using new techniques in cellular and molecular biology.

------

Background

Asthma is a chronic lung disease that is characterized by intermittent, recurring episodes of wheezing, breathlessness, tightness of the chest, and coughing. More Americans than ever before say they are suffering from asthma, according to a report released April 24 by the Centers for Disease Control and Prevention. The report entitled, ``Surveillance for Asthma -- United States 1960-1995'' also concluded that the increases in cases, deaths, and visits to doctors occurred in persons of all ages, spanned across all racial groups, and occurred in all regions of the U.S.

People with asthma experience well over 100 million days of restricted activity each year, and costs for asthma care exceed $6 billion annually. Children with asthma miss an average of twice as many school days as other children. Asthma attacks can vary from mild symptoms to serious, life-threatening episodes. More than 5,000 Americans died last year from asthma attacks.

The prevalence of asthma is greater for women (5.6 percent) than men (5.1 percent) and greater for blacks (5.8 percent) than whites (5.1 percent). Blacks also have significantly more emergency room visits, hospitalizations, and deaths from asthma than whites. From 1993-1995, there were an average of 38.5 deaths per million from asthma in blacks compared to 15.1 per million in whites. In 1995, blacks were more than four times more likely than whites to visit an emergency room because of asthma.

The cause of asthma is not well-understood, and scientists do not know why so many more people today are suffering from asthma and why symptoms appear more severe than they were 10 years ago. It is most likely that a combination of environmental and genetic factors is responsible. The best documented factor contributing to the development of asthma is atopy, the genetic, inherited susceptibility to become allergic. In susceptible persons with asthma, exposure to allergens such as dust mites, cockroaches, molds and dander from pets is associated with more severe symptoms. Further, children of smokers are more prone to develop asthma because exposure to environmental tobacco smoke can increase sensitivity to allergens. Although outdoor air pollutants have not been identified as causing asthma, several of them, particularly ozone, have been identified as triggers of asthma attacks. Respiratory infections in early childhood may influence the development of asthma. Some infections may increase the likelihood of developing asthma, while others might actually be protective. Researchers are exploring how respiratory infections early in childhood might stimulate an immune response that suppresses the development of allergies.

------

Ongoing Asthma Activities at HHS

The National Institutes of Health (NIH)

NIH is supporting an extensive range of research programs examining asthma management, genetics, epidemiology, demonstration and education, and prevention. NIH estimates it spent $92 million on asthma research in FY 1997, $99 million in FY 1998 with $107 million proposed for FY 1999.

-- Genetics of Asthma -- Researchers supported by the National Heart, Lung, and Blood Institute (NHLBI) and the National Institute of Allergy and Infectious Diseases (NIAID) are working together to identify the major genes that may contribute to asthma and asthma-associated phenotypes such as allergy and airway hyper-responsiveness. Early findings confirm that multiple genes may be involved in asthma and that they may vary between ethnic/racial groups.

-- Pathogenesis and Mechanisms of Asthma -- The National Institutes of Health supports studies about the role of inflammation in the pathogenesis of asthma. The studies are directed at the examination of the cellular and molecular events

that appear to initiate, direct, and perpetuate the development of airway inflammation. Researchers supported by NHLBI and NIAID are studying how respiratory infections in early life acting individually and in combination with each other, regulate airway inflammation, airway hyper-responsiveness, and airway remodeling, thus leading to the onset of asthma. A new NHLBI research initiative will examine the multiple risk factors for the onset of asthma in early life and the mechanisms that cause them. This will lead to the identification of novel interventions to prevent the development of the disease.

-- Epidemiologic Research -- The National Institute of Environmental Health Sciences (NIEHS) is sponsoring several studies involving asthmatics who live in areas where they are exposed to high levels of ambient air pollutants, factors that are associated with the risk of asthma-related hospitalizations and death, and the respiratory health status of minorities, children under age-5, and the elderly. Other epidemiologic research supported by NHLBI, NIAID, and NIEHS include long-term studies to identify the specific risk factors associated with developing asthma and the risk factors that lead to severe, life-threatening asthma attacks. This research increases our understanding about what causes asthma, and helps identify promising new targets for asthma treatments.

-- Clinical Studies -- NIH institutes are carrying out several clinical studies that focus on prevention of asthma and effectiveness of new treatments. Clinical studies sponsored by NIH include:

o The Environmental Intervention in the Primary Prevention of Asthma in Children Study (NIEHS)

o The Childhood Asthma Management Program (NHLBI)

o Asthma Clinical Research Network (NHLBI)

o The Asthma and Pregnancy Trial (NHLBI and the National Institute of Child Health and Human Development (NICHD))

o The National Cooperative Inner-City Asthma Study (NIAID).

-- Demonstration and Education Research -- NIH supports demonstration and education (D&E) research which evaluate educational and behavioral approaches and organization strategies that may improve the management of asthma. A major thrust of recent D&E research has been on identifying appropriate programs and methods for extending the benefits of asthma management to populations that have been traditionally harder to reach, and who experience a disproportionate burden of asthma illness-for example, minorities and economically disadvantaged children. Outreach education programs using non-medical settings (e.g. the school and community neighborhood centers) are testing the use of community-based and culturally sensitive behavior change strategies for asthma control.

-- Research Translation: Dissemination and Education -- An ongoing and important part of the HHS/NIH asthma research program is to translate and disseminate scientific findings to improve the health and quality of life of people with asthma. The NHLBI established the National Asthma Education and Prevention Program (NAEPP) in 1989 to improve the diagnosis, treatment, and control of asthma, to enhance the quality of life of the asthma patients, and to decrease asthma morbidity and mortality. The NAEPP has a

three-pronged strategy to achieve these goals: develop science-based clinical practice guidelines for the diagnosis and management of asthma; use partnerships among federal agencies, professional societies, and voluntary and private organizations to disseminate recommendations and implement asthma programs; and organize public communications.

Centers for Disease Control and Prevention (CDC)

As the nation's disease prevention agency, the Centers for Disease Control and Prevention (CDC) is working with state and local partners to implement core and comprehensive asthma prevention programs as well as to evaluate programs' success. These programs will include monitoring to identify local disease trends, community asthma prevention interventions, intervention and evaluation research, and state-wide education of practitioners, patients, and health community organizations. CDC sponsors a number of local programs, working with state and local health department partners, to examine how a change in environmental influences can reduce asthma. The goal is to translate research findings into public health action. These include:

-- ZAP Asthma, Atlanta, Ga.: CDC is one of 17 partners in this project that seeks to show that a comprehensive approach to controlling asthma will reduce the number of asthma hospitalizations for children.

-- The California Community-Based Asthma Intervention Demonstrations Project: This project seeks to show that a reduction in exposure to environmental tobacco smoke will result in a reduction in asthma hospitalizations in children living in Fresno.

-- Identification and Prevention of Air Pollutants and Other Environmental Determinants in Urban Minority Children: Los Angeles: This project tracks the asthma status of 100 black children in central Los Angeles County to evaluate the effect of air pollution on asthma among urban, minority children.

-- Asthma Surveillance in Wisconsin: The purpose of this pilot project was to identify the most effective methods to monitor the trends in asthma through a consensus workshop, and pilot surveillance projects based on the workshop recommendations.

-- Out-of Hospital Asthma Deaths: North Carolina: Since out-of-hospital asthma deaths may be preventable, this project is helping to determine what proportion of total asthma deaths they comprise and what populations they affect.

-- Asthma Prevalence Study in the Catano Area of Puerto Rico: In collaboration with the Puerto Rico Department of Health, CDC and EPA investigated the possible relationship between air pollution and asthma. The study described the prevalence and severity of asthma among school-aged children in the Catano area, obtained baseline measures for assessment of future trends in the prevalence and severity of asthma, identified risk factors for the disease, and established a framework for further research.

--

Food and Drug Administration (FDA)

The FDA is working in partnership with the pharmaceutical industry to facilitate the timely development and approval of new drugs for the treatment of asthma and related conditions such as

allergic rhinitis. This partnership has resulted in a significant number of approvals by the Agency over the past few years for new drugs to treat asthma as well as a significant increase in the number of drugs specifically approved for use in children with asthma and allergic rhinitis. For example, in the past two years the FDA approved the first three members of an entirely new class of asthma therapy that work by blocking leukotrienes which are important mediators of asthma. Other examples of important new products approved by the FDA for first multiple-strength metered-dose inhalers (MDIs) and three new multi-dose dry powder inhalers (DPIs). These new drugs and devices provide physicians and patients with valuable new options that may help to improve the management of asthma.

--

Health Care Financing Administration (HCFA)

As part of Early and Periodic Screening, Diagnosis, and Treatment (EPSDT), Medicaid covers all medically necessary services for the diagnosis and treatment of asthma in children, including X-rays, drugs, inpatient stays, outpatient and emergency room visits.

Medicare provides Part B coverage for both physician visits and durable medical equipment, such as nebulizers, and oxygen equipment required by some asthmatic patients, HCFA also covers the medication that is put into the nebulizers as a necessary supply for the operation of the equipment.

-- HCFA recently supported the Aetna Medicare Care Counseling Program in the Phoenix, Arizona, a pilot program for Part B beneficiaries with diabetes and asthma. The Aetna Care Counseling program was a voluntary, confidential, telephone support service offered free of charge to qualifying beneficiaries with asthma or diabetes. In providing care counseling by registered nurses, the program's purpose was to enhance customer service and to improve beneficiaries' health and quality of life by providing a better understanding of asthma and the medications and equipment used to treat the disease. HCFA is currently in the process of reviewing and commenting on the findings.

--

Agency for Health Care Policy and Research (AHCPR)

AHCPR is sponsoring the ``Pediatric Asthma Patient Outcome Research Team (PORT) II'' a randomized clinical trial, co-funded by NHLBI. The trial tests the cost-effectiveness of NHLBI's practice guidelines designed to reduce asthma morbidity among children. The agency is supporting several other studies measuring quality of life, patient outcomes and other issues related to asthma care.

-0-

/U.S. Newswire 202-347-2770/
APNP-05-21-98 1450EDT

# ADVISORY COMMISSION ON CONSUMER PROTECTION AND QUALITY IN THE HEALTH CARE INDUSTRY

# FAX TRANSMISSION

To: Chris Jennings

Date: 4/28/98

Fax #: 456-5557

Pages: 11 including this cover sheet.

From: Janet Corrigan

Subject:

COMMENTS:

HUBERT H. HUMPHREY BUILDING
200 INDEPENDENCE AVENUE, SW ROOM 118-F
WASHINGTON, DC 20201
PH: 202-205-3333 FAX: 202-205-3347

TO: Ad Hoc Group on the Forum

FROM: Janet Corrigan, PhD

RE: May 1, 1998 Meeting

DATE: April 24, 1998

Enclosed please find the agenda and meeting materials for the May 1st meeting. **Please Note:** the meeting will begin at 9:30 am (EST) and adjourn at 1:30 pm. The location for the meeting is Conference Room 640H of the H.H. Humphrey Building, 200 Independence Ave., SW, Washington DC.

The objectives of this meeting are twofold: 1) to plan for the Forum kick-off meeting to be convened by the Vice President in June 1998; and 2) to identify and discuss key issues related to the 6 month planning process that will commence in June and culminate with the establishment of the Forum in early 1999.

If you have any questions, please contact me at 202/205-3045 (or pager #202-490-0321). I look forward to seeing you on May 1st.

Lipschitz
assistance
Richard Sorian
June.
Melissa S.
message.

Distribution
Toby Donnenfeld, Office of the Vice President
John Eisenberg, AHCPR
Nancy Foster, AHCPR
Chris Jennings, Office of the President
Sheila Leatherman, United Health Care Corporation
Randy MacDonald, GTE
Meredith Miller, DOL
Paul Montrone, Fisher Scientific International
Christopher Queram, Employer Health Care Alliance Cooperative
Thomas Reardon, Adventist Medical Group
Gerald Shea, AFL-CIO
James Tallon, United Hospital Fund
Peter Thomas, Powers, Pyles, Sutter and Verville, P.C.
Gail Warden, Henry Ford Health System

# DRAFT AGENDA

AD HOC GROUP ON THE FORUM
May 1, 1998 Meeting

9:30 am Welcome and Introductory Comments
- Introduction of participants
- Purpose of the meeting

9:50 Discussion of Forum Planning Process (draft proposal attached)
- Facilitator and Institutional Base
(see attached biographical sketch for James Tallon)
- Foundation Support
- Discussion of Process
- Planning Committee
-- Composition
-- Nominees

11:45 Break for Lunch

12:15 Discussion of June Kick-off Event
- Background Information on Other Activities Underway
- Messages
- Participants

1:30 Adjournment

# PROPOSAL TO FUND A PLANNING PROCESS FOR A NATIONAL FORUM FOR HEALTH CARE QUALITY MEASUREMENT AND REPORTING

**DRAFT - APRIL 24, 1998**

This is a proposal to fund a process for planning the development of a Forum for Health Care Quality Measurement and Reporting ("the Forum"), a private-sector entity to be established to provide coordination and guidance to the multiple public- and private-sector parties involved in evaluating health care quality. Creation of the Forum was one of the major recommendations of the Advisory Commission on Consumer Protection and Quality in the Health Care Industry ("the Quality Commission") in its final report to the President.

This proposal begins by describing the need to coordinate ongoing work in the area of health care quality measurement and reporting, and by laying out the specific objectives, activities, and organizational characteristics of an entity to be created to undertake that effort. It then describes the objectives, time line, and budget of the proposed process for convening key stakeholders to assist in operationalizing the entity.

## BACKGROUND

### Need for Standardized Information on Health Care Quality

Routinely generating comparable, standardized information on the quality of health care is critical for both motivating and enabling improvement. Standardized measures of quality are needed to track the health care industry's progress in achieving national quality improvement aims and to guide public planning and policy making. Comparative information on quality also is needed for individual consumers, employers, and others to use in selecting health care providers and health plans. Furthermore, valid and stable quality measures are integral to health care providers' efforts to improve their performance. When standardized, such measures provide an opportunity for health care organizations to make comparisons and identify "best performers."

Despite a growing number of efforts to measure and report on health care quality, useful information is neither uniformly nor widely available. Improving our ability to measure quality has been the object of significant public and private-sector activity over the last decade, reflecting the expectation that measurement can serve as both a catalyst and a tool for improvement as well as to facilitate consumer choice. While considerable advancements have been made in the quality measurement field in recent years, current efforts fall short of fully meeting users' needs, do not provide measures for many of the most important health burdens (e.g., chronic conditions), and often are duplicative and unduly burdensome on health care providers, health plans, and others.

Draft 4/24/98

**Forum for Quality Measurement and Reporting**

*Objectives.* The Forum for Health Care Quality Measurement and Reporting is being established to build the systemwide capacity to evaluate and report on the quality of care. The Forum would develop and implement effective, efficient, and coordinated strategies for focusing incentives for quality improvement on national priorities while assuring the public availability of information needed to support the marketplace and the efforts of the various existing quality oversight entities.

*Activities.* To achieve its objectives, the Forum will need to:

- develop a comprehensive plan for implementing quality measurement, data collection, and reporting standards to assure the widespread public availability of comparative information on the quality of care furnished by all sectors of the health care industry;
- establish measurement priorities that address national aims for improvement and that meet the common information needs of consumers, purchasers, federal and state policy makers, public health officials, and other stakeholders;
- periodically endorse core sets of quality measures and standardized methods for measurement and reporting;
- foster an agenda for research and development needed to advance quality measurement and reporting and to encourage collaborative funding for such activities;
- develop and foster implementation of an effective public education, communication, and dissemination plan to make quality measures and comparative information on quality most useful to consumers and other interested parties; and
- encourage the development of health information systems and technology to support quality measurement, reporting, and improvement needs.

To evaluate the success of its efforts, the Forum will need to create and utilize feedback mechanisms designed to assess the feasibility and acceptance of the measurement sets it promulgates as well as the extent to which information is reported, available, and used by interested parties. Armed with this information, the Forum will be able to initiate improvement strategies as necessary.

*Structure.* The key organizational characteristics of the Forum that will enable it to accomplish its objectives are its status as a private-sector organization and its representation of key

stakeholders from both the public and private sectors.

Operating in the private sector will provide the Forum with two needed characteristics. First, it will have greater flexibility and the means to act quickly to respond to changes in the health system and advances in technology that have implications for measurement and reporting strategies and capacity. Second, it will be well-positioned to harness and coordinate the market forces needed to drive this initiative.

Because the Forum will operate in the private sector as a voluntary initiative, its success will depend upon the commitment and influence of a critical mass of stakeholders in the health care marketplace. The Forum will therefore need to be broadly representative of stakeholders. The users and potential users of information on quality must be involved in the process of identifying core quality measures for reporting if those processes are to succeed in addressing their common information needs. The Forum also will need to include a core constituency of influential stakeholders that can assure the implementation of the measures once they are promulgated. Compliance with reporting requirements will be attained by purchasers and oversight bodies (i.e., accreditation, certification and licensure entities) by the mechanisms available to them (e.g., purchasing contracts and oversight processes). A decision to participate in the Forum would be viewed as constituting an endorsement of its work and an agreement to leverage compliance with the results to the full extent of the participant's ability.

Also critical to the Forum's efforts will be the participation of key organizations involved in promulgating quality measures and collecting information on the performance of various sectors of the health care industry. Key organizations include those that undertake efforts on a national basis, as well as those emerging and established groups organized at the regional, state, or local levels. The Forum will need to work with these organizations to determine how best to assure that information on health care quality is available, affordable, and easily accessible in the public domain. The Forum itself would not compete with the innovative work already under way in the public and private sectors by developing performance measures itself, but would instead seek to encourage the progress being made in this area and improve it through greater coordination. It would help to identify areas of needed fundamental research related to quality.

## PROPOSED PLANNING PROCESS

A planning process is needed to provide key stakeholders with the opportunity to work through critical issues related to the Forum's governance, organizational structure, and source(s) of financial support. The Vice President will begin this process by inviting key stakeholders to a June meeting to form a Task Force to jump-start the planning process. He will select individuals to participate in this planning process based on their expertise and stature, as opposed to organizational affiliation. The decisions to use a neutral convener and to seek funding support from a private foundation were made as a means of ensuring impartiality and promoting

participation by stakeholders.

The planning process should take place over a 6-month period, commencing in May 1998 with the issuance of invitations to participate. Over the course of that time, during which three meetings will be held, the Task Force will accomplish four critical objectives:

- define the Forum's functions, operations, working relationships and membership criteria;
- determine the composition of the Forum's governing board;
- determine the source(s) of start-up and ongoing financing; and
- initiate a process to recruit the Forum's Executive Director.

## Objectives of the Planning Process

### 1) Define the Forum's functions, operations, and working relationships.

Defining the Forum's functions, operations, and working relationships will be among the most important objectives of the planning process. The Quality Commission's work provided a starting point for defining these characteristics, but additional work is needed to refine and operationalize those recommendations.

A number of issues to be addressed pertain to the manner in which the Forum will function. For instance, the planning process may identify policies and procedures designed to assure the public of the integrity of the Forum's work, promote widespread confidence in its outcomes, and minimize potential conflicts of interest. The planning process can serve to articulate specific policies and procedures that will provide for public input, public deliberation, and public access to documents produced.

Operational issues to be addressed include the Forum's organizational structure, budget, facilities, and meeting schedules. In defining these aspects, participants in the Forum's planning process may wish to look to the organizational structures of entities charged with undertaking functions that are similar in nature, scope, and scale. Entities such as the Financial Accounting Standards Board and the American National Standards Institute -- although not analogous to the Forum in all respects -- may provide alternative models for examination by the Planning Task Force.

Task Force Planning process participants will need to carefully consider how the Forum will relate to the public- and private-sector organizations whose work will influence or be influenced by the Forum's activities. Formal working relationships will in some cases need to be established; for instance, in the case of organizations responsible for the development of the health care quality measures that will be evaluated for inclusion in the core sets of measures to be

periodically endorsed by the Forum. Similarly, the ways in which the Forum will interact with existing local, regional, state, and national organizations that serve as repositories of data on quality will need to be considered.

**2) Determine the composition of the Forum's governing board.**

The composition of the Forum's governing board is a key issue to be addressed through the planning process. Both the precise number and the allocation of slots on the Forum's governing board will need to be determined.

The Quality Commission recommended that the Forum be governed by a board that includes:

- public and private group purchasers;
- individuals and organizations focused on representation of consumers/patients;
- providers;
- labor unions;
- experts in quality assurance, improvement and measurement;
- quality oversight organizations;
- health care researchers; and
- public health experts.

Balancing the need to have a strong purchaser role and representation of the full array of key constituencies will be a delicate and challenging task for the planning process participants. Substantial representation on the board of purchasers from both the public and private sectors and of consumer organizations will be critical to provide strong incentives for organizations to participate in these efforts and to abide by the decisions of the Forum. Representation of the full array of key constituencies on the board will be equally critical, so as to assure the buy-in of all participants and the requisite expertise to effectively carry out the Forum's responsibilities.

**3) Determine source(s) of start-up and ongoing financing.**

Participants in the planning process will need to consider alternative sources of start-up funding to assist in establishment of the Forum. The potential for obtaining a start-up grant from a foundation or public source will need to be evaluated. Such funds may be used to allay one-time expenses that will be associated with initiating the Forum (e.g., expenditures associated with outfitting staff offices). External funding is unlikely to be made available for ongoing financing of the Forum, however.

Thus, it is essential for the Planning Task Force to establish an ongoing source of financing for the Forum. Participants in the planning process will need to estimate the Forum's first-year operating budget and develop a dues-paying schedule for members. Such a schedule will need to account for the varying levels of resources available to different categories of stakeholders. For

instance, cross-subsidies may be required so that the Forum is able to attain adequate representation of consumer interests.

**4) Begin Recruitment of an Executive Director.**

Once the planning process has resolved operational, representation, and financing issues, the Planning Task Force will initiate a process to identify an Executive Director capable of providing leadership for the Forum. This will require defining the skills and qualifications of ideal candidates for the position, and seeking and conducting initial reviews of candidates. Responsibility for selecting an Executive Director from qualified candidates will fall to the initial Board of Directors of the Forum, but the Planning Task Force can expedite this process by initiating the search.

Candidates will need to possess a variety of professional skills and expertise to be successful as the Forum's Executive Director. These include strong leadership, management, and planning skills; a high level of credibility among the diversity of stakeholders represented at the Forum; technical knowledge regarding quality measurement, oversight, and health benefits; and the ability to effectively communicate in support of the Forum's mission. The Planning Task Force will need to determine the extent to which the Executive Director should be drawn from interests represented by the Forum. For example, a potentially highly qualified candidate may be a person with experience as a corporate benefits director with first-hand knowledge of purchasers' perspectives on the use of quality measures; negotiating experience with hospitals, clinicians, and oversight organizations; and an understanding of consumers' use of quality measurement information. Other individuals with the requisite experience and skills to serve as the Forum's Executive Director may include health plan executives, quality oversight managers, or experts in quality measurement and improvement.

The planning process for selecting an Executive Director will require identifying the desired qualifications of candidates as soon as the functions and operations of the governing body of the Forum are defined. This definition of the Executive Director position and desired skills of candidates needs to occur early in the Planning Task Force's process to allow time to recruit highly qualified candidates. The Task Force may elect to contract with an executive search firm to assist in the recruiting of suitable candidates. Once eligible candidates have been identified, the Task Force will need to review the qualifications of candidates applying for the position and identify top candidates for consideration by the Board of Directors.

**Draft- 4/24/98**

**Time Frame for Planning Process**

| | |
|---|---|
| June 1998 | First meeting of planning process<br>Purpose: Define Forum's functions, operations, and working relationships |
| September 1998 | Second meeting of planning process<br>Purpose: Determine the composition of the governing board, sources of ongoing financing for the Forum, and qualifications of Executive Director |
| November 1998 | Third Meeting of planning process<br>Purpose: Name governing board, and screen Executive Director candidates |
| December 1998 | Convene prospective members of governing board, select Forum's Executive Director, release start-up funds |
| January 1999 | First meeting of the Forum's Board of Directors |

**Budget for Planning Process** *[Note: Preliminary, rough estimates]*

Personnel costs $120,000
*[Estimated as 1 FTE * $100,000 annual compensation (including benefits) * 0.8 years + 1 FTE * $50,000 annual compensation (including benefits) * 0.8 years]*

Administrative expenses and overhead $ 40,000

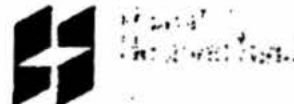
Meeting expenses (3 meetings) $ 85,500
-- facilities *[estimated as $3000 * 3 meetings]*
-- travel expenses *[estimated as 20 people * $800/mtg * 3 mtgs]*
-- overhead for services of contractors responsible for meeting logistics *[estimated as 50 percent of total meeting expenses]*

Honoraria for Planning Committee $ 60,000
*[estimated as 6 days meeting time * 20 participants in planning committee * $500 daily rate]*

Contract for executive search services $ 39,000
*[estimated as 30% of Executive Director's annual salary of $130,000]*

---

Total $344,500



# JAMES R. TALLON, JR.

James R. Tallon, Jr. is president of the United Hospital Fund of New York. The Fund, the nation's oldest federated charity, addresses critical issues affecting hospitals and health care in New York City through health services research and policy analysis, education and information activities, and grantmaking and voluntarism.

Mr. Tallon serves as chair of the Kaiser Commission on Medicaid and the Uninsured and is a member of the Joint Commission on the Accreditation of Healthcare Organizations (JCAHO). He serves as secretary for the Alpha Center and for the Association for Health Services Research, and is also on the boards of the Alliance for Health Reform, The Commonwealth Fund, and the New York Academy of Medicine. He recently concluded a three-year term as a member of the Prospective Payment Assessment Commission (ProPAC), and has held visiting lecturer appointments at the Columbia University and Harvard University schools of public health.

Prior to joining the Fund in 1993, Mr. Tallon served in the New York State Assembly for nineteen years, beginning in 1975. As majority leader from 1987 to 1993 and as chair of the health committee from 1979 to 1987, he spearheaded efforts to reform the Medicaid program while expanding eligibility for pregnant women, and children. His 1991 legislation required the implementation of Medicaid managed care programs statewide. Under his leadership, the Assembly also enacted measures to assure transitional health coverage for laid-off workers, reimburse hospitals in a fair and cost-effective manner, foster high-quality and cost-efficient home health care services, encourage organ donations, promote AIDS research and education, and foster regional health planning agencies.

Mr. Tallon received a B.A., cum laude, in political science from Syracuse University and an M.A. in international relations from Boston University. He has also completed graduate work at the Maxwell School of Citizenship and Public Affairs at Syracuse University. In 1995, he was awarded honorary doctorates of humane letters from the College of Medicine and School of Graduate Studies of the State University of New York Health Science Center at Brooklyn, and from New York Medical College.

February, 1998

FAXED
for
Jarah
FILE
QUALITY

******************************
*** MULTI TX/RX REPORT ***
******************************

| | |
|---|---|
| TX/RX NO | 1881 |
| PGS. | 27 |
| TX/RX INCOMPLETE | ----- |
| TRANSACTION OK | (1) 913015942168 |
| | (2) 913015942155 |
| | (3) 96906154 |
| | (4) 96906247 |
| ERROR INFORMATION | ----- |

FORUM NTBK

# THE WHITE HOUSE

Domestic Policy Council

DATE:_______

FACSIMILE FOR: John Eisenberg, Nancy Foster, Anthony So, Richard Sorian 301-594-2168, 301-594-2155 (F) 690-6154 (F) 690-6343 (P) 690-6247

PHONE: ( ) - FAX: ( ) -

FACSIMILE FROM: Sarah Bianchi

PHONE: ( ) - FAX: ( ) -

NUMBER OF PAGES (INCLUDING COVER):_________

[ ] FOR YOUR REVIEW
[ ] PER MY E-MAIL OR VOICE-MAIL MESSAGE TO YOU
[ ] PER YOUR REQUEST

# THE WHITE HOUSE

Domestic Policy Council

DATE:_______

FACSIMILE FOR: John Eisenberg, Nancy Foster, Anthony So, Richard Sorian
301-594-2168 301-594-2155 (F) 690-6154 (F)
690-6343 (P)
690-6247

PHONE: ( ) - FAX: ( ) -

FACSIMILE FROM: Sarah Bianchi

PHONE: ( ) - FAX: ( ) -

NUMBER OF PAGES (INCLUDING COVER):_________

[ ] FOR YOUR REVIEW
[ ] PER MY E-MAIL OR VOICE-MAIL MESSAGE TO YOU
[ ] PER YOUR REQUEST

COMMENTS: Comments on Quality Report.

**MEMORANDUM**

June 2, 1998

TO: John Eisenberg, Nancy Foster, Anthony So, Richard Sorian

FR: Chris Jennings and Sarah Bianchi

RE: Quality Report

Thanks for sending us a draft of the report. You have clearly done a great deal of work putting this together. In addition to the handwritten edits, we thought it might be helpful to give a few overall comments.

You have collected an impressive list of examples of companies and state and local governments, and others that are relying on this kind of data and information. We would suggest that rather than citing all of the examples on this comprehensive list, that we focus in a more limited set of examples and describe them in more detail. Specifically, we would recommend choosing the examples where you believe we can describe: (1) the problem that was being addressed (i.e. overuse of services, high rate of diabetes, etc); (2) how the quality measure was implemented to address that problem (why a certain approach was chosen, who uses it, etc.); and (3) what if any evidence that we have to verify that this was somewhat successful (either improved consumer satisfaction, address the defined problem in some way etc.) We are aware that in many cases, this level of information is not available, but we would suggest limiting the report to examples that we know more about. However, you should include a paragraph or so that gives a sense of how widespread the use of this information is.

We would also suggest defining the problem as much as possible, with using the examples that you have and any others that we can find, particularly with regard to how this is costing the health care system money (as well as costly in terms of human suffering) and improving outcomes.

Once you define how this kind of information works and can be useful, the report raises the question of why the existing system is not good enough and why we would need a Quality Forum. Therefore, we would recommend that you include a section that describes why the current system is not sufficient. This section may include a brief discussion of the fact that there is a patchwork of success stories with too little collaboration; that more companies have indicated an interest in using this type of information; and why it would be useful to have more collaboration or to have people relying on similar outcome measures.

We would recommend that the discussion of the forum would follow this section. You should discuss more fully the description of the forum -- using some of the language that is from the Quality Commission report itself. This section should include a discussion of why the forum, and the planning process is so important. It could also include a discussion of what the potential is with regard to improving quality, developing a consistent set of measure, and why that is so important.

The outline we are suggesting is as follows:

I. Introduction

II. Evidence of Quality Problems -- overuse of services, cost impact and human suffering etc. etc.

III. Evidence that these problems can be addressed -- through 10 examples of how this is currently working.

IV. Why the current system is not good enough and why there is great potential to do better.

V. What the Quality Commission recommended in this regard. Why the Forum has so much potential to improve quality, outcomes, etc.

VI. Why the planning process is the first important step to developing this critical system.

Is it possible for us to see a revised draft at the end of this week? Thanks again.

AGENCY FOR HEALTH CARE POLICY AND RESEARCH

*LIAISON OFFICE FOR QUALITY*

U.S. Department of Health and Human Services, 200 Independence Ave., S.W., Room 638G, Washington, D.C. 20201

# FAX

Date: 5/21/98

Number of pages including cover sheet: ~~26~~ 24

To: Sarah Bianci

Phone:

Fax phone: 456-5557

CC:

From: ANTHONY D. SO, MD, MPA
SENIOR ADVISOR TO THE ADMINISTRATOR

Phone: 202-690-7230

Fax phone: 202-690-6154

REMARKS: ☐ Urgent ☐ For your review ☐ Reply ASAP ☐ Please comment

# Memo

**To:** Sarah Bianci

**From:** Anthony So

**Subject:** Forum Background paper

**Date:** May 21, 1998

Over the last few days, we have worked to move from outline to draft background paper. To provide an early glimpse at this draft, Dr. Eisenberg asked that we fax to you the current version. It still needs to go through Department clearance, but your input and Chris's at this stage would be most helpful. As our e-mail system is down indefinitely, comments can be faxed to (202) 690-6154.

If possible, we would like to discuss how the paper might be used at the event. This would help us in making the next round of revisions. I can be reached at (202) 690-8205 or 690-7230.

## DRAFT-PLEASE DO NOT CIRCULATE

### Measuring and Reporting on Health Care Quality–
### Firm Foundation for the Forum

### Background Report

**Overview**

In December, 1994, a well-known health reporter for the *Boston Globe* suffered an accidental, but fatal overdose of chemotherapy at a major Boston academic institution. Undergoing treatment for breast cancer, she received a fourfold miscalculation of her chemotherapy drug, and later, her death became the subject of newspaper headlines. The Joint Commission on Accreditation of Healthcare Organizations responded to this incident and the report of a second accidental overdose by placing the hospital on conditional accreditation. The top leadership of the hospital departed, and the Dana-Farber Cancer Institute undertook an investigation of what went wrong. The result was a practical "internal revolution," and significant changes–from requiring staff physicians to countersign chemotherapy orders to a redesigning of patient charts and an effort to survey patient satisfaction with care–were implemented. However, more often than not, measures of quality–not the media–motivate improvements in how health care is delivered.

The real story of health care quality seldom makes the headlines. Many private and public sector efforts serve as example of how we can improve health care quality for all Americans. Measuring and reporting on quality has resulted in real gains for consumers in terms of health plan choice and better care. But as the Final Report of the President's Advisory Commission on Consumer Protection and Quality notes, we can do better. This report focuses on the promise revealed by these leading edge efforts.

These activities to improve health care quality make good business sense. They can result in increased productivity and decreased costs from higher quality care. The Business Roundtable found that companies surveyed for a report on best practices in health care "repeatedly emphasized their belief that future cost savings in health care depend on quality improvement." Major businesses have echoed this statement as well (The Business Roundtable, 1997).

Information on quality is also the sign of a "mature" health care market, as measured by the level of managed care penetration. Where managed care penetration was greater, health plans used quality to choose potential providers of tertiary care. In contrast, price dominated the choice of tertiary care providers in the less mature markets, and quality monitoring efforts in the contractual arrangement were less common (Schulman, et al., 1997).

Quality matters to consumers. By a wide margin, Americans cite high quality as their most important concern in choosing a health plan (AHCPR-Kaiser Family Foundation, 1996). To be

DRAFT-PLEASE DO NOT CIRCULATE

effective, consumers must become involved in these activities. From health plan selection to treatment decisions, consumers must be empowered to participate. Taking measure of quality may respond to consumer concerns over managed care. Such concerns have kept some employers from using managed care services.

— 1st talk about why impt. to the private sector

The Federal government also has an important, and complementary, role to play in these efforts to improve quality. The government funds clinical and health services research; supports the development of quality measures; sponsors surveys and databases that can track and benchmark changes in quality; encourages information exchange over best practices; and purchases or delivers health care for millions of Americans.

→ & is one of the largest purchasers

## Bridging the Gap in Health Care Quality

The President's Advisory Commission on Consumer Protection and Quality in the Health Care Industry affirmed that many Americans receive quality care from dedicated health care professionals (Final Report, 1998). However, it also found wide variations in health care practice, attributable in part to underuse, overuse and misuse of services.

For some services, underuse poses a challenge. For example, only 66% of children enrolled in the 330 managed care plans providing information to the National Committee for Quality Assurance (NCQA) had received appropriate immunizations by age two (NCQA, 1997). A nationally representative sample of women age 50 and older found that only 45% had a mammography, as recommended for early detection of breast cancer, in the previous year (CDC, 1993). In another study, a third of Medicare patients who survived a heart attack failed to receive aspirin within two days of hospitalization (Krumholz, et al., 1995). This was despite the fact that these patients had no contraindications to aspirin therapy and that aspirin use among elderly patients had been shown to reduce mortality by 22% in the first 30 days after a heart attack.

— don't use example of immunization b/c of President's immunization initiative

Overuse of services also presents problems. Half of all patients diagnosed with a cold and 66% of patients diagnosed with bronchitis received antibiotics (Gonzales, et al., 1997). In 1992, twelve million antibiotic prescriptions were written during office visits for colds, upper respiratory tract infections and bronchitis. Together, these prescriptions accounted for one out of every five antibiotic prescriptions to adults in that year. Yet antibiotics offer little or no benefit for these conditions. This overuse of antibiotics not only imposes unnecessary health care costs, but also places patients at risk for adverse drug reactions and contributes to the emergence of antibiotic-resistant pathogens. In a study of tympanostomy tube placement in children, researchers found that 23% of the procedures were performed for inappropriate indications while another 35% were for equivocal indications (Kleinman, et al., 1994).

Misuse of services and avoidable errors occur in the use of laboratory tests and medications. One study noted that 10% to 30% of laboratory test results were inappropriately classified as normal

based on rescreening reviews (Wilbur, 1997). These errors can result in missed or delayed diagnoses. Several studies have examined medication errors in hospital settings. One conducted in a teaching hospital found four errors per 1,000 medication orders. Investigators classified 70% of those errors as having the potential for serious adverse outcomes (Lesar, et al., 1997).

## Measuring Quality

To address these issues, the Advisory Commission called for the creation of two entities–an Advisory Council for Health Care Quality in the public sector and a Forum for Health Care Quality Measurement and Reporting in the private sector. Each fulfills an important and complementary role. The Forum is intended to improve the effectiveness and efficiency of health care quality measurement and reporting. Building on the promise of what public and private sectors have already achieved, the Forum has potential to take this work to the next quantum level. → how, what are the gaps that have been left?

To realize these gains in quality improvement, coordinated efforts at quality measurement, data collection and reporting are key. Through these two entities–the Council and the Forum–the Commission proposed coordinated efforts to improve health care quality. In its Final Report, the Commission found that "incentives to improve quality have been diluted by measurement efforts that vary widely in their aims and scope, and that have been, at best, only informally coordinated." This paper focuses on the potential that coordination of this work might bring.

Such coordination would serve several purposes. First, it would enable the marketplace to identify and update core sets of quality measures and standardized reporting methods. On the part of health care providers and plans, this would reduce needless duplication of data collection and reporting efforts. Such a process would also flag what measures are important and for what purpose. Second, it would allow consumers and purchasers to comparison shop for health plans. For employers and other purchasers, a core set of quality measures offers a common yardstick by which to assess provider performance. Finally, coordinated efforts can lead to the sharing of resources and best practices, both across and within private and public sectors. At present, employers and other group purchasers do not have a central repository for learning about best purchasing practices, nor do they have affordable access to the technical assistance that would permit replication of the practices of pioneers (Meyer, et al., 1997).

*Developing core sets of quality measures.* The Federal government and the private sector have both contributed to sets of measures from which a single core set might emerge. Importantly, many of these tools reside in the public domain, where they are more widely accessible.

- The Health Plan Employer Data and Information Set (HEDIS), developed initially by Digital, GTE and Xerox and later by the National Committee on Quality Assurance (NCQA), is one set of quality measures widely used by health plans. In October, 1997,

**DRAFT-PLEASE DO NOT CIRCULATE**

NCQA released its second version of *Quality Compass*, a database of HEDIS and accreditation information on 329 health plans across the nation. With *Quality Compass 1997*, NCQA published its first "State of Managed Care Quality," a report that provides benchmarks and national and regional averages based on HEDIS data.

- Working with RAND, Research Triangle Institute and Harvard, AHCPR sponsored the development of the Consumer Assessment of Health Plans Survey (CAHPS). CAHPS is a consumer satisfaction survey that gauges consumers' experiences with their health plans. Recently HCFA began surveying over 200 managed care plans serving Medicare beneficiaries to collect and report on CAHPS data. Next spring Office of Personnel Management will use CAHPS to survey Federal employees. Thus in FY 1999, over 45 million Americans will have access to CAHPS reports to help them make their health care choices.
- AHCPR and 19 state partners built a powerful tool for studying quality health care, the *Healthcare Cost and Utilization Project* (HCUP). This research database and tool provides a comprehensive source of hospital inpatient financial and clinical information. As more health care moves from inpatient to outpatient settings, the Agency plans to broaden the database to include ambulatory surgery, and this is underway in nine of the participating states. Many organizations lack the resources to build a benchmarking infrastructure to assess the impact of delivery system changes on quality. The *HCUP Quality Indicators* provides a user-friendly, standardized database and software program to track the impact of system changes on quality. At least ten state governments and state hospital associations use *HCUP Quality Indicators* for benchmarking and monitoring purposes. The Hawaii Health Information Corporation (HHIC), a non-profit organization that aids hospitals with their quality improvement programs, submitted the HCUP Quality Indicators to JCAHO for approval for the ORYX measurement initiative. JCAHO approved most of the indicators, opening the door for HHIC to use these indicators in the JCAHO accreditation process.
- Founded on the premise that "a more responsive health care system depends on informed, empowered consumers who help shape the system, hold it accountable for quality and act as partners in improving health," FACCT-the Foundation for Accountability-also has developed measures of health care quality. Over the past couple years, it has completed work on measures focused on adult asthma, breast cancer, diabetes mellitus, major depressive disorder, health status, health risks, and consumer satisfaction. Consistent with its goals of being consumer-focused, FACCT conducts focus groups for each of its measures and combines these patient expectations with the best available clinical knowledge and scientific research.
- The Health Care Financing Administration (HCFA) aided in the development of OASIS-the Outcomes and Assessment Information Set-a core standard assessment data set for home health agencies. Under a second proposed regulation in March 1997, HHS requires home health agencies to use OASIS to monitor patient satisfaction and conditions. OASIS requires a standardized assessment of new patients within 48 hours of

admission to determine immediate support needs and updated assessments continuously until the patient's discharge. Additionally, health agencies must use data from OASIS to improve practice through their quality improvement programs (HCFA, 1997).

- The Joint Commission for the Accreditation of Healthcare Organizations (JCAHO), the major accreditation organization for hospitals, has developed a quality measurement system called ORYX Plus. It is a voluntary option for hospitals and offers opportunities for national benchmarking and performance comparisons by stakeholder groups. Initially, JCAHO identified 32 measures for the system with expectations to increase the number and sophistication of measures over time (JCAHO, 1998).
- The American Medical Association has initiated the American Medical Accreditation Program (AMAP) for physicians. This voluntary program, developed in collaboration with specialty, state, and local medical societies, will reduce duplication in credentialing requirements. It will provide feedback on the quality of a physician's care to the physicians themselves as well as health plans and hospitals. State licensing requirements currently can involve credentialing or site reviews. Adding to this information base, AMAP plans to include other data on the physician's personal qualifications, clinical performance, and patient care satisfaction (AMA, 1998).
- The SF-36 Health Survey remains one of the most widely used generic health-related quality of life measures (Ware, 1998). Researchers developed the measure in a way that both allowed for group comparisons and used general health concepts not specific to age, disease or treatment group. The measurement instrument provides insight to alternate definitions of health–function and dysfunction, distress and well-being, objective reports and subjective ratings, and favorable and unfavorable self-evaluations of health status.
- Numerous stakeholders, including health plans health services researchers, experts in diabetes and primary care, HCFA, the American Diabetes Association, FACCT, and NCQA, have joined together for the Diabetes Quality Improvement Project (DQIP). This collaborative effort has resulted in the development of an initial set of diabetes measures. This project is ongoing with plans to field test new measures in the future. The participating organizations are considering this set of measures for inclusion in their measurement projects, including future versions of the HEDIS Reporting Set (NCQA, 1998).

*Complementing core measures.* The development and use of core sets of measures have encouraged firms and group purchasers to go a step further. Some have complemented core measurement sets with other yardsticks for health plan performance (Meyer, et al., 1997).

- In evaluating HMO performance, General Motors blends several measures of health care quality into one amalgamated quality measure and draws from direct indicators of quality from HEDIS, employee satisfaction measures, accreditation status, and impressions gained from site visits. GM also works with its plans to develop quality improvement strategies and facilitate the sharing of best practices.

this is a good example to spell out in much more detail. ~~why do~~ what motivated GM to do this? why did it work? are consumers happier

**DRAFT-PLEASE DO NOT CIRCULATE**

- Digital applies its own comprehensive set of HMO performance standards to evaluate quality. The company periodically updates these standards with the addition of new indicators, such as HEDIS, and the removal of outdated ones. Within this framework, Digital sets "stretch" goals that encourage HMOs to continuously improve their performance.
- The Chicago Business Group on Health contracted Hewitt Associate, which also participated as an employer in the group, to assess costs and quality in local health plans. Hewitt used results from individual interviews, HEDIS indicators, its own benchmarking database (Health Network Profiler), features of the Consumer Health Plan Value Survey, and other national benchmarking indicators (such as Healthy People 2000).

*Filling in the measurement gap.* Still, to meet the needs of purchasers, continued work to fill the gaps in quality measures must be undertaken. Some of this work requires cataloguing existing measures, but much of it involves research to advance the science of measurement.

- AHCPR works to fill the gaps in quality measurement by supporting the Q-SPAN project. In a series of cooperative agreements to develop and test new measures, the Q-SPAN project currently focuses on eight measures for specific conditions, patient populations, and health care settings: clinical performance measures for dental care plans, developing and testing asthma quality of care measures; development of a global quality assessment tool for managed care, expansion of quality measures for cardiovascular disease, functional outcomes in patients with hip fractures, measuring quality by achievable benchmarks of care, ongoing development and evaluation of HEDIS measures, and quality outcomes in subacute and home care programs (AHCPR, 1998).
- In the area of child health, AHCPR, the Maternal and Child Health Bureau and HCFA are funding NCQA to pursue quality measures of relevance to children and adolescents. This funding will support the collaboration of NCQA and FACCT in the development, testing and implementation of child health measures, as well as their inclusion in future versions of HEDIS.
- FACCT also works to fill the measurement gap and has under development measures on alcohol misuse and dependency, coronary artery disease, end of life, and HIV/AIDS.
- AHCPR has developed a catalogue of existing quality measures-CONQUEST. Designed for providers, managed care plans, purchasers and policymakers, it uses a common language so that individuals can quickly identify a group of measures for use. Currently, CONQUEST contains 1,185 clinical performance measures and information on 52 common or costly clinical conditions, such as diabetes, hypertension, depression, cancer, and pregnancy. Unlike some private sector databases of measures, CONQUEST is available in the public domain (AHCPR, 1998).
- In an initiative undertaken to provide a catalogue of performance measures in a standardized format, the JCAHO started the *National Library of Healthcare Indicators: Health Plan and Network Edition*. It provides profiles of 225 performance measures that

can be used to assess the performance of health plans, integrated delivery networks, provider sponsored organizations, and other delivery systems. Each profile adheres to a sophisticated classification system, and each measure is selected based on an "expert-based face validity screening process" (JCAHO, 1998).

*Minimizing redundant efforts.* Multiple competing core sets of quality measures can lead, however, to unnecessarily duplicative and expensive data collection efforts by health plans and providers. Public-private partnership on developing core sets of quality measures can minimize this while preserving the room required for continued development and improvement of measures. For example, the National Committee for Quality Assurance (NCQA) will merge their consumer assessment survey with the Consumer Assessment of Health Plans Survey (CAHPS), which was created through AHCPR funding. Along these same lines, group purchasing arrangements have helped consolidate the measurement requirements. Using HEDIS 3.0 quality and enrollee satisfaction measures, the California Cooperative Healthcare Reporting Initiative (CCHRI) reports annually these results to purchasers in the Pacific Business Group on Health and others.

*Cascading effects from the development of quality measures.* What cannot be measured cannot be improved. Downstream, the development of quality measures has triggered a cascade of activities to improve health care quality.

- Developed by the AHCPR-sponsored cataract Patient Outcome Research Team (PORT), the VF-14 is an instrument used to measure functional status in patients with cataracts. Now considered the gold standard, the VF-14 has now been adopted by several Medicare carriers as part of the routine pre-operative assessment of cataract patients. Based on data collection strategies and tools developed by the cataract PORT, the American Academy of Ophthalmology launched a large national project enabling ophthalmologists to collect standard clinical information on their cataract patients. The AAO has invested over $1 million in this effort, called the National Eyecare Outcomes Network (NEON). The AAO and the physicians believe that this database enables them to provide reliable performance data on their cataract surgery when competing for managed care contracts. They also use the data to detect differences in patient outcomes that may allow specific providers or groups to identify quality problems and improve quality of care. A national organization of ophthalmology residencies plans to use the database to monitor the quality of residency programs in the country. At least one program requires all of its residents to submit data to the database and uses the information to measure performance of the residents.
- To assess prostate symptoms better, the American Urological Association (AUA) symptom index was developed and validated. It proved to be a superior measure of symptom severity compared to various physiological and anatomic measures commonly used in practice. The Maine Medical Assessment Foundation has used the AUA

evidence

**DRAFT-PLEASE DO NOT CIRCULATE**

symptom score along with other measures to collect outcomes on patients with benign prostatic hyperplasia. Over 60% of practicing urologists in Maine now use the symptom score. Its use has changed the way urologists practice with greater attention to informed patient decision making.

## Competing on Quality

The public availability and public reporting of these quality measures play an important role. When used for comparisons in the marketplace, this information allows consumers and purchasers to evaluate and select health plans and providers on the basis of quality, not just cost. For the marketplace to compete on quality, employers and coalitions must also incorporate these considerations into their purchasing strategies.

These measures often take the form of report cards made publicly available. Various groups produce these guides, deliver them in print or electronic formats, and make them publicly available for free or for purchase. For example, *U.S. News & World Report* and *Newsweek* publish ratings of health plans, as do consumer organizations like Washington's *Consumer Checkbook* and *Consumer Reports*. Using HEDIS measures and an NCQA consumer satisfaction survey, *U.S. News and World Report* published a report card in October 1997 of 223 managed care plans (Brink and Shute, 1997). *Newsweek* followed with a December report card of 88 plans based on the FACCT framework and measures (Spragins, 1997). Several states have followed suit with customized report cards examining local health plans. The New Jersey Department of Health and Senior Services and the Maryland Health Care Access and Cost Commission (HCACC) both present HEDIS data, and New Jersey uses the AHCPR-sponsored CAHPS survey for its consumer satisfaction data (New Jersey Department of Health and Senior Services, 1997, and Maryland HCACC, 1997). Through its Web site, the National Committee for Quality Assurance provides selected findings from HEDIS measures of health plans on "Quality Compass."

Employers such as Motorola and J.C. Penney also generate such reports on health plans for their workers (The Business Roundtable, 1997). In fact, J.C. Penney personalizes report cards on HMOs to the specific home zip code of the employee. These report cards carry such information as NCQA accreditation status, plan member satisfaction rates, and the number of contracted plan specialists. Again, some purchasers have gone beyond core measurement sets. General Motors, First Chicago NBD, and others are involved in the Southeast Michigan Health Care Consortium, which is collecting outcomes data for all health care centers in the region. They plan to publish data on angioplasty and coronary artery bypass surgery in the fall of 1998 (The Business Roundtable, 1997).

This work has also arisen out of public-private partnerships. The Massachusetts Healthcare Purchaser Group, a statewide coalition of 67 public and private members, publicizes information

**DRAFT-PLEASE DO NOT CIRCULATE**

on the ability of local health plans to meet specific cost and quality goals. Public sector representatives include the Massachusetts Division of Medical Assistance which runs the state Medicaid program; the Group Insurance Commission which purchases health care for state employees; and several municipalities and nonprofit colleges. The group examines HEDIS data, publicly reports on the number of indicators that plans produce, and ranks plans relative to each other and to benchmarks. They developed a report card for the first time in 1996, and they hope to develop a group purchasing strategy by January 1999. In another example of public-private partnership, the California Office of Statewide Health Planning and Development and the Pacific Business Group on Health have developed the California Coronary Artery Bypass Graft (CABG) Mortality Reporting Program. This program collects and reports risk-adjusted, hospital-level mortality data for California hospitals that perform bypass surgery (Meyer, et al., 1998). The growing availability of these measures speaks to consumer interest in this information.

Studies have shown that the public reporting of quality measures can result in improvements in the delivery of health care.

- Since 1989, the New York State Department of Health has collected and released hospital-level data on coronary artery bypass surgery. From 1989 to 1992, actual mortality decreased from 3.52% to 2.78%. Because average patient severity of illness increased, risk-adjusted mortality decreased even more over that same period–by 41% from 4.17% to 2.45% (Hannan, et al., 1994).
- The Missouri Department of Health developed a consumer report on obstetrical services. Within 1 year of the report, approximately 50% of hospitals that did not have car seat programs, formal transfer agreements for high-risk infants, or nurse educators for breast-feeding prior to the report either instituted or planned to institute these services (Longo, et al., 1997).
- In 1993, 27 corporate and government health care purchasers formed the Massachusetts Healthcare Purchaser Group (MHPG). Sixteen health plans representing 15 different health care organizations submitted 1992 data on 6 clinical indicators. A "clinically significant average range" was defined and health plan performance was summarized for each indicator in the "Cost/Quality Challenge Report" released in March 1994. Most of the purchasers MHPG surveyed about their assessment and use of the Cost/Quality Challenge Report found it useful. To promote quality improvement activities among health plans, MHPG showed purchasers how to pursue performance issues with health plans, held a best-practice forum on C-section, and created a follow-up endeavor, the Coordinated Purchasing Initiative (Jordan et al., 1995).

let's expand this one

Apart from purchasing health care, quality measures serve an important role in flagging areas for improvement and motivating practice change. Both the public and private sectors have effectively used quality measures to accomplish these ends. Some have done so by publicly reporting the information, and others, by providing feedback more directly to health plans and

**DRAFT-PLEASE DO NOT CIRCULATE**

providers. In each case, the evidence shows that quality measures can result in improvements in health care services.

The public release of data on quality of care has its role in ensuring public accountability. However, not all quality measures work best when used in this way. Health plans and providers see patients, who may differ in their severity and pattern of illness. To compare across plans and providers, risk adjustment for these differences needs to be done, and done well. Sometimes the motivation can come from within these plans and practices instead of from the public release of such information. When used for improvement, quality measures can provide health plan and provider feedback that changes practice behavior and results in continuous quality improvement efforts.

## Applying Quality Measures

Leading the way in value-based purchasing, some firms and group purchasing coalitions have applied quality measures to how they contract and arrange for care, educate employees to become better health care consumers, provide incentives to reward the practices of employees or providers, and become involved in improving the delivery of health care services (Meyer, et al., 1997). By taking responsibility for educating and offering incentives in their employees' health care decisions, employers and group purchasers are forging a new relationship with their workers.

*Contracting and arranging for care.* The use of quality measures has changed the way employers and group purchasers select health plan options and offer these choices to their employees. Several businesses and group purchasing coalitions provide information on quality, alongside benefit package comparisons, to employees and consumers. They also use such information in narrowing the choice of plans to offer. It has also become part of the process to involve employees in evaluating the health plans that the employer offers. The following examples demonstrate various approaches taken by employers and group purchasers on the leading edge.

- International Paper Company has an extensive information database for use by its employees. This database, called the Medical Information Resource System, includes information on physicians taken from the American Medical Association, 12 annually developed fee schedules, surveyed physicians' fees, the frequency of performing certain procedures by specialty, and contracted hospitals' charges (The Business Roundtable, 1997).
- GTE uses a subset of HEDIS measures and looks at the accreditation status of health plans with which it contracts. With in-house expertise, the company has created a database which GTE uses in lieu of NCQA's database, the Quality Compass, to evaluate health plans (Meyer, et al., 1997).

again, what has improved why does this matter

**DRAFT–PLEASE DO NOT CIRCULATE**

- The Buyers' Health Care Action Group (BHCAG), composed of 23 self-insured, private employers, collectively contract with "care systems" that meet a standard set of criteria. BHCAG provides comparative information about costs and quality to consumers (The Midwest Business Group on Health, 1997).
- Hershey Foods Corporation used risk-adjusted mortality data from the Pennsylvania Health Care Cost Containment Commission, along with other information, to select a network of hospitals for its point-of-service plan (The Business Roundtable, 1997).
- Balancing choice and quality, Motorola sought to establish its own managed care network to include 80% of physicians recording at least 10 encounters a year with an employee. If an employee's physician was not included, Motorola encouraged them to recommend the physician for inclusion and accepted all those meeting the plan's credentialing and other requirements. By doing so, the company notes that it is "primarily interested in selecting the physicians based on their quality of service" (The Business Roundtable, 1997).
- The United Auto Workers requires NCQA accreditation for all health plans offered to its memberes, and it is working on a strategy to provide information, including NCQA accreditation status and some quality assessment based on HEDIS measures (AFL-CIO, 1997).
- After an initial screening, *Ryder System* brings HMO finalists before panels of representative employees in each of 27 market areas. The employees then quiz the HMOs on measures such as the size of the network, the hospitals used, how doctors were paid, and the process for referral to a specialist. This input contributes significantly to the plans chosen for *Ryder System* employees (The Business Roundtable, 1997).

*Educating employees to become better health care consumers.* Though more information to compare health plans is now available, consumers still need programs and tools to navigate through the health care system. After the plan selection is made, difficult treatment decisions arise, and patients sometimes require assistance in making those decisions with their providers.

In addition to report cards on health plans, several groups have developed interactive tools to aid consumers in comparing one plan to another.

- *Health Pages* publishes a magazine and offers an online service for consumers. It provides information on specific health topics as well as community-specific comparative information on physicians, hospitals, allied health professionals and health plans. Through its work, *Health Pages* has assisted the employees of General Motors, McDonnell Douglas, Edison, US West, and Chevron. Its interactive Web site allows consumers to search for insurance plans, dentists, physicians, maternity services, and mammography clinics in their area, with comparative and provider-specific information (e.g., board certification, fees for selected procedures, and medical school attended for physicians; baseline HEDIS data and description of benefit packages for health plans) (Health Pages, 1998).

**DRAFT-PLEASE DO NOT CIRCULATE**

- American Express makes a videotape on health plan choice available to employees. In a mock focus group format, the videotape discusses issues that commonly arise in deciding among managed care options (Maxwell, et al., 1998).
- AHCPR has sponsored a variety of interactive tools for target populations ranging from low-literacy groups to families making decisions on care for the elderly. *Elder Care* is a project that assists families in deciding on the best living and care arrangement for elderly relatives. Through either a CD-ROM or its Web site, the program allows families to evaluate the ability of their elderly relatives to function in various settings from an independent living situation to the nursing home. In addition, the program assists the family in assessing their ability to provide care for an elderly relative.
- The Health Care Financing Administration recently debuted its Medicare Web site. The www.medicare.gov Web site is designed for Medicare beneficiaries and the people who help them make choices about their health care. It contains basic information about Medicare as well as the *Medicare Compare* database, which provides consumers with the ability to compare health plan benefit packages in their home area.

Of course, tools–particularly for assisting treatment decision making–also belong in doctors' offices. The work of health services researchers has now generated promising results. On the near horizon, these tools may complement the efforts of providers in better educating consumers about their health care decisions. They also have a role in disease as well as demand-side management, but importantly, they help make consumers co-producers of their care.

- The Shared Decision Making Program for benign prostate disease is an interactive, videodisc-based patient education program designed to allow patients to explore and make an informed choice about whether to undergo transurethral resection of the prostate or follow a program of "watchful waiting." In a pilot study, the results were promising (Wagner, et al., 1995), although a study with a larger sample is needed to gain a clearer picture of the impact of the program. Before viewing the videodisc, two thirds of the men favored an approach of watchful waiting. Afterwards, this percentage increased to 79%. Investigators found that 27% of the men who initially favored surgery changed their mind while only 1% of those initially inclined to wait opted for surgery.
- With AHCPR funding, CHESS (Comprehensive Health Enhancement Support System) offers on-line computer support for patients. This includes a computer-based module to help care-givers make critical decisions in caring for Alzheimer's disease patients. Patients suffering from AIDS, breast cancer, or depression also can tap into the CHESS database to find answers to personal questions. Additionally, they can use a hotline to speak anonymously with a physician or to obtain peer-level support from other patients. Early data show that AIDS patients who use CHESS are more efficient in their use of health resources. They actually have lower health care costs, fewer hospitalizations, and shorter hospital stays. HIV-infected persons who used CHESS reported fewer and shorter hospital stays (and a forty percent decrease in hospital costs) compared with

nonusers. By interacting with the home-based computer system, users monitored their health and spotted warning signs of serious illnesses so they could alert their doctors quickly. This tool will serve as an important resource for patients and their families as they will have easy access to information in their home and will have a greater ability to participate in critical decision making.

*Providing incentives to reward the practices of employees and providers.* Value-based purchasing is not only practiced at the firm level, but also encouraged at the employee level. Two approaches taken by employers and group purchasers are 1) setting the premium contribution to plans making a quality benchmark and 2) placing a portion of the premium at risk, contingent upon performance. Involvement in total quality management efforts, standard setting and quality benchmarking are part and parcel of incentive setting. Several firms have gained important experience in these approaches.

- Digital Equipment Corporation emphasizes value in its health care purchasing decisions. It defines value as the sum of quality of care and consumer satisfaction, divided by costs. Using information yielded from its performance reporting requirements, Digital identifies each region's best plan as the "benchmark" plan, and the company's contribution towards enrollee health care costs is based on the premium of this plan. This provides financial incentive to employees to purchase care from these health plans (Meyer, et al., 1997).
- The Pacific Business Group on Health requires HMOs to set aside 2 percent of the premium dollar and awards this amount only if the HMO attains the performance standards set in customer service, quality, data collection, and other areas (Bodenheimer, et al., 1998).
- The Gateway Purchasing Association provides financial incentives to health plans to implement a satisfaction survey, report quality indicators, and make a subset of those indicators available for an independent audit. This coalition of thirty-one St. Louis employers also put 4 percent of total premium dollars at risk depending on a health plan's willingness to comply with these reporting requirements.

*Improving the delivery of health care services.* Improving quality means improving the delivery of health care services. Some improvements result from the information that surfaces in plan-to-plan comparisons, which are shared widely. Others come from disease-specific initiatives led by group purchasers and employers in partnership with their health plans and providers.

- The Health Care Financing Administration, the Office of Personnel Management, and local business coalitions in seven communities will be working with FACCT over the next couple of years to look at treatment outcomes for specific diseases. Other large purchasers, such as GM, Ford, Chrysler, the State of Florida, the State of Wisconsin, the State of Iowa, and Washington State are also involved in this venture. The selected diseases include diabetes, asthma, breast cancer, and depression (AFL-CIO, 1997).

DRAFT–PLEASE DO NOT CIRCULATE

- The Dallas-Ft. Worth Business Coalition on Health has identified five services for measurement. In their pilot study, they sought to develop best practices for pregnancy and childbirth. These efforts included measuring quality across an entire episode of care, integrating data across inpatient and outpatient settings, and using this information as feedback to improve the quality of care. The Texas Medical Foundation took the lead to define appropriate clinical indicators while the Business Coalition planned the consumer satisfaction survey (Meyer, et al., 1997).
- With General Motors and Chrysler, the United Auto Workers (UAW) has created the Center for Community Health Care Initiatives. This center will identify "best practices" on both local and national levels, promote community-wide access to high quality care and improvement in health care delivery systems, develop prevention programs, and make advancements in data collection and information systems. Several communities involved in this project have already made progress. In Flint, Michigan, the initiative has developed "best practices" for both left heart catheterization and Cesarean sections. The initiative has also organized a free asthma clinic in Anderson, Indiana. General Motors and UAW also have collaborated on disease management programs for diabetes and cardiac care in Flint (AFL-CIO, 1997).
- Cleveland's Health Quality Choice has reduced mortality from pneumonia by 21% over a six month period at one area hospital following the implementation of a critical pathway (Health Network & Alliance Sourcebook, 1995).
- Firms like AT&T and First Chicago NBD have disease management programs in diabetes and asthma. AT&T uses organization benchmark data for these programs, and these measures allow the company to ask their health care vendors to target their efforts on specific parts of the country or to specific types of patients (The Business Roundtable, 1997). Others have focused their efforts on unnecessary hysterectomies, clinical depression, or mental health more broadly.

These sound interesting - can we elaborate

Some have gone further to influence the management of the health plans with which they contract. For example, Digital Equipment has applied the same principles of total quality management (TQM) that the firm uses in purchasing electronic components to the purchase and delivery of health care services for their employees (Maxwell, et al., 1998). To strike up long-term partnerships with their managed care plans, Digital worked with them to improve quality. By requiring managed care plans to set standards for their own suppliers, Digital implemented a TQM approach throughout the supply chain and anticipated lower costs over time.

Importantly, providers have tracked their own outcomes in order to improve the quality of care. Presented earlier, the Maine Medical Assessment Foundation's use of AUA prostate symptom scores and the American Academy of Ophthalmology's National Eyecare Outcomes Network are cases in point.

- Health Data Registry, Inc., provides another example. As a company that manages

clinical registries from hospitals and physicians, it has tracked data on cardiac surgery patients over several years and can flag performance levels that differ from other health care providers. Between 1992 and 1996, the program spotted an unexpected rise in the incidence of severe renal failure among these surgical patients. Further study attributed this complication to a "fast track" protocol, and subsequent work resulted in reducing this problem (Page and Washburn, 1997).

- Spurred by variation in mortality rates for CABG operations across five hospitals in northern New England, a group of clinicians, scientists and hospital administrators initiated the New England Cardiovascular Project in 1990. This program involved three phases: feedback of risk-adjusted outcome data to hospitals and surgeons; continuous quality improvement training for the providers; and site visits in which outside teams observed the CABG system in each hospital. The researchers collected data during the pre-intervention period and after the final report on the site visits. They found a 24% reduction in the mortality rate after the intervention. Four out of the five hospitals improved. The one hospital that did not improve had the lowest pre-intervention mortality rate. Both process and system changes in the individual hospitals accounted for the quality improvements (O'Connor, et al., 1996).

this sounds potentially good one

## Why Businesses Need to Care: Better Quality Can Cost Less

Members of the Business Roundtable (1997) have sized up health care quality and what it means to their business. Their words, as well as their actions, speak for them:

- "Quality health care is lower cost care." (Sears, Roebuck)
- "At some point, you can't squeeze anymore. We think that [health care] finance is going to be driven by taking poor quality out of the process. In the final analysis, that will be the value equation: doing it right the first time." (Allied Signal)
- "We're not just driven by philosophy, we're driven by economics. We think that improved quality inherently costs less. Improve the quality of health care and, in turn, improve the quality of life." (GTE Corporation)
- "Why do we care about improving health status [of employees] as a core strategy? There's a business case for it. By creating enthusiastic employees, we'll build better products and services and create enthusiastic customers, which in turn will result in enthusiastic stockholders." (General Motors)

lead this section w/ evidence & why this works rather than quotes

Though many of these efforts to improve health care quality are on the leading edge, the results indicate that quality health care not only can save lives, but can sometimes save costs as well. Apart from the savings that come from negotiated discounts, business coalitions and others have realized savings from improving care, avoiding unnecessary procedures, and bringing greater efficiency to health care delivery.

**DRAFT–PLEASE DO NOT CIRCULATE**

- Working with local hospitals, the Chicago Business Group on Health spurred the development of critical pathways for coronary artery bypass graft. This intervention significantly decreased the hospital length of stay for this procedure and removed delays that resulted from the poor coordination of hospital services (Meyer, et al., 1996)
- Across a range of health care services, the Business Health Care Alliance of Appleton, Wisconsin reported successes in increasing preventive screening, boosting immunization rates, decreasing asthma readmission rates, and dropping Cesarean sections from 21.3 to 13.7% in just two years (Meyer, et al., 1996).
- One Peer Review Organization found that an education program for providers and patients in five hospitals based on the AHCPR-sponsored guideline for the diagnosis and treatment of benign prostatic hyperplasia led to a 75% reduction in surgery and $1.3 million in cost savings for Medicare (AHCPR, 1995).

As the following examples suggest, the potential savings may be substantially greater (AHCPR, 1995).

- AHCPR-sponsored research suggests that providing anticoagulation therapy to prevent strokes among patients over 65 with atrial fibrillation could save $660 million per year. If this treatment were provided to only 20% of the eligible cases, $132 million in cost savings would result.
- Appropriate eye-screening for diabetics in government programs saves up to $247.9 million at a 60% screening rate.
- AHCPR research published in the *New England Journal of Medicine* reports that "ensuring optimal antibiotic treatment" could translate to savings of $113 million if applied to all surgical patients.
- If applied to only 20% of eligible patients, appropriate treatment of the opportunistic infection *Pneumocystis carinii* among AIDS patients could lead to $48.8 million in annual savings.

again pick one or two & spell out in more detail

This is not to say that all quality improvement efforts reap savings. However, some initiatives to improve health care quality can carry the promise of a return on investment. In July 1997, the Washington Business Group on Health established a Task Force on Health & Productivity Management to "identify and promote health care purchasing and human resource management practices that optimize workforce health and performance and demonstrate human capital investment value." What are the tools and measures that demonstrate the value of these health investments? That is one of the questions that the Washington Business Group on Health plans to begin to answer at a national conference in June of this year.

**<u>From Quality Measure to Quality Care</u>**

The many examples of public and private sector initiatives provide a snapshot of our nation's

efforts to improve quality. However, two examples–the story of beta-blockers for heart attack victims and the story of childhood immunizations–might offer a better picture of the potential of moving from quality measures to quality care.

*Beta-blockers to save heart attack patients*

Randomized clinical trials have provided definitive evidence that the use of beta-blocker therapy after a heart attack saves lives. Over the past two decades, these trials, including the β-Blocker Heart Attack Trial, have involved more than 35,000 heart attack survivors. As a result of this work, this treatment has become known as "one of the most scientifically substantiated, cost-effective preventive medical services" (Soumerai, et al., 1997). Organizations such as the American College of Cardiology and the American Hospital Association have integrated recommendations for the use of beta-blockers into their guidelines (Ryan, et al., 1996).

Despite the demonstrable clinical benefit, beta-blockers remain underused in clinical practice. In a study of Medicare beneficiaries in New Jersey, investigators found that only 21% of eligible patients received the therapy (Soumerai, et al., 1997). Patients were actually three times more likely to receive a calcium channel blocker, a medication of questionable efficacy for post-AMI patients. In this study, the mortality rate for patients using beta blockers was 43% less than those not using the medication. The use of such interventions could prevent an estimated 18,000 deaths each year (Chassin, 1997).

Based on the strength of this evidence, the National Committee for Quality Assurance also included a measure for "Beta Blocker Treatment After a Heart Attack" into HEDIS 3.0, and the Health Care Financing Administration (HCFA) will require health plans under Medicare to report on this measure in 1998. Once this practice became the focus of a quality measure, various approaches to improve the care of these patients ensued.

Under the Cooperative Cardiovascular Project, HCFA organized the development of quality indicators for the treatment of patients with a heart attack. Four Peer Review Organizations (PROs)–Alabama, Connecticut, Iowa, and Wisconsin–refined and used the indicators to monitor beta-blocker use after a heart attack in Medicare patients. The PROs provided this feedback to all practitioners in their states. The result was that beta blocker prescriptions climbed from 31.8% to 49.7% during the follow-up period. Another study used local medical opinion leaders to influence the prescription rates of beta blockers and aspirin (Soumerai, et al., 1998). When local medical opinion leaders supplemented educational outreach programs, the prescription rate for beta blockers increased 63%.

## Conclusion

Quality measures serve as an important driver for improving the quality of health care. They

offer information for marketplace purchasing, give feedback for improving practice, and change the way employers evaluate and provide health plan options to their employees. The leading edge work in the public and private sector reveals the potential to be gained by narrowing the gap between actual and best practices. The best practices of a few have the promise of becoming the benchmark for the many.

As examples of these leading edge efforts reveal, success demands the involvement of a broad range of stakeholders from employers and consumers to providers and health plans. Coordinated efforts in quality measurement and reporting can build upon and multiply the gains realized so far. Both the public and private sectors have important roles to play. Research to fill the gaps in measures, model value-based purchasing efforts, tools for continuous quality improvement–these steps will require stakeholders across the health care system to do their part. In recent months, employers and business groups have come together under the umbrella of the Employer Quality Partnership, and three health care quality oversight organizations–AMAP, JCAHO and NCQA–have announced their intentions to collaborate on performance measurement activities. Similarly, the President established the Quality Interagency Coordination Task Force to bring Federal agencies together. With this momentum in both public and private sectors, there can be no clearer signal that the time is right to seek greater system-wide coordination of quality measurement and reporting.

include why existing system is not enough.

## DRAFT-PLEASE DO NOT CIRCULATE

### References


AFL-CIO. *Union Guide to Quality Managed Care*, 1997.

Agency for Health Care Policy and Research. *Better Quality Can Cost Less: The Evolving Role of AHCPR: Interim Report to the National Advisory Council*, September 1995.

Agency for Health Care Policy and Research and Kaiser Family Foundation. *Americans as Health Care Consumers: The Role of Quality Information. A National Survey.* October 1996.

Agency for Health Care Policy and Research. http://www.ahcpr.gov.

American Medical Association, http://www.ama-assn.org/med-sci/amapsite/qa/qa.htm, 1998.

Bodenheimer T, Sullivan K. How large employers are shaping the health care marketplace? *New England Journal of Medicine* 1998; 338(14): 1003-1007.

Brink S, Shute N. "Are HMOs the right prescription?" *U.S. News and World Report*, October 13, 1997, pp. 60-78.

The Business Roundtable. *Quality Health Care is Good Business: A Survey of Health Care Quality Initiatives by Members of the Business Roundtable*, September 1997.

Centers for Disease Control. Mammography and clinical breast examinations for women aged 50 years and older-behavioral risk factor surveillance system, 1992. *Morbidity and Mortality Weekly Reports* 1993; 42: 737-741.

Chassin MR. Assessing strategies for quality improvement. *Health Affairs* 1997; 16(3): 151-161.

Foundation for Accountability (FACCT). http://www.facct.org.

Gonzales R, Steiner JF, Sande MA. Antibiotic prescribing for adults with colds, upper respiratory tract infections, and bronchitis by ambulatory care physicians. *JAMA* 1997; 278(11): 901-904.

Hannan EL, Kilburn H, Racz M, Shields E, Chassin MR. *JAMA* 1994; 271: 761-766.

*Health Network & Alliance Sourcebook.* Washington, DC: Faulkner and Gray's Healthcare Information Center, 1995.

**DRAFT-PLEASE DO NOT CIRCULATE**

Health Care Financing Administration. "Home Health Care: Improving Quality, Tightening Standards." HCFA Press Office Fact Sheet, August 8, 1997. http://www.hcfa.gov/facts/f970808.htm.

Health Pages. Web site – http://www.thehealthpages.com 1998

Joint Commission on Accreditation of Healthcare Organizations. http://www.jcaho.org.

Jordan HS, Straus JH, Bailit MH. Reporting and using health plan performance information in Massachusetts. *Joint Commission Journal on Quality Improvement* 1995; 21(4): 167-177.

Kleinman LC, Kosecoff J, Dubois RW, Brook RH. The medical appropriateness of tympanostomy tubes proposed for children younger than 16 years in the United States. *JAMA* 1994; 271: 1250-1255.

Krumholz H, Radford M, Ellerbeck E, et al. Aspirin in the treatment of acute myocardial infarction in elderly Medicare beneficiaries: patterns of use and outcomes. *Circulation* 1995; 92: 2841-2847.

Lesar TS, Briceland L, Stein DS. Factors related to errors in medication prescribing. *JAMA* 1997; 277: 312-317.

Longo DR, Garland L, Schramm W, Fraas J, Hoskins B, Howell V. Consumer reports in health care: do they make a difference in patient care? *JAMA* 1997; 278: 1579-1584.

Marciniak TA, Ellerbeck EF, Radford MJ, et al. Improving the quality of care for Medicare patients with acute myocardial infarction: Results from the Cooperative Cardiovascular Project. *JAMA* 1998; 279(17): 1351-1357.

Maryland Health Care Access & Cost Commission, http://www.hcacc.state.md.us/hmo/hmo.htm, 1998.

Maxwell J, Briscoe F, Davidson S, Eisen L, Robbins M, Temin P, Young C. Managed competition in practice: 'Value Purchasing' by fourteen employers. *Health Affairs* 1998; 17(3): 216-226.

Meyer J, Silow-Carroll S, Tillman IA, Rybowski LS. *Employer Coalition Initiatives in Health Care Purchasing*. Volumes 1 and 2. Washington, DC: Economic and Social Research Institute, 1996.

Meyer J, Rybowski L, Eichler R. *Theory and Reality of Value-based Purchasing: Lessons from*

**DRAFT–PLEASE DO NOT CIRCULATE**

*Pioneers*. AHCPR Publication No. 98-0004, November 1997.

Midwest Business Group on Health. *Public-Private Healthcare Purchasing Partnerships*, 1997.

National Committee for Quality Assurance. *The State of Managed Care Quality*. Washington, DC: NCQA, 1997.

National Committee for Quality Assurance. http://www.ncqa.org/hedis/nqip.htm, 1998.

New Jersey Department of Health and Senior Services. *New Jersey HMOs: Performance Report.* http://www.state.nj.us/health/hmo/report.htm, 1997.

New Jersey Department of Health and Senior Services. *Coronary Artery Bypass Graft Surgery in New Jersey 1994-1995*. http://www.state.nj.us/health/hcsa/cabgs.htm, 1998.

O'Connor G, Plume SK, Olmstead EM, et al. A regional intervention to improve the hospital mortality associated with coronary artery bypass graft surgery. *JAMA* 1996; 275(11): 841-846.

Page US, Washburn T. Using tracking data to find complications that physicians miss: the case of renal failure in cardiac surgery. *Journal of Quality Improvement* 1997; 23(10): 511-520.

Ryan, et al. Management of acute myocardial infarction. *Journal of the American College of Cardiology* 1996; 28(5): 1397-98.

Schulman K, Rubenstein LE, Seils D, Harris M, Hadley J, Escarce JJ. Quality Assessment in Contracting for Tertiary Care Services by HMOs: a case study of three markets. *Journal of Quality Improvement* 1997; 23(2): 117-127.

Soumerai SB, McLaughlin TJ, Spiegelman D, et al. Adverse Outcomes of Underuse of β-Blockers in Elderly Survivors of Acute Myocardial Infarction. *JAMA* 1997; 277(2): 115-121.

Soumerai SB, McLaughlin TJ, Gurwitz JH, et al. Effect of local medical opinion leaders on quality of care for acute myocardial infarction: a randomized controlled trial. *JAMA* 1998; 279(17): 1358-1363.

Spragins E. "How to Choose an HMO." *Newsweek*, December 15, 1997, pp. 72-81.

Wagner EH, Barrett P, Barry MJ, Barlow W, Fowler FJ. The effect of a shared decision making program on rates of surgery for benign prostatic hyperplasia: pilot results. *Medical Care* 1995; 33(8): 765-770.

**DRAFT–PLEASE DO NOT CIRCULATE**

Ware J. "The SF-36 Survey." http://www.sf-36.com/general/sf36.html.

Wilbur DC. False negatives in focused rescreening of Papanicolaou smears: how frequently are 'abnormal' cells detected in retrospective review of smears preceding cancer or high-grade intraepithelial neoplasia? *Arch Path and Lab Med* 1997; 121: 273-276.

File: Forum NHLL

**United**
**Hospital Fund**

Empire State Building
350 Fifth Avenue, 23rd Floor
New York, NY 10018

# FAX COVER PAGE

| To: Sarah Bianchi 202 456-5585 | | From: Tracy Miller 212 494-0767 |
|---|---|---|
| Fax Number: 202 456-5557 | | Company: UNITED HOSPITAL FUND |
| Date: 6/8/98 | Total Pages: 2 | For Information Call: (212) 494-0722 |
| Subject: Addresses | | Fax Number: (212) 494-0830 |

**Notes:**

**Attached is a list of names, addresses, telephone and fax numbers for the foundation heads of the foundations that will be funding the planning process. With the exception of Jim Knickman, a Vice President at the Robert Wood Johnson Foundation, these names may already be on the invitation list because I passed them on to Nancy Foster. (Please note an area code change for Drew Altman. The new area code is 650.)**

**We would appreciate your sending the three foundation presidents a letter of invitation to the June 17 event, indicating they are welcome to bring key staff members to the event. It would also be helpful if Jim Knickman received a fax of the letter sent to Steven Schroeder.**

**As I mentioned over the telephone, Commonwealth (but not Kaiser or RWJ) has confirmed the funding commitment. Jim Tallon will follow up with Steve Schroeder and Drew Altman, seeking resolution of their commitment before the 17th so that the foundation support can be announced.**

**As I mentioned in my phone message, Jim Tallon would like confirmation that Chris has no problem with Jim's redrafting of the third paragraph of the letter that will be sent from the Vice President. I will be leaving the office at 2:30 pm and would appreciate your calling David Gould (212 494-0740), Senior Vice President for Program at United Hospital Fund, to confirm the changes - if you do not have a chance to call me before I leave.**

**I look forward to working with you on the planning committee process.**

Karen Davis, Ph.D.
President
The Commonwealth Fund
Harkness House
One East 75th Street
New York, New York 10021 Tel: 212 606-3825
Fax: 212 606-3876

Drew Altman, Ph.D.
President
The Henry J. Kaiser Family Foundation
Quadrus
2400 Sand Hill Road
Menlo Park, California 94025 Tel: 650 854-9400
Fax: 650 854-4800

Steven A. Schroeder, MD
President
The Robert Wood Johnson Foundation
PO Box 2316
Princeton, New Jersey 08540 Tel: 609 452-8701
Fax: 609 243-5894

James R. Knickman, Ph.D.
Vice President for Research and Evaluation
The Robert Wood Johnson Foundation
PO Box 2316
Princeton, New Jersey 08540 Tel: 609 452-8701 Fax: 609 987-8746