

From the CEO

Knowledge is Power, or So They Say

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One of the formulas currently being promoted for health care reform is “Quality care equals cost-effective care plus good outcomes plus patient satisfaction.” Upon the order of the president, the federal government is now channeling resources into providing “transparency” of cost and quality information for consumers and rewarding providers of health care for good outcomes. The plethora of activities swirling around—development of electronic health records, quality indicators and measurement, tying payment to performance, publishing of information, to name a few—are intended to give consumers/patients the ability to choose cost-effective quality providers. In turn, smart consumer decision-making theoretically will facilitate reform and stabilize the U.S health care system for aging baby boomers and generations to come.

A primary underpinning of this movement is the premise that consumers can and want to be sufficiently educated in order to be self-determining in selecting their hospitals and providers. This was summed up in a recent statement by Health and Human Services Secretary Mike Leavitt when the Centers for Medicare & Medicaid Services unveiled its posting of information on what Medicare pays for the top 30 elective procedures and other hospital admissions. “Once people gain better information, they become better consumers of health care and that helps get health care costs down and quality of care up.”

But does it really? Do consumers (a.k.a. patients) make health care decisions based on objective data? Is the information provided by CMS the appropriate information to enable patients to make decisions? Does the way in which information is presented facilitate the public’s ability to acquire and act on answers to questions such as, “Which hospital would give me the best chance for a successful outcome for a quadruple coronary bypass while costing me the least out-of-pocket expenditure?”

On June 1, CMS announced the availability to the public of Medicare cost information consisting of ranges of payments made to hospitals within specific counties for the top 30 diagnosis related groups, along with the number of procedures performed. This is the first category of data widely available and

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will be augmented with comparable data for individual hospitals on the costs of common procedures done in ambulatory settings and, finally, for hospital outpatient and physician services. The information posted by CMS is a gold mine for those of us who enjoy poring over charts, percentiles and data analysis. But for patients whose doctors recommend surgery, how would they fare in this exploration?

Assuming that senior consumers are Internet adept and engaged, they can go to the CMS Web Site for information on the cost of the top 30 common DRGs by county and state. (See the detailed list on the CSA Web Site.) The site presents large data files listing the states and, within them, counties in alphabetical order. After finding a state and county, cost information for each DRG can be viewed. Although the cost information is aggregated by county, specific hospital figures will be available soon. See <www.cms.hhs.gov/HealthCareConInit>.

CMS made an effort to translate some of the medical terminology into layperson's terms. For example, DRG 154 is described as "Stomach and Esophagus Operations in Adults with Complications or Preexisting Conditions." Some of the procedures within that DRG include "Remove part of stomach and small intestine," "reattach the remaining stomach to the small intestine (jejunum)" and "sew up ulcer in small intestine (duodenum)."

Another government site, <www.hospitalcompare.hhs.gov>, has hospital-quality information and can be accessed from the CMS Web page. Hospitals voluntarily report these data or risk lower payments from Medicare. Because California has a large number of hospitals, it is divided into two segments: northern and central California and southern California. Searches can be done on hospitals in geographic areas by state, county, city or zip code, and up to 12 facilities can be selected to compare quality measures. Currently, quality data are available for heart attack, heart failure, pneumonia and postsurgical infection prevention.

Following this track takes one to quality measures: for example, "Percent of Patients Given ACE Inhibitor or ARB for Left Ventricular Systolic Dysfunction (LVSD) for heart attack." Most patients won't know what it means, and the brief explanation—"ACE (angiotensin converting enzyme) inhibitors and ARBs (angiotensin receptor blockers) are medicines used to treat heart attacks, heart failure, or a decreased function of the heart"—probably will not enlighten most of them. However, when the option to present summary information in graph and table form is selected, the information can be understood easily. The narrative accompanying the treatment description tells the reader what scores are better (higher percentages) and why the information is important. Those who have gotten this far can get useful information in an understandable form.

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Finally, a tool under development by CMS will include both cost and quality data on one chart. See a Model Health Care Decision-Making Tool at <http://www.cms.hhs.gov/apps/mockup/mockup.html#>. This shows an example, using Florida counties, of how cost and quality information ultimately will be presented.

How Useful is Available Information for Patients?

More information about cost and quality (as defined) is available than ever before. The good news is that the hospital information acquired via Medicare requirements is consistent across the board; that is, the same cost and quality indicators are measured and presented in the same format. For those consumers/patients interested in researching diagnoses they may someday experience (e.g., heart attack), they can know in advance which hospital in their vicinity is “best,” and they can cross-reference the quality measures to the cost using the decision-making tool.

The general public is just beginning to be informed that the above information is available. Some magazines and newspapers have published articles to begin the educational process. Most of it is unknown to the majority, and perhaps the most well-known source of quality information is the annual *U.S. News & World Report* that ranks hospitals on quality indicators including mortality, complications and reputation among physicians.

For most patients, the decision-making process is at the opposite end of the continuum. When faced with the need for either elective or emergency care, consumers make their selections based on the facility with which their health plan is contracted and where their physicians direct them. Most people are not even aware that objective data is available, and as it is currently reported in the news and popular press, the majority will not research their options. Secretary Leavitt's assertion likely will not be proved during his tenure, but he may possibly take credit for pushing public awareness of costs to another level.

As consumers, patients and providers, anesthesiologists should find the information to be of interest, if only to review how their own place of practice currently fares in terms of hospital Medicare costs, annual number of procedures (of the top 30 DRGs) compared to other facilities, and how they compare on the quality measures summarized in the Hospital Compare reports. The top 30 DRGs selected for the transparency table are available on the CSA Web Site at www.csaq.org.