Transparency in Health Care

by Andrea Trudeau

Team members deserve to know the quality and cost of their health care. Health care transparency provides team members with the information necessary, and the incentive, to choose health care providers based on value, quality and price.

Providing reliable cost and quality information empowers consumer choice. Consumer choice creates incentives at all levels, and motivates the entire system to provide better care for less money. Improvements will come as providers can see how their practice compares to others. Education will then help tribal members seek the appropriate care they need to increase the health and control the claims cost their tribal governments bear.

"Every American should have access to a full range of information about the quality and cost of their health care options."

- HHS Secretary Mike Leavitt

America's health care sector is shifting to a system where patients can get better information about the quality and cost of their care, ultimately encouraging competition to provide the best value, HHS Secretary Mike Leavitt reported on May 9, 2007 at a roundtable of key business, union, government, community, and health care leaders from across the U.S. "Consumers have extensive information to help them make good choices when they buy cars or get mortgages," Secretary Leavitt said. "But when it comes to choices about their health care, little information about quality or cost has been available.

Less than a year after launching his Value-Driven Health Care Initiative, Secretary Leavitt announced that more than 100 million Americans are now served by health plans that are committed to providing consumers with transparent quality and cost information. The federal government; half of the states; about 775 employers, including almost half of the top 200 U.S. corporations; and numerous unions, communities, doctors and hospitals have joined the movement.

In August of 2006, President Bush signed an Executive Order committing the federal government to the "four cornerstones" of value-driven care: health information technology, public reporting of provider quality information, public reporting of cost information, and incentives for value comparison. Since that time, Secretary Leavitt has traveled to 34 states to talk to communities that are piloting this approach, medical associations that are assisting in the development of quality information, businesses, unions, and other employers who are interested in implementing this approach for their employees.

Most plans that are committed to the value-based approach will embody the principles of value-driven care in their next contracting cycle, generally for 2008. And most enrollees in these plans are expected to have access to Web-based "report cards" on quality or cost within the next 12 months.

Progress toward a value-driven system is being made because of action across the spectrum of stakeholders:

- ***Employers:*** Currently, about 775 employers have committed their health plans to value-based, consumer information approaches, representing about 21 million employees and their families covered by company health plans. A total of 97 of the top 200 U.S. corporations, as well as 25 states and state employee health plans have committed to value-driven care.

- ***Federal Health Programs:*** Federal programs were committed to value-driven approaches under Executive Order 13410, signed by President Bush on August 22, 2006. These include approximately 43 million persons covered under Medicare, almost 5 million covered under the Department of Veterans Affairs, more than 8 million covered under Defense Department programs, about 3.5 million federal employees and families with insurance under the Federal Employees Health Benefits program, and more than 1 million Native Americans covered under the Indian Health Service. All federal programs that contract with health plans will include language in their next contracting cycle to incorporate consumer reporting and other value-driven features in their plans.

- ***Medicaid:*** So far, 18 states and the District of Columbia have committed to the initiative, representing more than 26 million enrollees.

- ***Health Plans:*** Companies that provide health insurance plans have been leaders in developing value-based approaches. This includes a growing number of Web-based "report card" products that make it easy to look up assessments of performance and costs by health care providers. Also included are tools to help patients learn more about their own conditions and details about their care and treatment options, as well as the estimated out of pocket cost. For example, Great-West Healthcare offers "Questions to ask your Doctor", to members considering elective surgery, on its Patient Navigator website.

- ***Providers and Regional Collaboratives:*** Of special importance is leadership by physicians, hospitals and other health care professionals in creating standards of care. Accurate and reliable standards can help deliver effective care to patients while also helping in the measurement of quality of care. As part of the initiative, a system of local and regional collaborative organizations

is being formed to bring providers, payers and others together to measure and report on quality and costs of care. However, compared with other industries, little quality and cost information has been available to health consumers until recently.

Measuring Quality

Health care is like any other service; some providers are better than others. Quality of care is of critical interest to patients; their health, even their lives, can be at stake. They need and deserve to know. Doctors want to know too.

Measuring health care quality is complex. As a medical discipline, it is still in the pioneering phase. Some professional health groups are already doing it. Organizations of insurers and health care providers have joined forces to create standards and measures for health care quality. Organizations involved include:

- AQA (formerly the Ambulatory Quality Care Alliance), which has steering committees focused on performance measurement, data aggregation and reporting.
- Hospital Quality Alliance (HQA), a reporting initiative providing information on the quality of care in hospitals.

Initial standards focus on physician services and hospital care. Claims and other data will be aggregated and used to measure specific providers against the standards. Under a Medicare initiative in six pilot cities - Boston, Indianapolis, Minneapolis, Madison, San Francisco, and Phoenix - community collaborations will apply and broaden the pilot efforts.

Comparing Hospitals

One of the first steps toward providing consumers with data on quality was created by the Centers for Medicare & Medicaid Services (CMS) and the HQA. The Hospital Compare site provides quality information from more than 4,000 hospitals on an initial set of conditions - heart attack, heart failure, pneumonia, and surgical infection prevention.

Hospital Compare shows how often hospitals provided the recommended care to get the best results for most patients. For instance, the site describes the recommended care for a heart attack, and consumers can see how often hospitals they are considering provided that care. New information, on patient satisfaction, treating asthma in children, and intensive care unit services, will be added to the Hospital Compare site as it becomes available.

Physician Services Standards

The AQA began in 2004 as an effort to create a method for measuring physician performance in ambulatory care and provide consumers with this information to help them make better choices. The original alliance members from the American Academy of Family Physicians, the American College of Physicians, America's Health Insurance Plans, and the Agency for Healthcare Research and Quality have now been joined by other supporting organizations, and the scope of the alliance's efforts has expanded to include all areas of physician care.

The fundamental principal to keep in mind is that through greater transparency, i.e. the education of team members about the actual cost and quality of health care, and by encouraging health care consumers to make more informed decisions, the result will be an overall decrease in health care costs while increasing the quality and customization of care. Those organizations with health clinics can also begin to capitalize on delivering a higher quality of care to the specific needs of their tribal members. Through the elimination of wasteful practices - including unnecessary doctor visits and unneeded medications or high cost drugs when alternatives are available - greater balance will be introduced to the programs offered and the rising costs of healthcare/claims for all entities will begin to be peeled back. ♣

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