

Peggy O'Kane

Peggy O'Kane:

I don't know if you noticed, but the four names that Chris mentioned are all women. And I think --

[applause]

One of the things that I find remarkable about the Quality Movement is that women have played such an incredible role, and I see many of you here also in your plans are the people that are doing the heavy lifting and trying to keep the organization moving forward. So I think we should all be proud and those of you that are men, I think, welcome to our world, and I think it's a sign of progress.

You know, I think, as I think about my talk today, I think the question is, "Is the glass half full or half empty?" And I would say, "The glass is half full," and I'm in a real hurry to get it to be full. I think you'll hear a lot of back and forth in my talk about what's been accomplished, what's really wonderful, but also about what needs to happen in order for us to realize the potential of our healthcare system. So I just wanted to take an opportunity to reflect on that and share that with you.

So I'm going, I think most of you are from health plans and so you pretty much know NCQA. You may not deal with us but we've got an impact on your world. I want to talk about what's at stake. I want to celebrate a decade of improvement and talk about what the impact of that is. I want to talk about assessment of special-needs plans. If you are one, I know, we're probably not your favorite organization right now. But I think there's a real reason why we have this urgency to have a strong accountability agenda for special-needs plans, and I hope I can make the case to you. And then I want to look forward a little bit and talk about, you know, having now come through what I think of as phase one of quality, which was kind of the easy part, believe it or not, what do we need to do to make the quality agenda really robust and really deliver for patients in the future?

So that's a lot to cover and so you know, perhaps, that we're a nonprofit health care quality oversight organization. We spun off from the HMO industry in 1990. Our mission is very simple: to improve the quality of healthcare. We're committed to doing that through measurement, transparency and accountability, and I think we certainly have got measurement on the agenda. We've got measurement everywhere. We've got some transparency, not painless. The accountability part I think remains to be really well defined, although at the health plan level, I think we're really pretty far ahead. And then NCQA works through uniting the different stakeholders around the table; the consumers, the purchasers, the quality experts, the physicians at the delivery system level, the health plans, et cetera.

So it was really remarkable when I discovered, in the 1980s, when I started working in this field that one of the problems -- everybody said, "You can't define quality." I mean, I remember having meetings where people would say, "There's no way you can define

quality." And what I realized was, everybody had their own idea of what quality was. So part of what has made quality move is coming up with a common definition, even if it's not perfect, we kind of get it. We understand the sort of dimensions of where we're trying to go, and I think that will be changing as we learn more. I mean, one of the wonderful things about my work -- and I've been in this job for 18 years -- is that we keep learning from our experience. So you can't, you can try looking out five years, but you will find that as you're going forward, you are learning things, and the need to constantly be changing and evolving the agenda is always there.

So I think you know our major business is accreditation of health plans. That's what we're here to talk about today. And certainly it's kind of again, a half full/half empty kind of picture because, for the HMO sector I think there's no question that NCQA has changed the world. Two thirds of HMOs in the United States are accredited by us. But we also need to have information about whatever kind of health plan you are. So we're very rude about this. We say, "We don't care what your acronym is or, you know, if you are a health plan, then you have a value proposition to explain." And, you know, we've had some success with that I think in general, leaving politics aside. There's a general understanding that health plans can and do make a difference, and if you're one that doesn't make a difference, then I think you have some explaining to do.

We also do physician recognition programs. We're very proud of this. We have programs for diabetes, heart and stroke, back pain care, and office care systems or physician practice connections; patient centered medical home maybe the way in which you've heard about this. We just recently recognized our 10,000th physician. That's a drop in the bucket when you think how many there are out there, but certainly it's -- we've come a long way since we first started with these programs in the 1990s. And part of the point is there is no single accountability agenda. What we need are accountability agendas at all levels of the system, and they can't be fighting with each other. They need to be congruent and coherent.

So you all know about HEDIS that, you know, we're very proud of what's in HEDIS. We're very anxious to make sure that what's not in HEDIS gets incorporated over time. The Cap survey was developed by the government and its research partners, and we're happy to use it. It really gives us important information on what the experience of members is, and you know that we have a requirement that this be independently collected. Both HEDIS and CAHPS, if you're not that familiar with us, drive the outcomes of your accreditation to a large extent. So I think it's like 40 percent now of the score is driven by HEDIS and CAHPS. So I think that's a real breakthrough.

How many of you have seen this picture? If you've heard me speak, okay -- good. I've got a newbie audience. This is my favorite picture in healthcare, and I owe this picture to Niko Prock [spelled phonetically] who works at Health Partners in Minneapolis. It was in a book written by George Halverson and George Ishem called *Epidemic of Care*, and what it represents is how to think about a population and a population's health.

So if you look at those bubbles up there, think of the population of the United States. At

any moment, most of the people are healthy and low risk, in that green bubble over there. And there I would say the role of healthcare is to help them really maintain their health, and I think health care has done not a very aggressive job at this. We've kind of said, "That's their problem. Let them figure it out." That hasn't been working too well, as you know, with the obesity epidemic and the threats to public health.

Medical care, when we think of preventive services, some of them are keeping people healthy directly like immunizations. Some of them are finding people in the at risk category, so finding women with breast cancer through mammograms, through finding people with cervical cancers through Pap smears, colon cancer screening, et cetera. And HEDIS, I think, has done an excellent job walking behind the U.S. Preventive Services Task Force with a lot of measures to say, "How effectively does this health plan keep people healthy?"

High risk people, our job really is now to begin to help them stay as healthy as they can be, and keep them from moving into the early symptoms and active disease stage. Disease management programs work over at that end of the spectrum and, you know, they've had mixed success I think, you know, we could talk during the break or whatever about Medicare health support and the reasons why that didn't work so well. But what we know is that the people up at this far end of the spectrum is where the money goes, and if the money were only going to keep them as healthy as possible and to relieve their suffering, I think we could all, you know, be relaxed about it. But as we all know, that there's a lot of money going on at that end of the system with poorly coordinated care, with medical errors and harms, and the cost curve, which is that black line that you see going up, reflects how much spending is actually going on there, at the end of life and with the active disease.

So we have a very complex and fulsome agenda and agenda for quality, and I think HEDIS has done a very good job at prevention, chronic disease management, and we still have work to do on the wellness end of things and on the far end of the spectrum, you know, with coordinating with others on hospital care and the patient safety agenda. So again, the glass is half full, and we're moving towards getting it full.

So what's at stake? How many people know who this lady is? Okay. That's Kathleen Casey Kirchlind [spelled phonetically], and she's on her boat and she is the first boomer, so she's the first person that went onto Medicare. So she is the beginning of a tremendous wave and you all know about this, and many of you are part of the wave, just like I am. By 2030, one in five Americans will be 65 or older. And an estimated 80 million Americans will sign up for Medicare over the next 20 years. So that works out to one new Medicare beneficiary every ten seconds of every day. So that makes the economists sweat, and there's really good reason for them to be sweating and for us to be sweating, as future Medicare beneficiaries.

This picture is about as shocking as you can get. What this shows is assets as a percentage of expenses from 1970 to 2025 projected. So you can see that in 2008 -- that's the high point. The assets in the Medicare trust fund were about 150 percent of expenses.

So but look what goes on after that. There is a sharp drop. Now this is based on projections of what the current expenditure patterns are, and so what it's telling us -- that line where it hits the bottom there -- that's 2019. That's when the Medicare trust fund goes broke.

Now you may say, "Well, that will never happen." You know, how could that possibly happen? All those boomers are going to vote and so forth. But the question is, where is the money coming from? And we have to do something about the fact that our health care system has now become unaffordable, not just for the 47 million uninsured, not just for many of the employers -- 40 percent of the employers in this country who can't afford it, but for the country as a whole, and so we've got to be bold and we've got to put the affordability agenda front and center. And it's not to the exclusion of the cost of the quality agenda. They are in sync, and they can be completely coherent. And that is really what I spend most of my time thinking about and working on these days, is how do we move that? How do we make that real?

So as I look back on when we started, you know, in the mid-80s when I started really trying to build a quality agenda, which I was shocked to find didn't really exist -- just to tell you a little bit about myself. I was once a respiratory therapist. I worked for five years in various hospitals on the East Coast of the United States. I absolutely got religion about quality, as a respiratory therapist because I saw so many things that were troubling to me, including how respiratory therapy worked, which was kind of vague. We didn't have guidelines. We knew that different doctors had different philosophies about how ventilators should be set up and so forth. So I went to Johns Hopkins. I got my master's degree, and I wrote my essay about wanting to improve the quality of health care. And I showed up in my health policy class, my first day, and he had us go around, the professor, and say what we wanted to do or what we had been doing and I said, "I want to work on quality." And he said, "You want to work in a PSRO doing chart reviews?" And I thought, "Oh, isn't this sad?"

So, you know, we -- in those days, we believed that we had the best healthcare in the world. Measurement was done by some people that reported in medical journals that very few people read. And it was kind of considered a novelty, if not foolishness. But what happened was HMOs went through a period of turbulence and quality threats and so forth and so Jim Dougherty [spelled phonetically], who was then the head of the Group Health Association of America thought, "We actually need a quality agenda for HMOs that's real."

And so I went to work for them and, believe me, it wasn't easy. But what happened was the purchasers came forward and they said, "We're all doing continuous quality improvement. We can tell you our data. Show us your data. Show us how you're doing. Tell us how many diabetics you have in your plan." And nobody could answer these questions. So it was really kind of an alignment of the stars, is the way I think about it. The world was ready for this, and NCQA was ready to take the opportunity. And CMS has been a key supporter of this agenda, really quite all along the way.

There was strong resistance at every level of the system. You know, there are still people who believe that you can't measure quality. I think there is much more consensus now that you can do it, not in everything, but really in a lot of very important areas.

But the next big surprise was the performance gaps that were revealed. So people were assuming, for example, that immunization rates were like in the 90s. I remember going on an NCQA survey before we had HEDIS. And somebody saying, "Why are you measuring immunization rates?" One of our surveyors said that. "They're always 100 percent. Why don't you pick something that's actually meaningful?" Well, weren't we shocked when we got our first data? We found out that pretty much anything that we measured, it was in the 30s, and then people said, "Well, that's the HMOs. They're, you know, kind of sub par players." Well, I mean, we've gone through a lot since then, and we know -- Beth Laglynn [spelled phonetically] certainly showed us that even in all kinds of different practices it's about 50 percent, no matter what you're looking at. So, you know, we really I think -- it's that knowledge, that understanding that has given the Quality Movement the engine that it needed to really move forward.

The second really big point is that people didn't get it about patient safety and what a problem that was. And the IOM report on medical errors, *First Do No Harm*, that made the scales fall off everybody's eyes, and people do understand that there is a convergence of harm to patients and waste of money in that agenda that makes us very powerful. So when you have CMS saying, "Sorry, we're not paying for these things anymore. We're not going to reward you for doing the wrong thing. You're going to have to figure out how to do this." That changes everything. And the quality managers that used to be in the doublewide behind the hospital are moving into the executive suites. So it's a great thing.

So that notion that we have to trade off cost and quality, which was really -- that was the way people talked about it when I started in this field. That notion has been exploded. You know, we know that there are probably some areas where, you know, something that cost \$1 million might give somebody an extra year of life, but really, if you look at the broad mass of care, we know that if you do the right thing the first time, if you avoid doing the wrong thing, that there is no trade off, that quality can go up as costs go down.

So I have a bunch of slides here about how measurement has driven improvement. So you can see there's steady -- these are Medicare results only, since that's what we're talking about, Medicare advantage plans. You can see that rates have gone up. It's been not as rapid as in the commercial population. I'm not sure what that's telling us, but maybe it's more challenging or maybe there's not enough incentive to do the right thing. I don't know, and I'm really not going to comment on that on this particular issue, until later.

Hypertension control; I think, you know, some modest progress but again, not as much as we've seen in the commercial plans, where we saw a 50 percent improvement over time. We had a specification change in 2006, so the results aren't actually worse. We just set the bar at a tighter point.

Beta-blocker treatment, I think there was dramatic improvement in this one. In the commercial side between when we started on the commercial side in 1996 to 2006, when we actually retooled this measure or retired it, if you will. But Medicare didn't really start requiring this to be collected until 2000, and so we missed the point of the sharp improvement on this one.

Hemoglobin A1C control, now this is higher is better here. We turned this measure around, so this is keeping people below nine. There's been actually a decrease in quality here. We think this is partly a result of all the newbie plans that are reporting, but we're not sure exactly why this is happening but again, there's a quality agenda here, and there's a quality agenda for each of you to understand better. If your results are like this, why aren't they better?

We also know that improvement save lives so if you just take -- this is commercial, commercial and Medicare combined. If you take just four measures; beta-blocker treatment, cholesterol management, the ones I just showed you, controlling high blood pressure and poor hemoglobin A1C control and you look at the time from when they were implemented to today, there were at the low end, 73,000 lives saved; at the high end, 124,000 lives saved. So actual lives saved because of your efforts, because of our efforts, and it's really mostly because of your efforts that these people are walking around and in better health than they would have been without this agenda. So I know you know that, but I'd just like to remind you so we can celebrate our victories.

But we have a long way to go. You know, we were really troubled this year by the Medicare results. Again, in the commercial plans there were 30 out of 44 measures that improved. In the Medicaid plans, 34 out of 43, which was a great showing. Medicare plans only improved on average, and you may be a plan that's really breaking through and so forth, but this is as a rule, eight of 21 measures. And again, our analysis showed that part of this is due to first-time reporters who may have not have a quality program, may have data collection issues and so forth.

There are 64 MA plans reported HEDIS for the first time in 2006, so and their results were definitely not as high as the average. Plans reporting for the years 2005 and 2006 improved on 13 of 21 measures. Remember, we're always looking back a year, so our latest data that we've reported is 2006. So anyway, I think what this is showing you is that we need to do this better for the Medicare population. They definitely have more at stake. Illness is definitely more of an issue for the elderly, so the opportunity to do good at the same time is greater for the elderly. So I think CMS -- we, you, we all have here an agenda staring us in the face, and we have to figure out, how do we move it better?

Special-needs plans, I have a real soft spot in my heart for special-needs plans because my mother is a person who's institutionalized and who really has these kinds of needs, and I know that the HEDIS measures that we have, while they're reasonable, they don't begin to address the particular needs of these kinds of populations. And I think those of you that are working these plans know that there is, again, a huge intersection of waste

and harm with these patients. So I think it's a challenge and it's a new kind of challenge. It's really like starting over with the Quality Movement. It's not, it's really, you can't just take preventive services task force and chronic disease measures and hope to meet their needs. So it's got us all, I think, thinking about what would it look like if these plans did a really excellent job, and that's really what we're trying to do with these evaluation requirements.

So the timetable is -- it's phased. I may not feel like it's phased because I know you've have a lot coming at you. In 2008 we will be reviewing 477 special-needs plans. We'll be evaluating performance on 13 HEDIS measures, and again, they are the usual HEDIS measures for the Medicare program. We will assess the structure and process, case management, member experience and quality improvement. So I think it's a reasonable start. For those of you that have other products, I think it's all going to make a lot of sense. For those of you that are new, I hope it makes sense and I hope we can be helpful, as you're trying to come into compliance.

In 2009 there are 787 SNIPs, so we'll expand the suite of HEDIS measures with a focus on measures of care for these fragile adults, and we'll integrate the CAHPS survey and health of senior survey. We'll expand HOS -- I'm sorry, I misspoke -- we'll expand the structure and process measures to include care transitions, plan design and caregiver experience, and we'll test benchmark measures. And 2010, because the enrollment was frozen, I think to the relief of some, it'll be 787 plus. We'll refine the benchmark measures for collection and expand the set of applicable HEDIS measures.

So why is it so important that we have to be racing forward with this? Why can't we take our time? Well, if you have paid any attention to what's going on on Capitol Hill, there is a lot of questioning about, why do we need these plans? Are they worth it? I mean, they are getting paid plenty of money and so there is a tremendous desire on the part of Congress to understand if these plans are really delivering for the Medicare program, for the members, and for the taxpayers. So that is the reason for this and we appreciate the opportunity to work with CMS in moving this agenda forward. We think there's really little that's more important than this at this point.

So let me just reflect a little bit on, you know, having now talked a little bit about stage one of quality and what's been achieved, I think there was a group of us that sat together and said, "What do we need now to move the quality agenda forward?" This is going to be a paper in *Health Affairs* this month. There's a special issue of *Health Affairs* this month that is a primer for the new administration, so we're thrilled to have done this, and if you've ever written a paper with 12 people, you can imagine how thrilled we really are. So [laughs] --

[laughter]

So I think this is one where the glass really feels like it's half empty and maybe we've got a hole in the glass because we've really got a problem with the accountability agenda for Medicare as a whole, so only one in five Medicare beneficiaries are enrolled in

accountable systems. So traditional Medicare, other than an occasional *New England Journal* article by Steve Jenks [spelled phonetically] -- we have really not a population health agenda. We have an agenda for individual physicians. We have an agenda for hospitals, but we need to really bring ourselves up to the population level and think about that as well.

We have MA HMO plans, so they're 15.4 percent. There's a robust accountability agenda there; PPO plans, 2.4 percent. It's coming along. It's not as good as the HMO agenda yet because of certain issues with ability to report. Special-needs plans, 2.7 percent. The one that really sticks in my throat is the private fee for service plans, 5.1 percent, getting paid a lot of money, not clear what the value proposition is supposed to be. So I realize this is very political environment. There's a reason that we have these plans that's political. It has not much to do with quality or accountability, but I think it's something that really eats at me and really threatens to undermine the whole overall quality agenda.

And if you look at the growth and where it's been, it's in these private fee-for-service plans, and so that turquoise segment there is showing you the growth that's happened and that's projected to happen to 2016. We were reading about the deliberations of Medpak [spelled phonetically] and I guess it was Glenn Hackbarth [spelled phonetically] that said he was having a hard time getting to feeling disappointed. I mean, he was devastated by these projections. So I think this is a very important part of our agenda, especially if you're a special-needs plan and you've got all this stuff coming at you. I've got to believe there's a fairness issue here, but maybe you're a plan that has both. I don't know but, you know. This just makes no sense to me, and I'm not speaking, I'm not criticizing CMS because they really operate in a very political environment and they're doing a great job, given the constraints, but this is something that needs to change.

So it all comes back to, what's the value we're getting for the taxpayer dollar? How are we going to rescue the Social Security trust fund? So we really need to do this and, you know, I said I think I've said enough about that, but I think it's certainly top of my agenda.

So what else, though, has to happen, you know, and as we go into Stage 2 of the quality agenda? Well, we need accountability models to go beyond the health plan. So we're now down at the individual physician level and I'm going to tell you in a minute why that's very interesting. For some specialties it's very, very urgent. For many others, it's not so clear that you can create coherence at that level. We need to implement a comprehensive strategy for stewardship of medical evidence.

If you look at the evidence base, and we've done a lot of medical investigation in this country, we've done wonderful clinical trials, but how many of them have actually been done on the elderly? And so what we do is we develop the science, using patients that have a single disease that are not as complicated, and then we generalized to the elderly and we say, "Well, if it works this well with people under 65, it must work just the same with people over 65." So there is an urgent agenda here, you know, on what should be

done with people that are elderly, that have complex conditions and so forth. This is something that is certainly not within the purview of NCQA or CMS, but I think we should all be really cheerleaders for -- it's been called comparative effectiveness. I don't like that term because I think it's too narrow. I think we're talking about a board that looks at what we know and then says urgently what we need to know and that tries to drive the research agenda to meet the needs of our society and of the patients.

We need to develop more bundled severity adjusted payment models. So we have today tremendous opportunities for the kind of technological breakthroughs that I've seen at some of the health plans and some of the medical groups who have put in an electronic medical record. And they've also typically got e-mail and so forth, but if you do that, you will lose money under the current payment system unless you happen to be in a demonstration project. So we need, we already know that this can be done so much more efficiently in a way that so much easier for patients. Particularly when you think about the elderly that may be homebound, there are opportunities to keep people out of institutions, but we need payment models that actually encourage this kind of technological, using technology to make the delivery systems so much better for everybody. So again, that's an important piece of the agenda.

And then overall, we need a public/private strategic plan to improve population health. I just picked up a report from Sweden reporting on the health of the country, and it's got all these public health things in it, as well as HEDIS-like measures. So it's kind of one country with one set of problems and, you know, it's not as lily white as everybody thinks in Sweden. They actually have a lot of immigrants, and it's a complicated society as well, but the thing that makes it possible to do this in other countries and all the other countries in the world that are developed have national health insurance, is that there is a notion that we're all in this together, and we've got to spend our dollars wisely. And those two facts are very much aligned.

So I mean, going back to the idea of individual doctor measurement, the average Medicare beneficiaries see seven doctors. That's not the sickest ones. So what you have is you have each of them doing their own thing, and sometimes they're coordinating with each other. If they're a medical home, they're trying to coordinate with the six others. This is a real challenge, though, and there are issues with who do you, who do you blame or who do you reward if something happened right or didn't happen right? But really, the most important problem is you have tremendous gaps in care, and then you have people coming out of the hospital and nobody's really there to make sure that their transition goes well and so forth.

So this kind of creating "systemness" is something that I think measurement can drive, but it isn't fair to say, "Well, this didn't happen," when nobody really thought that it was their job, right? We have to have the accountability models defined for measurement to really work. Otherwise it's just a bunch of, you know, you know, whining and complaining and saying, "The system is broken," which I think, I bet you're all sick of saying it. I sure am. So that's why we need these accountable models.

So I'm going to skip past this because I think I want to have a little time for questions. Payment reform; I think you can do a lot with this. I think tying it to outcomes -- it is really partial capitation or bundling of care. Okay, do people trust that? No. Why did it fail before? Partly because we didn't have enough information about what was actually happening. The public was very worried about withholding of care, so the transparency absolutely has to be right there with the payment reform. And I think that's well understood these days. And the good news is we have the means to do it.

I like the idea of gross national health. I was in Bhutan a few years ago and they have the concept of gross national happiness and they measure indicators of the country. If we think of our health as a precious asset in this country and it is, then we have to figure out how do we maximize that? How do we not have our children obese? How do we not have people becoming diabetic, when they didn't need to be, and so forth. So again, this is not simple. But it is possible and I think we have the tools today. Really it's a matter of will.

And so when we think about population health management, think back to my picture. It's keeping healthy people healthy, finding disease early, and trying to deal with it; keeping the chronically ill as well as possible, improving care coordination for patients with complex conditions, providing compassionate and coherent end of life care. I used to work in it, in ICUs, and it is not a place where you want to spend the end of your life, but in many parts of this country, that's where you're likely to be. And then identifying and eliminating medical errors, which is kind of not like the others, but I think absolutely a part of this agenda.

So strong population health management, for those of you that believe all Americans deserve health insurance, our agenda has to be a triple agenda. It's quality, it's access, and it's affordability. And if we try to just optimize one, we may do damage with the others. So it's a big job, but I think were up to it. And I think we can get that glass at least three quarters full in the next ten years. And I think we really appreciate the opportunity to be here today, and the opportunity to work with CMS on advancing this agenda, and do I have time for questions? Okay. And, you know, feel free to make comments, you know. We like to hear from people. We realize that there's a lot going on, so, okay, come on. Somebody's got to have a question or comment. Yes.

Male Speaker:

We'll need you to come up to the microphone, as I indicated earlier. The conference is being recorded.

Peggy O'Kane:

Thank you very much. And if you could say who you're with, unless you want to say something rude, you cannot say who you're with. We don't want to have any censorship here. Yes, pleas.

Alison King:

I'm Allison King with Procter and Gamble. Thanks for a great talk, a great way to start

the program. You mentioned no trade off with quality and cost. And one of the challenges that many of us experience is that prevention in the short run may increase costs and the congressional budget office, usually doesn't score these cost savings.

Peggy O'Kane:

Well, I have good news for you. I just sat with Peter Orszag. We had our gala last week, and he was sitting at my table and he told me that they're working on this and that they -- he actually is trying to do a review. He's willing to be convinced that there is money there. So I think that if you've met him, you know, he's not afraid to think about quality of health care, which is a wonderful thing. So anyway, I cut you off, so finish your point.

Alison King:

That was -- I was just going to ask what you thought, you know, whether you're working with --

Peggy O'Kane:

Well I think that, I mean, the problem is that we have to be thinking long term. That's why we need a strategic plan for population health. Because what you do today may not pay off today, but it may pay off in the future. And if you're a health plan that knows you're going to have a lot of turnover, you may not want to do it. But if you're a society -- if you're a Medicare program and you know the things can be done out there that are going to have an impact on the health of your population, then there are things that can be done in public policy to encourage this kind of thing. So I think that this is something that employers are very much interested in.

We're actually developing a program for -- it's a voluntary module for health plans, and also for the vendors that may sell to employers. We're going to be trying to quantify some outcomes, not in the economics, because we think it's really too long term and that's a research question that we hope others are working on. But in terms of ability to get people to quit smoking, to manage their weight, to exercise regularly, we think that those kinds of things can be measured and that we can have more information about who's successful in this sphere. Thank you. Yes.

Carla Parks:

Hi. I'm Carla Parks from Care Source, and we are a managed Medicaid and now Medicare advantage in Ohio and Michigan. And we've been noticing at least in the Midwest, in Ohio, Indiana, Michigan, an effort to develop regional health information organizations with the thought of sharing health information electronically across payers, clinics, hospitals, doctors. How do you see that interacting or interfacing with the quality and with NCQA?

Peggy O'Kane:

Thank you for asking that question. Actually I am taking a course, believe it or not, I'm taking an online course in medical informatics partly because of really wanting to understand these issues better from a strategic perspective. How can they change the quality agenda? So I think for me the jury's out on RHIOs. I think there's no question

that we need electronified medical information. You know, when we look at other countries, we see the adoption of EHRs, electronic health records, is enormous, and that's because the government has encouraged it or it's made it, you know, it's kind of paid for it or something. So I am absolutely 100 percent bullish on this agenda. I think the question becomes, if you -- in California this is an issue. Kaiser, you know, has implemented EpiCare, so they have connectivity across their hospitals and their whole ambulatory delivery system.

Healthcare Partners, the chairman of my board, is from Healthcare Partners. They have Allscripts and a lot of the other big groups have bought Allscripts, and what the chairman of my board says to me is, "We have these private RHIOs that are, you know, our version within our delivery system." Now is that okay? I don't think so, because if you're a Kaiser patient and you go to an ER that's not at Kaiser, there needs to be some connectivity. I think this can be sorted out and, you know, I know there's a CalRHIO [spelled phonetically] that's trying to sort these things out.

So I think the question though is, do we just assume that nobody has electronic health records and try to engineer all of this outside of organizations, or do we try to make sure that we're encouraging organizations to build their models within, so that we don't have to go through all the pain of, you know, such slow growth. When you have disaggregated providers, it's no fun to be trying to figure out how do you connect them all? So I think, you know, there have been papers really talking about the limitations of this. I think that there may be successful examples, you know. If anybody knows more about this and wants to e-mail me, I'd appreciate it. My e-mail is okane@ncqa.org. But I think we need to understand this better and what's the way to think about it? Thanks.

Renee Rule:

Hi. I'm Renee Rule, and I'm from Commonwealth Care Alliance. We're a special-needs plan in Boston. And --

Peggy O'Kane:

Is that Bob Masters' plan?

Renee Rule:

Yes.

Peggy O'Kane:

We've all heard such wonderful things about.

Renee Rule:

Exactly, so my question is are you at all worried about what might happen with all of these new SNIPs suddenly producing HEDIS measures and the potential for first-time small plans to maybe not look so good, and are you worried about that, and if that happens, what do you think we can do?

Peggy O'Kane:

I am worried about the ability to deliver the data actually. I think, you know, this is a very rushed agenda and so, you know, we've had like a whole battle plan at NCQA to make sure we can do all this. So, you know, we're prepared, but when we know what we're meeting out there with some of these plans that have a hundred members or less and so forth, we are worried about that.

Now am I worried that the plans aren't going to look good? Not so much to be honest with you, because I think that I don't, you know, I don't think anybody's going to get kicked out in year one. I don't know about year two. I think that making sure that we're serious about this agenda is absolutely urgent. So I think that what this will do though is probably thin the numbers of special-needs plans. And, you know, small plans; I mean, can they do it? Yes, they can do it. You know, depending on what the resources are and so forth. But to put our fragile elderly in the hands of plans like this and pay them a lot of money, there is an expectation that they're going to be delivering some value. So I actually think it will be healthy just to understand what we're buying.

You know, we go to the drugstore; we're assuming that, you know, the FDA did its work. It's not perfect and it's changing actually. But this is a similar idea. We're putting the health of these seniors in the hands of these plans. We must understand how they are doing, and I expect that some organizations are going to do incredibly well and will hopefully thrive as a result. And others may say, "Well, this is just too hard. We didn't really realize what we were getting into," and maybe won't go forward. But I think that's actually a healthy thing.

Renee Rule:
Thank you.

Peggy O'Kane:
Any other questions? All right. I appreciate your attention and I hope you'll enjoy -- it looks like a wonderful program for the next couple of days. I hope you'll enjoy it. Thank you.

[applause]

[end of transcript]