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**Health Journalism 2008 - Day 2
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KARL STARK: My name is Karl Stark. I'm from the Inquirer and one of the things I like to do at the Association meetings is really to have actual news take place. And to have a story that people can actually write. And today we have a really good example of that.

We're going to hear from HHS Secretary Mike Leavitt. Certainly, I'm sure he's no secret to you all. He's a three term governor from Utah. He ran the EPA and he now runs—since 2005 has run HHS.

One out of every four federal dollars actually goes through his agency which I'm sure must keep him awake at night. It certainly would me. He's also very intensely focused on quality and price. And that's really the focus of today's press conference.

He's going to be unveiling a new Web site and it's going to be—folks are going to be downstairs where the food is to actually demonstrate this Web site afterwards if you want to take a drive through it.

And there is also going to be a question and answer session after his remarks, so, without further ado Secretary Leavitt.

[Applause]

MIKE LEAVITT: Thank you, Karl, and thank you for inviting me. I think many of us have had a chance to encounter

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one another over the course of the last few years and I always enjoy the interaction or almost always.

[Laughter]

And I know I will today. As was pointed out I'm actually here to make an announcement that I think has been discussed with you earlier and that is our new hospital compare Web site. I'd like to reserve that toward the end of my formal remarks because I'd like to give some context to why this is such an important step forward.

And then I'd like to—at the end we'll have, I think, quite a bit of time that we can interact in terms of your questions.

I'd like to start today just to, I think, give this context with why it's important. And I'd like to reference a story that I think many of you will have worked on in the last few days and it's the Medicare Trust Fund.

Each year the trustees of the Social Security Trust Fund meet. That includes the Medicare Trust Fund. And we receive a report from actuaries on what the status of the fund is and our role as trustees is to communicate with the public as to the actual status of the trust fund and what people can count on.

In the Trust Fund report, I think, it could best be considered a kind of stark warning that was issued. Now, I made the comment at the press gathering that I noted that day

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the cherry blossoms had bloomed in Washington. It happens about the same time every year. And one of the worries I have is that Medicare warnings have become so routine that they're almost part of the flow of nature now.

And that we have become numb to their severity and their importance. This is a very serious problem. The trustees pointed out that we will essentially run out of money in 2019. And while that's a few years away this is such a big ship that changing it takes time. And the sooner we deal with this problem the more opportunity we have to make a transition that is less hurtful and painful.

But it's a very serious problem and I want to just highlight it because I think it's understandable to me though disappointing that we haven't seen it emerge as a Presidential campaign issue. And I understand why it's difficult for political figures to talk about.

I don't understand why the media is not talking about it more. It's a very serious matter that needs to be reported on and talked about. So, if you will excuse that bit of coaxing I will appreciate it.

I'd like to shift then from Medicare to the larger healthcare sector. I believe, however, that Medicare and the larger healthcare issue or the cost of healthcare is symbiotic. They are essentially one and the same.

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Medicare is the largest payer. It is also the force in the marketplace that nearly all large insurers follow. It is clearly the most influential and absolutely has to be dealt with if the larger system is going to be in fact impacted.

If Medicare were a patient I would suggest that it is a patient with multiple chronic conditions. Though I am not a doctor let me suggest what I think they are.

The first one I would call silo syndrome. That is to say everything is paid separately. There is no one there to align the expenditures or the treatment. I've tried to imagine building a house or building a car this way.

If you were building a home you would essentially call a group of contractors and say we want to build a house and please come. And I know you do bathrooms and you are into landscaping. Just send us the bills at the end. It would be a process that would have a predictable result.

And it's essentially the result that happens in our current system of billing with Medicare. It's silo syndrome. Everyone pays separately. There is very little coordination.

The second would what I would refer to as chronic "more" disorder. Everything is based on volume. There are no incentives in Medicare or for that matter the larger healthcare system for anything but more. Volume is kind in Medicare.

Many of you have probably heard the story before but I walked into a hospital just after I became Secretary and a

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hospital administrator said to me, "Do you know what the most expensive device is in our hospital or in any hospital?" And I was thinking of some high resolution scanner. And he said, "No, it's a ballpoint pen in the hand of a physician."

And when you look at the differences in practice patterns and how they—and this whole idea of chronic more everyone is incentivized for more. Someone pointed out to me that we have created a system that perfectly produces the result it was designed for. It's the way the system was designed.

Now, the third thing I'd like to point as a chronic condition of Medicare is what I'll refer to as quality indifference disease. The problem is straightforward. We pay the same whether the care is good or whether it is not good. In fact, you can make a case that there are times when we pay more for bad care.

If a person goes into a hospital and in many cases receives—gets a hospital borne disease or has some kind of mistake until recently we paid for all of those. And we still pay for too many. But we rewarded bad quality.

If a hospital or doctor is prepared to work with diabetes patients and monitor them very carefully and make certain their hemoglobin A1C is tested on a regular basis. And sets up a tracking system we pay them the same as a physician who does none of that.

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So, not only are we indifferent to quality sometimes we even reward bad quality. So, I would put those into the context of not just Medicare but they're also the entire healthcare system. We're siloed, we pay chronically more, and we are indifferent to quality.

And those are the three things that I believe need to change. Now we often refer to needing to see the healthcare system improve. Just to be provocative today I'd like to challenge that fact that we even have a healthcare system. I believe what we have is a large, rapidly growing, robust healthcare sector.

But there is very little that would qualify healthcare to be an economic sector or system, rather. Let's just think about some of the systems that we depend on in our lives.

I'm guessing that almost all of you in your wallet or purse have a bank card. Mine is blue, yours may be red or yellow. The banks competed for your wallet space on the basis of how their location, their cost, their interest rates, and their convenience to you. But they all used exactly the same system to optimize the value that I get as a blue card holder. Or you get as a red card holder.

I fly on airlines a great deal as do some of you. Airlines compete on the basis of our quality, their quality, their service, their cost. But they all use the same system to optimize the value that they provide.

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Another good example would be the Internet or for that matter your cell phone. I mean we are surrounded now by—in a connected world with economic systems that, in fact, all use allow different competitors to vie for our services.

That is not true in healthcare. Now, I'd like to spend just a minute and talk about what I believe the healthcare system of the future looks like. And I'd like to define that really as what I believe are challenges. It's to take the sector we have and organize it into a system.

And if you don't mind, if you've got a piece of paper as I see many of you do, just turn it over and I want you to draw a picture with me of what this system will look like. And let's organize our picture by giving it a title first. And let's call in Sector Two System because that is, in fact, our goal.

And then underneath that, if you wouldn't mind, why don't you draw a square that's about two inches on each side. And I'd like for you to put four circles on each corner or just one on each corner for a total of four. Just bear with me and I'll pull this together for you.

[Laughter]

Now, right in the middle of that square I'd like you to write the word volume. And then I'd like you to cross it out quickly and right underneath it value. Because I think that's

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an important statement of philosophy. The current sector is all about volume. The future is about value.

Now there are four cornerstones that I believe will go into the system of the future. Label them if you'd like. The first one is electronic medical records, the capacity to mobilize medical data in a way that we can use it for many different purposes.

The second cornerstone would be quality measures. The ability to know exactly or as well as possible what quality is and how to measure it on a standard basis that the healthcare sector of the healthcare providers have agreed with and are comfortable in measuring.

The third would be price groupings, the ability to know how much you pay. Now may I just say editorially here that anyone who's been in the hospital knows this problem. It's impossible to know what you pay in our healthcare sector in most cases.

If you've been to the hospital or a loved one has you just started getting this barrage of paper. It will say this is not a bill or don't pay this. And you will have been to the hospital and then suddenly you start getting things from the anesthesiologist. And then you get something from the lab. And then you get something from the surgeon. And it's just impossible to know what you are paying.

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So, part of the system that is not just oriented to value and the reason that or to volume and the reason all those folks are sending you bills is because it's siloed. They've got silo syndrome and everybody is sending you bills and there is no one there to coordinate it.

And, as well, there are no understandable price groupings. And so the third cornerstone is developing price groupings so that ordinary people can understand what has gone into their healthcare.

Now, the fourth cornerstone I'm just going to ask you to mark as incentives. And essentially what I'm asking there is that we recognize—that's everyone ought to have a motivation to get better quality and lower cost.

And I'm talking about the consumer. I'm talking about the doctor, the hospital, the insurance company. We ought to align the incentives. And right now very few of them are because the whole system has a philosophy of volume.

Now, I'd like to show you if someone is going to run my Power Point who is? Very good, no that's not the one I want. No, that's not it either. I don't think you have the one I want, there, no that's not it. Yes, that's close enough. That's close enough.

I just wanted to show you what I think the picture of the future looks like. This is very simple and it's obviously hypothetical. And it shows a heart attack and it begins to

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show the kinds of information that a consumer would need to have if in fact they were going to have value or quality be their—the philosophy of this system.

It includes how many cases of a certain type did a physician or a hospital deal with. What were the outcomes according to some standards that we've all agreed upon? How much did it cost? Now, this would transform the experience of being a consumer. It would transform the ability, the nature of healthcare because we would all now be driving toward value or that is to say quality and price instead of just volume.

Now, having run you through all of my slides already I'd like to give you just a little report on how we're doing in actually constructing this new paradigm of a system. Let's take your first little quarter up there in whatever corner you chose and talk about electronic medical records.

Now why is this important? Well, if we're going to gather information—if consumers are going to have information it needs to be mobilized and it has to be digital and electronic and very little of it is today.

Now most of you know that more than 85 percent of all medical records are paper. Well, that—none of us would deal with a bank, none of us would deal with an airline, none of us would deal—we couldn't because they wouldn't be competitive. But healthcare is still working towards digitization.

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And so we—three years ago we had 200 vendors who were producing electronic medical record systems. The problem was none of them were the same or had no common standards. And, therefore, they didn't have the capacity to interconnect to create a system.

Over the last three years we have developed a means of being able to create standards. And we have formed what we call the CCHIT which is a Certification Commission on Health Information Technology, CCHIT.

When a doctor or a hospital is going to buy a system they can now look for that stamp of approval. And if it is CCHIT approved or certified then they know they're on a pathway to interoperability.

It's a very important development. Now, I want to admit to you that interoperability if it's this big we're still only about here, but next year we'll be here and the next year we'll be here. We are moving towards satisfying the needs of that first cornerstone. And we have a process in place.

The second cornerstone quality measures there have developed a quite robust but still rather clunky process to develop quality measures. It isn't fast enough. We're not exacting at enough yet. But we're making progress and you'll see some of that in just a moment where we've been able to develop and gain agreement within the medical community on a

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series of ways to measure quality in high frequency and common procedures that didn't exist three years ago.

The third cornerstone is price groupings. The same thing is true as I just said on quality measures. We're having the insurance companies, the doctors, the hospitals, the federal agencies, and others who have and large employer groups work to develop these price groupings so that we'll all know what we're paying for in the future.

So there is significant progress that's being made on this point. Now, I'd like to ask the question, I'd like to move to the question of, "Well, if we're going to have this system and who is going to do the measuring then where we can have information like this?"

It won't surprise you to find out that we were—we found over 100 different communities where there were doctors working with hospitals or in small groups or insurance companies working with large employers or all of them working together to try to crack the code on quality. The problem was almost all 100 of them in varying degrees were measuring it differently.

So, our effort has been to find ways to begin to harmonize, if you will, the way different communities have begun to measure quality. Now you might ask, "Well why don't we just have the federal government decide that unilaterally? And let everyone match that standard."

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Well, I had a very interesting conversation one day with an OB/GYN in Indianapolis and he said, "I am part of one of these 100 groups you've talked about. And so imagine how surprised I was when an insurance company rated my quality as being one star out of five a 20 percent doctor on the subject of testing my patients for HIV." He said, "I knew it was wrong because I am a sole practitioner and we don't give them a choice."

He said, "I've checked my system. We've done everyone. I wanted to see if I was losing money and not billing it." And he said, "We were billing them so why did I get rated that way?" Well, it turns out that the people doing the rating were using a different kind of code than those—that he was. And consequently he was—they were talking by each other.

His point to me was this if you're going to rate me and put information so that people can judge the value of my care you better get it right. And I learned from him that trust is a very important part of this between the providers, doctors and hospitals and those doing the measuring.

So, what we've concluded is that this local effort to identify and measure quality is very important. And our motto essentially needs to be "Using national standards but neighborhood solutions." In other words, we've begun to use the same standards nationally and I don't think we've got the slides here so I'm not going to talk about it.

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But we've begun to use a brand known as Chartered Value Exchange. I want you to write that down and think about it for a minute because we have taken the top 100 of these or the more than 100 that we have found and we identified the 14 most mature.

And we have begun to give them—we've given them this Chartered Value Exchange brand which essentially means that in the future we're going to begin to give them a lot of data from Medicare and other things and we're going to develop a network where the local communities measuring value will, in fact, be nurtured.

Now, I just want to acknowledge one thing to you today we're not very good at this. [Laughter] But we're making a lot of progress. I was explaining to my son the reason for these slides about the first video game that I ever looked at. Do any of you remember Pong? Can you find that one up there? Yeah, alright.

It was a blank screen essentially with a bead of light that would pop back and forth and it was terrific technology at the time. [Laughter]

I spent a lot of quarters at a pizza place in my hometown where we played this. But it was very rudimentary. The next generation was do you remember Pac Man and Donkey Kong? Well, we added a little technology. We got a little

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more sophisticated. There as music and some strategy. And it was the new technology.

Things continued to improve we're now for Christmas some of my family members got a Wii that you can--this is a Tiger Woods golf game. You not only play it on screen but you do it with your hand and it senses your movement. There are-- they say clever things at the right time.

There is interaction between the players. Things change when the wind blows. Not only that you can play somebody in Japan. There is a lot of connectivity to it now.

I just want to acknowledge that we are just leaving the Pong era-- [Laughter] --when it comes to measuring quality. But it is a fundamental if we are to change from a sector to a system. If we're going to begin to orient the philosophy of that system to value and not to volume--to value not volume, I mean I think you begin to get the picture.

Now, with that context I'd like to turn now to the major point of our discussion today. And that's the hospital compare Web site that many of you will have had the chance to see earlier today.

This is a joint effort between many of the various operating divisions of HHS but primarily driven by CMS. It includes information on some 2,700 hospitals around the country that are participating. And we expect more in the future.

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We're going to be adding information about what Medicare pays in the near future. Now many of you had a chance to see that and rather than for me to try to describe it, Herb, I am going to put you on the spot and I am going to ask your mouse driver to go to the, I think we're hooked up there aren't we? OK, would you mind just--?

Alright well this is a little impromptu but as I stand here I just feel better about this.

[Laughter]

I'd like you to just navigate through the site and I, yes, you want to come up and talk about this Herb?

HERB: What we have beginning in 2005 was the launch of the hospital compare Web site. It started as a pretty rudimentary site as the Secretary was talking about it where we had just basically ten quality measures.

But since that time it has really advanced now to the point where we have 26 quality measures, 24 which are process measures dealing with things like pneumonia, heart failure, heart attack, and surgical infection and then two additional measures which are outcome measures that look out heart attack and heart failure.

And this information has been part of our Web site for now for three years. It's continued to grow. And this year it's going to get more robust as we're going to begin to add information in terms of pneumonia outcome.

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What's new this year is that we're beginning to put up patient satisfaction information. We have what we call the H-CAPS or the CAPS survey. It's a patient satisfaction measure survey a standardized survey that's been through a process to make a determination that it is a standard survey of 27 questions.

Those 27 questions now have been rolled up into ten quality measures that look at things in terms of the communication between the nurse and the physician. Whether the quietness, the cleanliness of the hospital, would you recommend this hospital to someone else?

Basic information that people have been looking for for a long time, what your neighbor basically thinks about the institution, good information that's out there.

And then for the last couple of years elsewhere on our Web site we've had information in terms of price and volume that's been out there. So, for the first time we're able to bring all this together so people can access it, they can learn about it, they can use it and then use it to help them make important decisions.

What you see here is just one sample and the Web site is a beautiful Web site that really walks you through a variety of different areas that you can look at not only individual hospitals, groups of hospitals in your community or a large

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geographic area. Or you can look at specific diseases and get some information on them.

But one of the new features of what you're going to begin to see is in the patient satisfaction area. And this slide gives you a sense of that. It talks about how well did nurses communicate with their patients. And what you'll be able to see here is what the national reporting nature was, where you see there at the top of 73 percent.

What was going on in that individual's state and in the various hospitals in that area, how they compare to both the state average and ultimately the national average. It's good, it's powerful information.

And just to take this one for an example. As Dr. Caroline Clancy is here from the Agency for Healthcare Research and Quality will share with you is that the readmission rate for hospitals in this country is about 15 percent within two weeks for people who really did not get good discharge or good communication from their nurse or their physician when they left the hospital.

Absolutely one of the key drivers for quality healthcare in this country is good communication. Perhaps all of you have experienced at one time or another the fact that you needed to stay or a friend or someone else with a loved one or a friend in the hospital 24 hours a day, not only to watch the kind of care they were getting. But to take copious notes

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over the fact the instructions that they were getting from the physician or the nurse that was there.

Communication is key. But what you're going to see in terms of these ten majors that we have is loaded with this kind of information to help drive quality. So, that will be an enormous enhancement and value to this Web site.

Mary Andes [misspelled?] can we go to the next one? This gives you a sense then a little bit of what also will be available on the Web site. Again it's been elsewhere but again it's all brought together is the other dimension that we're putting out there is basically what Medicare pays for given services.

In this case we have hip and knee or replacements DRG544 that's how Medicare pays in these DRG's or these payment cells. But it begins to give you a sense in terms of what Medicare pays.

It will tell you the range of payment across the country in this area. And also it will begin to tell you the range of payment in the individual state that's out there.

So, the three kinds of critical areas that people have always talked about is what they need to really begin to assess and evaluate, quality information, patient satisfaction information, and price and volume information for the first time are really brought together.

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This is a big change and I think it will be an impactful change as they go forward. So, Mr. Secretary I'll turn it back to you.

MICHAEL LEAVITT: Thank you. So, let's just go back to our little model of a system. You can see that once we have information that is mobilized and we can begin to digitally bring it together we can create powerful information.

But in order to do that we have to have the second cornerstone which is quality measurements so that we have the ability to compare and create value measurement.

And lastly you need to know what you're paying because it is the combination of quality and cost information that allows one to choose value. Just like we choose value in our banks and our cell phones and airlines or anything else we buy.

So, summary we go from a sector to a system, four cornerstones, records, electronically generated quality measures and the ability to know what you're paying and the ability to then construct the entire system where it is driven by value, not volume.

Now, with that could we open it up and just have an interaction. You just seem very anxious. Go ahead.

MALE SPEAKER 1: Well, I'm curious to know whether the patient satisfaction how it correlates with the price and the outcomes? Are the people who giving the high marks giving high marks that correlate with the quality of the outcomes?

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Or maybe is the number three guy on this getting high patient satisfaction because the nurses talk to them more but they're being treated more poorly?

MICHAEL LEAVITT: I think you will see a correlation but it will be better drawn by you to sit down and navigate on this site you can pull up any three hospitals you want and compare them. I did it instantly in my hometown because I knew the hospitals and I knew the management.

And I was quite interested. And I think you will be too. I hope all of you will take a look at the hospitals in your hometown and ask the question what are they doing in my town to begin to measure quality and enhance this capacity?

GARY SCHWEITZER: Thank you for joining us Mr. Secretary. I am Gary Schweitzer with the University of Minnesota School of Journalism. And I am married to a nurse and she knows that I am here. [Laughter]

So, she's trusting. And with the example that you gave about how well did nurses communicate. I'm wondering right now and I understand we're just leaving the Pong era but can you crosscheck that with other seems to be vital data such as what were the nurse staffing ratios that might explain why he or she didn't communicate that well on a given day?

MICHAEL LEAVITT: That is a great enhancement as we get closer to Pac Man. That's the kind of thing once data has begun to mobilize that we can enhance and create more. Now,

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one of the other—there are several weaknesses that become evident in this. It is Pong like.

But one of the—you've pointed out one of them. Another is that we only—this is, by the way, I needed to tell you all patients 18 or over not just Medicare patients. But it still is not as robust and experienced as we need it to be.

For example, it will be a lot better when we can start to add patient data rather than just claims data. And that will take some sophistication. Do you want to follow up or?

GARY SCHWEITZER: Well, yes, if you could because you know this better than we do. So, I just identified one playing off an example that you showed. Can you show us one other leaving the Pong era example of where the cross checking of data doesn't exist so that we can kind of keep tabs on the progress that we hope you'll be making with this?

MICHAEL LEAVITT: Well, one of the things that I personally aspire to see is a better, you'll see certain places where we have taken certain quality measures and we have identified the top 50 hospitals and the bottom 50 hospitals.

And most of the rest are in the middle. Now, that's a clear symptom of Pong era. We need to have bigger sample sizes. And we need to have more confidence and we need to build enough trust within the medical family that they understand what this is doing.

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And that we're working collaboratively with them. That's a very good example. I don't—I aspire to see the day when it will not just be Medicare data but we'll begin to see all data from insurers that are private and publically funded insurers.

It will then begin to have a more robust feel to it and it will have larger sample sizes and it will have cohorts that are and new things we can measure with it.

Now we also—let's acknowledge the fact that this is what's happening in hospitals. Much of what happens doesn't occur in a hospital. We still have gaps in information coming from clinicians outside hospitals.

And particularly small and medium sized physicians. That's what it will take to get us through each subsequent step. But we're on a clear pattern to begin focusing on value.

TODD ZWILICKER: Hi, Mr. Secretary. I'm Todd Zwilicker [misspelled?] with Web MD and others. Do the clinical outcomes you have MI and heart disease, was that mentioned? The ones you have—the clinical outcomes?

MICHAEL LEAVITT: Yes, those are the two that we have.

TODD ZWILICKER: Are they compared hospitals individual performances with the state and national averages?

MICHAEL LEAVITT: They are.

TODD ZWILICKER: Have are they compared in the same way—

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MICHAEL LEAVITT: Local, state, and national.

TODD ZWILICKER: In the same way for consumer, they are yes in the same way for consumer?

MICHAEL LEAVITT: They are and that's—I'm getting nods from the front row so I know that's true.

TODD ZWILICKER: Why only two actual areas of outcomes at this stage? I know you're adding—

MICHAEL LEAVITT: Because we're still learning. We're still—this is a first iteration. We'll get better. It will be more robust and we'll have more. But this is a process of learning.

TODD ZWILICKER: To what extent has—I realize they're cooperating with you and cooperating well but to what extent has hospital and or physician resistance slowed the progress towards more clinical outcomes data being included in something like this, mortality data?

MICHAEL LEAVITT: Well let me again talk about the tensions that are here and they are real and understandable. I have two conversations on a regular basis and I will symbolize them by first starting with the OB I told you about who said to me, if you're going to measure me that's good but you better be right before you make that information public, because it would be a disservice to me and to my patient if you're wrong.

So, I'd like you to have it near perfect before people see it. On the other hand you have the large payers

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represented by a CFO I will tell you about who said to me, my CEO's hair is on fire.

And he tells me if we don't get some progress on this issue that our comparative advantage as a company is being undermined and we could literally be driven out of business by the cost of healthcare to our employees.

He wants progress. He doesn't care if it's perfect. He just wants some measures and metrics and value. So, there is this tension between the MD's and the MBA's and that tension is a very powerful but valuable thing. On one hand the doctors hold the—they hold us all accountable to get this right. And the MBA's recognize there is an urgency here.

So, is there resistance? There is an understandable caution. But we have an imperative. We have to accomplish this because literally it—healthcare is beginning to undermine the competitive—the capacity of our country to be competitive.

TODD ZWILICKER: Very quickly, are there other clinical outcomes that you feel you could have but for the resistance that you just described?

MICHAEL LEAVITT: This is not all about resistance. It's about having data that we feel confident with and having enough of it and experience in dealing with it.

Now, you will see this instrument continually improve. You are seeing Pong and it's important to recognize that we will get to the other stages as rapidly as possible.

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CARLA JOHNSON: Hi, I'm Carla Johnson from the Associated Press. How many patients don't have a choice where they go to the hospital because they live in a rural area or because their insurer doesn't cover all the hospitals in town?

MICHAEL LEAVITT: At the root of your question I think is this this is not about eliminating anyone. It is about improving everyone. And if a patient lives in an area where they don't have a robust choice it has been our observation that every healthcare provider wants to provide high quality.

Doctors don't go to work with the idea that I'm going to be mediocre. They're there to heal. But many of them do not know about how their practice pattern compares with others in that area or another.

And we have discovered, observed I should say wherever in healthcare there is robust information about quality and cost the cost goes down and the quality goes up. We've seen that in our nursing home compare information.

The minute a provider sees that they are at lower quality than the marketplace requires they improve. Why, because the market will begin to discriminate against them in a forceful and powerful way if they don't.

So, even if you're living in an area where there isn't a lot of competition this is very useful to the providers of healthcare who want to know how their practice compares. In most cases those 100 communities I talked about where people

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are trying to crack the code on this, started by doctors just wanting to know how to do it better.

DIANA MASON: Diana Mason, American Journal of Nursing and WBIA radio. Secretary Leavitt, I appreciate the efforts that you are making to have responsible public reporting and hope to see these expanded.

Yesterday some of us made a field trip. We were right down the hall from your office. We saw the HHS Emergency Response Command Center that was quite impressive.

We then went to one of the poorest wards in Washington, D.C. and saw the family health and child birth center where Ruth Lubic a certified nurse mid-wife and Linda Randolph have worked to produce this wonderful family health birthing center that has better outcomes than the Washington, D.C. mean and the national mean.

They have lowered infant mortality rates. They have saved the system \$1.5 million last year. And they're cost for running the center were a little bit over a million. Ruth Lubic at the age of 81 had to go out to raise \$500,000 to support this center because she only gets paid 53 percent of the Medicaid rate.

What are your plans for extending this to Medicaid and comparing hospital based care with community based care?

MICHAEL LEAVITT: My aspiration would be for this to permeate the entire healthcare system. And to see

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reimbursements at least in part be focused on value not simply volume.

You have given a wonderful example of a setting where quality was delivered but the brand was compensated somewhere else. If you look around healthcare you'll begin to realize that people make their decisions currently on the basis of the brand of an institution, their billboard and their TV ads and their sort of reputation.

One of the things that's become evident without a measurement of quality what is the surrogate for quality? It is cost. In many places people assume that if it's more expensive it's better. That isn't the case. In fact, there are many examples now of studies demonstrating that high cost and high volume does not necessarily mean high quality.

When you go through this though it's limited and you'll see its limits when you—but it becomes glaring that there are some in many cases big brands that may not have better quality and they have substantially higher price.

Now what will that do in the marketplace? We hope it will have the impact of driving quality up and cost down.

DIANA MASON: And so will you be doing this with Medicaid?

MICHAEL LEAVITT: The fourth cornerstone is incentives. And the answer is we think that states as our partners in

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Medicaid very clearly need to begin looking for ways to compensate value.

We're looking to learn how to do this more rapidly in Medicare. And we need to do it in Medicaid. And we hope that it will, in fact, begin to permeate the entire system.

KARL STARK: We want to try to reach everyone's questions so if you could [inaudible] and one follow up question.

ANNE: Hi, I'm Anne. I work for a newspaper in Allentown, Pennsylvania. Our state and New York have sort of been at the fore front of collecting data and disseminating to the public on cost and quality. I wondered how much you're learning from Pennsylvania, number one.

I understand Medicare also has a paper performance model. I'm wondering what you've learned from that along these lines? And where is your data coming from on satisfaction? Because all of our local hospitals collect and I'm—I don't know.

MICHEAL LEAVITT: Let me answer that one first then go back to the first part of your first question. With respect to where are we getting the data, it's coming from patient surveys that have been conducted under a series of guidelines that Medicare has developed.

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In many cases they have used contractors to do it. We have established a process that gives us confidence that the data has integrity.

Now, with respect to your first question I'd like to reference back to what I began telling about the 100 communities that we know of an effort to crack the code on quality. We identified as I indicated some 14 of the most mature. We have designated them as Chartered Value Exchanges.

If you begin to look at those collaborations you will see that they were in the cities you talked about. I was in Philadelphia last week to give a designation and in Pittsburg. That's because there is a lot of work happening in Pennsylvania in the reporting of various hospital results.

And they are—we are learning from them and very soon, I hope, we'll be able to take what they've learned and begin to populate this kind of information. If you had a map of where all 14 of them are you would see that they are in places like California, Wisconsin, Minnesota, Indianapolis, Utah, let's see, Washington, Phoenix, Massachusetts, I was there yesterday.

There are centers of excellence that have begun to develop. Now, again our effort is to have each of them begin to learn from one another. And then harmonize. If you look at the Web sites of these 14 different places you will see that they all have web products. They're different than this.

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But one thing we now know is that they're beginning to measure the same things because of these standards. I believe at some point we'll begin to see the graphic interface and the display of that data begin to be more common.

That gets into the Pac Man period. But it will happen naturally as we get better at this.

STEVEN LANGHALL: Yes, Steven Langhall with Congress. I just wanted to get your take on concerns that some hospitals have. And Medicare advocates that if indeed this data on customer satisfaction eventually is used let's say for reimbursement rates that that might not be the best way to go because customer satisfaction can be subjective.

It may not be related necessarily to health outcomes or to cost factors and so forth. I wanted to get your response to that kind of concern.

MICHAEL LEAVITT: Let me clarify that I do not see anyone basing their compensation or reimbursement rates based on patient satisfaction. What I think you will see is an effort to begin to take other quality measures that would, for example, did a provider test the hemoglobin A1C on diabetics?

Those are measureable outcomes that we know when practiced will produce a better outcome. Those are the kinds of areas where we will begin to reward quality. Our purpose is to in the long term is to reward quality and to pay providers,

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doctors and hospitals, at least in some part on the basis of their capacity to provide quality.

Now let me just your question was short and my answer isn't but let me just make one other point. One of the things we are working hard to accomplish is to have small and medium sized physicians adopt electronic medical records.

One of the challenges is that they don't see the reason that they ought to invest \$40,000 per physician in a system when it's the insurer or the consumer that gets the benefit. So, we're looking for ways to change the macroeconomics where everyone shares in that value.

We have a Medicare demonstration that will take place in 12 different communities across the country. In the past, I might add, we would have gone to 12 communities and asked them to participate.

In this case we're going to 35 or 40 communities and asking them to develop a community plan to become a demo site, and if they become one we'll provide additional payment to 100 of their small practice practices the first year if they report on electronic medical records, the second year if they report quality measures, the third, fourth, and fifth year if they can demonstrate the performed quality outcomes using the quality measures as reported by an electronic medical record.

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So, you begin to see the four cornerstones come into play and how we're beginning to work to figure out how we can make everyone share in the value.

STEVEN LANGHALL: So, customer satisfaction would never play a role with value based purchasing or anything of that sort?

MICHAEL LEAVITT: I think it's safe to say that it's unlikely. Herb, am I-

HERB: [Inaudible]

MICHAEL LEAVITT: Herb [misspelled?] thinks he knows of a way. [Laughter]

My thinking has not evolved to that point. But that's only because Herb told me his thinking yet.

ELLEN DURCAL: I'm Ellen Durcal. I'm doing work for ABC News. I was in my former life the Director of Public Relations for a large Catholic hospital in Houston, Texas.

And we were going about these quality measures at the time and this particular hospital took care of many indigent patients in the area. So, our mortality rates were a lot higher than say Methodist Hospital where they turn you away at the emergency room.

So, I'm just wondering on your survey if hospitals that take care of a lot of the indigent they're going to look, well their mortality rates are too high. Because these people come

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sick, they don't have insurance, they don't come until they absolutely have to, so, how is this system allowing for this?

MICHAEL LEAVITT: That's a very thoughtful question. We face this problem in the way we compensate those hospitals, as well, and we have become increasingly good at what we call risk adjusting.

It is a series of factors in a case that tell us at Medicare that this is a more serious case and will likely involve more care. We'll use that same risk adjusted data to be able to factor in the severity and the nature of the cases that ultimately come.

That's one of the enhancements over time that we'll get better at as we begin to use this and enhance it.

GARDNER HARRIS: Gardner Harris from the New York Times. There has been some discussion early this morning about international comparisons. There are some data out there that compare countries about value.

Quality measures, cost measures, on just about any scale that you look at the United States comes out at least on the value measure at the bottom. Why is it that a lot of countries have managed to get electronic medical records years and years ago?

Is our healthcare system the best in the world? How can we get it there?

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MICHAEL LEAVITT: I pointed earlier, Gardner, to three areas that I believe are chronic problems with not just Medicare but our healthcare system. I referred to them as Silo Syndrome where because everyone is acting in an uncoordinated way the idea of chronic more, which adds to the cost substantially and does very little to add to the quality and the quality indifference. I would suggest that one of the reasons we would have the highest cost system are those three.

And when you begin to look at efficiency in terms of outcomes versus what the cost is we naturally do not score well and we need to get better at it because the global marketplace is now putting us in a position that we can—we're competing with people who are developing outcomes on health and hence have a workforce that is healthy or maybe as healthy as our but they're doing it on half of the percentage of their gross domestic product.

So, very clearly I think the same three things that I've spoken of drives that. We have an extraordinary healthcare in this country. People from all over the world come here to get it.

But the system is saturated with inefficiency. And it's because we have a sector not a system. And we value volume and not value.

CHARLIE ORNSTEIN: Hi, Mr. Secretary, Charlie Ornstein from the L.A. Times. You had said earlier that this is not

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about eliminating anyone it's about improving everyone. But as you've—you're now on your third year of having this data online.

As you keep adding data and refining it and improving it over time you'll realize that some hospitals are not improving, that their number remains flat, they remain below state averages, below national averages, their costs are high.

At what point are there going to be consequences? So, not that you're—you may reward the systems that are improving but are there going to be penalties or are they going to face elimination from Medicare if they don't improve?

MICHAEL LEAVITT: It's unlikely that I will be secretary when that occurs. [Laughter] I will just say I hope so.

CHARLIE ORNSTEIN: And why?

MICHAEL LEAVITT: Well, this is about transparency and accountability and without consumers and regulators and others having a means of measurement then we continue to reward mediocre and in some cases poor performance.

And while we're not—this is not about eliminating those who are not performing well we should certainly not assume that those who are poor performers will not be eliminated either by the marketplace or by those who oversee quality.

CHARLIE ORNSTEIN: Thank you.

MICHAEL LEAVITT: I want to, go ahead.

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GIDEON GALE: Hi, Gideon Gale from the Boston Globe. Studies of transparency efforts like this have mostly shown that consumers just don't use them very much.

And so I wanted to ask you what makes you confident that consumers will use this site and the satisfaction data? And the second part of that is is it your hope not to just that consumers use this but do you think that hospitals themselves that it may have a more powerful result?

Where the hospitals themselves don't want to be the bottom hospital in their market and will act on it?

MICHAEL LEAVITT: I believe that will be the first thing that happens. I think by this afternoon there will be hospitals looking at this data identifying the places where they need to improve.

I believe we will begin to see hospital administrator compensation linked to improvement of this data. Now, let me just talk a little bit about the consumer and the consumer's use of this.

I believe ultimately this will begin to change the way patients interact with medical information. I think it will change everyone in the provider chain. I think it's likely that at some point in the future insurers, employers, payers of healthcare will be saying to their patients we need you to be a participant in finding value and we will reward you in various ways if you do find value.

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And here is information that will allow you to make those judgments along with us. If you insist upon going to your brother-in-law who is a low quality, high cost physician you're going to need to pay a portion of that.

However, if you'll pick a moderately priced, quality provider then we'll pay at the highest rate. Now, that's just one way. I believe we'll begin to see and we are already beginning to see with recent announcements by Google and Microsoft and other major players.

Now, they're moving into this space because they know the Internet is now five to seven percent of all searches, or excuse me that health is five to seven percent of all searches.

They will quickly, I think, begin to develop personal health records that will allow people to have their health information and I think that very soon we'll begin to migrate toward Travelocity for healthcare.

And we'll begin to see an entirely new generation of involved consumers. We have seen this Part D of Medicare. There were skeptics about whether consumers would shop, whether they would be and there was a little grumpiness at first about needing to make a decision they hadn't before.

But they are a powerful generation of consumers now and they are well schooled in how to make this system work for them. And we now have 86 percent of those who have a plan happy.

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And those who aren't have the capacity to change. And they are driving quality up and cost down. When people have information and they have choice they make good choices and they improve the quality and drive the cost down.

SUSAN JAFFE: Hi, Susan Jaffe, Washington Correspondent for Florida Health News. I'm wondering what have you learned from some of the problems experienced with nursing home compare? And Medicare Advantage compare?

Namely that the fact that violations are not listed along with quality measures and I would think that while people would be interested in how nurses communicate with each other they would also be interested in knowing if the facility has violated any of the rules required for participation with Medicare.

And I'm thinking about last year there was a Florida Medicare HMO that got top reviews even though CMS had cancelled its contract for not providing necessary treatment to their members.

MICHAEL LEAVITT: We're just leaving the Pong era when it comes to learning how to measure and reward value.

SUSAN JAFFE: Well no actually you do have those—you have that information listed in corrective action plans which are in huge zip files that you have to be a rocket scientist to figure out how to open. It's not consumer friendly.

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So, you do have the information in one part of the Web site but not as accessible.

MICHAEL LEAVITT: That sounds like a problem worth noting. And one worth improving and I thank you for pointing it out.

We are seeing robust use of this data and one thing it has taught us is that if consumers have access to data they will use it and they will use it in increasing amounts.

I expect that we will see in very short order the hits on our Web site go up dramatically and it will be passed from person to person and it will grow virally. And it will grow even more as we improve and take care of problems like the one you just pointed out.

SUSAN JAFFE: Just one quick follow up. I'm curious about why you think that seniors have exercised choice when picking a Part D plan when we've seen the enrollment concentrated, I think, more than 50 or almost 50 percent of the enrollment in just two plans.

Humana, which typically is like the cheapest plan available for prescription drug coverage only and United Healthcare which is endorsed by AARP and some market analysts have said that United Healthcare benefited from the AARP brand recognition.

MICHAEL LEAVITT: Well when 43 million people make a decision you have to assume it's because they were following

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quality and price and what you've suggested I think is without commentary on either plan. If the marketplace is beating a path to their door it's because they're satisfying a need and the minute they don't those 43 million people will go somewhere else.

SUSAN JAFFE: Thank you.

MICHAEL LEAVITT: Thank you. I'd like to just conclude with this thought. I talked today about Medicare and the imperative we have as a nation to deal with that.

I made the point that Medicare is symbiotic with the larger healthcare sector and that we need to shape it into a system. This is all being driven first of all by a humanitarian need to have high quality healthcare.

At the root of this is a desire for people to have better lives. But there is also an economic imperative that allows our society to continue to be a prosperous, successful, powerful force in the world for good. We are competing in a global market.

And there are just three ways to approach competition in a global market. You can fight it and fail. You can accept it and survive. Or you can lead it and prosper.

Every generation in this country's history has been required to overcome a challenge that allowed our nation to remain the economic force that it is today. I believe the healthcare is this generation's challenge.

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And we will be required as a country to get better at this. We cannot remain—there is no place on the global leader board for a nation that pays 25 or 30 percent its gross domestic product on healthcare.

It will push out education. It will push out innovation. It will push out research. It will push out all the things that make a society competitive in a global market and it's my belief that American's will rise to this occasion.

We will begin to focus on the development of a system of healthcare that is based on value. Thank you. [Applause]

KARL STARK: Just a quick note there's going to be, you're going to be able to—

[END RECORDING]

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