NEW FRONTIERS IN QUALITY INITIATIVES

HEARING

BEFORE THE

SUBCOMMITTEE ON HEALTH

OF THE

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U.S. HOUSE OF REPRESENTATIVES

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CONTENTS

NEW FRONTIERS IN QUALITY INITIATIVES

THURSDAY, MARCH 18, 2004

U.S. HOUSE OF REPRESENTATIVES,
COMMITTEE ON WAYS AND MEANS,
SUBCOMMITTEE ON HEALTH,
Washington, DC.

The Subcommittee met, pursuant to notice, at 10:10 a.m., in room 1100, Longworth House Office Building, Hon. Nancy L. Johnson (Chairman of the Subcommittee) presiding.

[The advisory announcing the hearing follows:]

ADVISORY

FROM THE COMMITTEE ON WAYS AND MEANS

SUBCOMMITTEE ON HEALTH

FOR IMMEDIATE RELEASE
March 11, 2004
HL–6

CONTACT: (202) 225–3943

Johnson Announces Hearing on New Frontiers in Quality Initiatives

Congresswoman Nancy L. Johnson (R–CT), Chairman, Subcommittee on Health of the Committee on Ways and Means, today announced that the Subcommittee will hold a hearing on health quality initiatives. **The hearing will take place on Thursday, March 18, 2004, in the main Committee hearing room, 1100 Longworth House Office Building, beginning at 10:00 a.m.**

In view of the limited time available to hear witnesses, oral testimony at this hearing will be from invited witnesses only. Witnesses will include representatives from the Administration, the Medicare Payment Advisory Commission (MedPAC), and the private sector. However, any individual or organization not scheduled for an oral appearance may submit a written statement for consideration by the Committee and for inclusion in the printed record of the hearing.

BACKGROUND:

This hearing will focus on the changes needed to improve health care quality in America's health care systems. According to MedPAC, Medicare beneficiaries were affected by more than 300,000 adverse health events, such as postoperative sepsis and respiratory failure. In fact, from 1995 to 2002, rates of adverse events in 9 out of 13 categories tracked by MedPAC increased.

The United States Department of Health and Human Services (HHS) is developing, testing, and implementing new measures of the quality of care furnished by hospitals, nursing homes, and home health agencies. Building on the HHS work, the Medicare Modernization Act (MMA) included a provision whereby hospitals were given a financial incentive to report on 10 quality indicators, such as whether a patient with an acute myocardial infarction receives a beta blocker at admission. As of February 12, 2004, more than half (2,727) of all hospitals have committed to provide public reporting on the 10 measures.

In addition, physicians are encouraged by provisions in the MMA to use e-prescribing to reduce medical errors and to realize administrative efficiencies. In addition, hospitals are adopting technologies compatible with e-prescribing such as development of electronic medical records that capture patients' clinical histories and physician orders like laboratory tests and pharmacy. Accurate information allows caregivers to better deliver appropriate services at the right time.

These initiatives illustrate steps that may be taken to both improve quality of care and provide valuable information to patients and purchasers. Ultimately, this kind of information can be used to encourage the use of providers who deliver high-quality care while decreasing health costs.

In announcing the hearing, Chairman Johnson stated, "In the current technological environment, urging physicians to print neatly is not enough. We must provide market-oriented incentives that encourage the delivery of quality health care. Without good information, consumers cannot make intelligent choices between physicians, hospitals, or other providers, and better care will not advance."

FOCUS OF THE HEARING:

The MMA includes provisions designed to improve quality of care. Advances in the private sector may be instructive in incorporating additional methods in the Medicare program. The hearing will focus on what is known about the current state of health care quality, recent changes to the Medicare program, and what lessons can be learned from experiences in the commercial market. The first panel will examine public measures of quality and government initiatives to improve care. The second panel will discuss private initiatives and the importance of competition and comparative information to improve quality.

DETAILS FOR SUBMISSION OF WRITTEN COMMENTS:

Please Note: Any person or organization wishing to submit written comments for the record must send it electronically to *hearingclerks.waysandmeans@mail.house.gov*, along with a fax copy to (202) 225–2610, by close of business Thursday, April 1, 2004. In the immediate future, the Committee website will allow for electronic submissions to be included in the printed record. Before submitting your comments, check to see if this function is available. **Finally**, due to the change in House mail policy, the U.S. Capitol Police will refuse sealed-packaged deliveries to all House Office Buildings.

FORMATTING REQUIREMENTS:

Each statement presented for printing to the Committee by a witness, any written statement or exhibit submitted for the printed record or any written comments in response to a request for written comments must conform to the guidelines listed below. Any statement or exhibit not in compliance with these guidelines will not be printed, but will be maintained in the Committee files for review and use by the Committee.

1. Due to the change in House mail policy, all statements and any accompanying exhibits for printing must be submitted electronically to *hearingclerks.waysandmeans@mail.house.gov*, along with a fax copy to (202) 225–2610, in WordPerfect or MS Word format and MUST NOT exceed a total of 10 pages including attachments. Witnesses are advised that the Committee will rely on electronic submissions for printing the official hearing record.

2. Copies of whole documents submitted as exhibit material will not be accepted for printing. Instead, exhibit material should be referenced and quoted or paraphrased. All exhibit material not meeting these specifications will be maintained in the Committee files for review and use by the Committee.

3. Any statements must include a list of all clients, persons, or organizations on whose behalf the witness appears. A supplemental sheet must accompany each statement listing the name, company, address, telephone and fax numbers of each witness.

Note: All Committee advisories and news releases are available on the World Wide Web at *http://waysandmeans.house.gov*.

The Committee seeks to make its facilities accessible to persons with disabilities. If you are in need of special accommodations, please call 202–225–1721 or 202–226–3411 TTD/TTY in advance of the event (four business days notice is requested). Questions with regard to special accommodation needs in general (including availability of Committee materials in alternative formats) may be directed to the Committee as noted above.

Chairman JOHNSON. The hearing will come to order. I would like to open the hearing on new quality initiatives. While Americans enjoy one of the finest health systems in the world, there are some serious gaps in quality that may threaten patient safety and health outcomes. Providers are striving to improve quality for their patients but need better information and improved incentives to get the job done. The state of play in quality shows mixed results. According to Medicare Payment Advisory Commission (MedPAC),

Medicare beneficiaries were affected by more than 300,000 adverse health events, such as postoperative sepsis and respiratory failure. In fact from 1995 to 2002, rates of adverse events in 9 of 13 categories tracked by MedPAC increased.

In 1999, Congress required the Agency for Healthcare Research and Quality (AHRQ) to report annually to Congress on progress made toward improved health quality. The most recent report released in December found that, while 20 of 57 measures of quality tracked by the agency have improved, 37 have stagnated or worsened. According to the agency, most receive the care they need in many geographic areas, but we know low rates for primary and preventative care are abundant and vary widely across regions. Study after study by the Institute of Medicine, the RAND Corporation and others document the significant financial and health impact of avoidable medical errors and failure to adopt known best clinical practices. Medicare beneficiaries and disabled Americans suffer from chronic illness in larger numbers than any other groups, they use health services more frequently than their counterparts. They are disproportionately affected by these deficiencies.

Congress made great strides in the recently enacted Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) (P.L. 108–173) to improve quality for Medicare beneficiaries. First and foremost, seniors in both fee-for-service and managed care under Medicare will have access to chronic disease—chronic care management which holds the potential to dramatically improve health while reducing costs. Our hope is that Medicare will change from a payer of bills to a promoter of wellness. Secondly, the new law provides financial incentives for electronic prescribing. Too many avoidable illnesses and even deaths result from inappropriate or counter-indicated prescriptions. Electronic prescribing will dramatically reduce adverse drug interactions while promoting administrative efficiencies by reducing pharmacist callbacks to physicians. The law provides grants to physicians to implement these programs and allows plans to provide incentive payments to doctors for improving drug compliance.

Thirdly, the law requires development of formularies by practicing doctors and pharmacists, mandates drug utilization review and quality assurance and sets up a grievance and appeals process for off-formulary drugs. It expands the work of the Quality Improvement Organizations to Part C and D and requires the Institute of Medicine to evaluate and report on health care performance measures. Lastly, as a condition of receiving a full update for hospital services, the law requires the reporting of 10 quality indicators so that we have a baseline for hospital performance. The Administration has also made great strides, and I welcome Dr. Clancy from AHRQ to discuss their initiatives to improve quality. Specifically, the Administration will discuss data-reporting initiatives provided by hospitals, nursing homes, and home health agencies. These initiatives will make providers, consumers, and purchasers better informed about their health positions.

Finally, we want to learn from the work conducted by the private sector. Purchasing strategies, such as paying for performance, and improving information collection, and dissemination are important, and hopefully, we will be able to use their successful experience in

the private sector to improve public policy governing our seniors, both to improve the quality of care and to reduce its costs. Our distinguished panel includes experts from hospitals, consumer advocates, employers and health plans, and we look forward to their testimony. I also am very pleased to welcome Dr. Hackbarth of MedPAC for in their current report and also in their report of 6 months ago, they focused heavily on quality indicators and how Medicare specifically can move toward providing higher quality care to our seniors. Mr. Stark?

Mr. STARK. Well, Madam Chair, I want to thank you very much for having this hearing and once again to reopen a topic which I know you are very concerned about, and that is quality. Recent RAND studies suggest that adults receive appropriate care roughly only half of the time, resulting often in preventable deaths or more serious illness. I know that, and I have to talk about some philosophic things here and some budget things. I hope I can say this in a nonpejorative sense, but I think it would be fair to suggest that on your side of the aisle, many of your Members have trouble with government regulation.

I then get to this question of information technology (IT) for people like Dr. Hackbarth, Dr. Clancy, National Institute of Health, unless we are able to collect data and get everybody, I don't care whether it is the doctors and the chiropractors and the pharmacists, to agree on a format and a system, we aren't ever going to get anywhere. That means that I am going to have to help you to do whatever you need to do to convince your Members that there are—I have three credit cards here. I can walk into a store and put one in to get money out, and it will say, "You are a bum." So, I could put the other credit card in to another bank on the other side, and they still know I am a bum. Yet, we can't do that when going in to buy a prescription. If I go in to RiteAid, they may not have the same information as Walgreens Co. Somehow I think you have to take the lead to create the atmosphere in the community where we are going to have standardized reporting and standardized forms, and I assure you that I will do whatever I can to make that an easier task for you.

I want to, also, while I did vote against the Medicare bill, it did include $50 million for AHRQ. I don't believe your budget includes it, and I bet ours doesn't either. I would like to help if I can to see if we can get that $50 million. It wasn't in the Bush budget. I don't know if it is in the House Republican budget. I am not at all sure that it is in the Democratic budget, because it is one of those things that often falls through the cracks—but I would pledge, if you want to continue to push for that, to try and get that $50 million for our friends at AHRQ who do such a good job, and I am pleased to see Dr. Clancy here. I want to help, and I am sure that my colleagues will help on our side in any way we can. You have to lead it. It is going to be your group that is going to have to approve both the legislation and push it through or add it someplace if we can do it, and we certainly intend to help you in every way we can. Thank you again for the hearing.

Chairman JOHNSON. Thank you very much, Mr. Stark, and we certainly will have to make sure the $50 million is there.

Mr. STARK. I would also like to ask unanimous consent to put a much more eloquent statement that my staff wrote in the record.

[The opening statement of Mr. Stark follows:]

Opening Statement of The Honorable Pete Stark, a Representative in Congress from the State of California

Thank you Madam Chair.

I am very pleased that we are again talking about quality healthcare and hope this year we can begin again to work together to ensure those who actually have access to healthcare services get the best quality of care possible. While the U.S. is first in healthcare spending relative to other countries, many of our health indicators (e.g., life expectancy, etc.) fall short. This suggests we could be getting more bang for the U.S. healthcare buck.

In fact, a recent RAND study suggests that adults receive appropriate care roughly half of the time, resulting in serious threats to the health of the American public that could contribute to thousands of preventable deaths in the United States each year. Fortunately there are some very innovative ideas under discussion that could have a real positive effect on patient care and outcomes.

Advances in information technology have been widely utilized in other sectors of the economy, but healthcare continues to lag behind in implementing technology that is shown to improve quality and efficiency. Electronic medical records, computerized physician order entry and clinical decision support programs can all increase quality. We need to find a way to ensure that providers implement these kinds of technological advances, and I hope some of our witnesses today will have ideas on how we can improve quality through the use of information technology.

We have talked about adopting pay-for-performance policies for years, and it finally seems like purchasers and providers are catching on. Physicians and other providers will improve quality if reimbursement is tied to specific clinical and service measures. I think the Medicare program can truly lead the market in this respect, and I hope we can learn from the Premiere demonstration project and create a broad pay-for-performance program in the near future. I look forward to MedPAC's testimony on this topic and want to recognize their efforts to advance this debate.

In addition, a discussion about quality of care would not be complete without talking about the use of evidence-based medicine to improve clinical practice. Though I voted against the Medicare bill, it did include $50 million for AHRQ (ark) to study the comparative clinical effectiveness of healthcare services and prescription drugs. The Bush budget, however, does not include money for this program, jeopardizing an important area of research that could lead to improved quality through evidence-based practice standards and lower costs.

Finally, I want to say that I am pleased to see Dr. Clancy here. Our Committee has an important historic relationship to your agency that has been under-utilized in recent years. AHRQ is conducting and supporting a lot of important research on quality, innovation and cost of healthcare that can be used to improve Medicare and other public and private programs. I hope we will renew and strengthen our ties to the agency in the future.

I look forward to hearing from all of our witnesses today, and hope to work together with many of you on an ongoing basis to improve healthcare quality.

Chairman JOHNSON. So acknowledged. Also on the issue of standards for technology and standards for meeting, for demonstrating quality, I think we will learn a lot about that in this hearing, and I think a number of avenues of action will be clear to us. I do have a very advanced legislative initiative in the area of technology and standards, but there are a lot of things we will be able to work on. That is why we are having this hearing. This is a totally bipartisan issue, and we thank you all for being with us today. Actually, I don't know protocol. Dr. Clancy?

STATEMENT OF CAROLYN CLANCY, DIRECTOR, AGENCY FOR HEALTHCARE RESEARCH AND QUALITY, U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES

Dr. CLANCY. Good morning, Chairman Johnson, Congressman Stark and distinguished Subcommittee Members. Thank you for inviting me to testify at this important hearing on initiatives to improve the quality of health care in America. We know that challenges exist in making sure all Americans receive the high quality healthcare services they deserve, and I want to assure you that addressing those challenges is a top priority for President Bush, Secretary Thompson and the entire U.S. Department of Health and Human Services (HHS). My written testimony, which I am pleased to submit for the record, details numerous examples of current HHS quality improvement activities, especially those affecting Medicare beneficiaries and people enrolled in Medicaid and the State Child Health Insurance Program (SCHIP).

I want to take a few minutes to highlight some examples of these activities. The mission of AHRQ is to improve the quality, safety, efficiency and effectiveness of health care for all Americans. We help achieve that goal by sponsoring research and other programs that target the quality challenges we face and develop the tools and resources to overcome them. Thus we are health care problem solvers working with doctors, nurses, patients, purchasers, hospital administrators, States and others to help them make the critical health care decisions they face every day. This work includes assisting our colleagues at Centers for Medicare and Medicaid Services (CMS) responsible for managing the Medicare and Medicaid programs as well as working with beneficiaries themselves. Because the vast majority of physicians and hospitals provide care to both publicly and privately insured people, close collaboration between the public and private sectors in assessing and improving quality of care is not just a nice idea, it is actually essential. You can't have providers confronting two sets of requirements.

That kind of collaboration is at the heart of how we operate at AHRQ and throughout the Department. The private sector can benefit from public investments in science measures and tools as well as the power of CMS as a purchaser while the public sector can learn from the private sector's flexibility and capacity for innovation in delivering health care. Hospitals and other health care facilities often struggle with how to collect information to gauge the quality of their services, as Mr. Stark noted. To address that problem, AHRQ has developed a family of measures sometimes called indicators that address key aspects of care. These indicators can be used with other information hospitals already are collecting to help them monitor their performance, compare how they are doing with other facilities in their State or region and to make improvements when needed.

The investment required to develop these indicators is not one that hospitals can shoulder alone, but once the indicators are available, hospitals have the capacity in place to use them, and we are very pleased they were included in the MedPAC report. In the critical area of patient safety, we are helping to find out more about how and when medical errors occur and how science-based information can help make the health care system safer. This has resulted

in reports like the one we produced highlighting 73 proven patient-safety practices that would help improve quality by reducing medical errors across the health care system. Specifically, the report identifies 11 practices that are known to work but are not routinely used in the Nation's hospitals and nursing homes. I am very pleased this has become a blueprint or a starting point for many organizations as they start their safety efforts.

To help get all of this information to people in the field who can speed up the process of quality improvement, we have developed innovative strategies to share new findings about safety and quality of care. For example, we sponsor monthly web-based medical journals that showcase patient-safety issues drawn from actual cases of what are referred to as near misses. This online journal allows busy health care professionals to learn right at their own computers and benefit from insights beyond their own institutions and also get CMS credit for doing so. In general, IT, including computerized order-entry systems, computer monitoring for potential adverse drug effects and handheld electronic devices for electronic prescribing has shown tremendous promise in reducing errors and improving safety.

The President's fiscal year 2005 request for AHRQ includes $84 million for patient safety, and $50 million of that will be focused on helping hospitals and other health care organizations invest in these new technologies in evaluating their impact on quality and safety. This funding particularly targets small communities in rural hospitals which often don't have the resources or the information needed to implement cutting-edge technologies like the ones mentioned.

The CMS is spearheading a number of equally ambitious and important quality-of-care activities. Under Secretary Thompson's leadership, HHS launched the Secretary's Quality Initiative in 2001, focused on achieving better quality of care in nursing homes, home health care and in hospitals. In general, the initiative is built on ensuring that Americans receive high-quality health care in these settings through improved information for consumers coupled with the implementation of specific improvement strategies implemented either directly or through Medicare's quality improvement organizations. The Nursing Home Quality Initiative is a four-pronged effort which involves, first, regulation and enforcement efforts conducted by CMS and State survey agencies; second, community-based quality-improvement efforts; third, collaboration with nursing home experts; and fourth, hosting nursing home performance information on CMS's Nursing Home Compare website.

In our role as problem solvers, AHRQ is assisting by putting together research findings that can help with the quality-improvement piece. For example, a recent AHRQ study found that educational programs targeted at nurses and doctors can reduce the use of drugs like nonsteroidal anti-inflammatory drugs and substitute Tylenol so the patients can avoid serious complications from the nonsteroidal drugs. The Home Health Quality Initiative uses a similar four-pronged approach. On the Hospital Quality Initiative, also known as the Voluntary Hospital Reporting Initiative, CMS has worked closely with the American Hospital Association, the Federation of American Hospitals, the American Association of

Medical Colleges, American Association of Retired Persons (AARP), the American Federation of Labor-Congress of Industrial Organizations (AFL–CIO) and others to help expand the information available to consumers on health care hospital quality.

The AHRQ is a close partner in this initiative working side-by-side with CMS to develop a new standardized survey that hospitals can use to find out patients' perspectives on the care they receive. This new survey is based on AHRQ's successful Consumer Assessment of Health Plans (CAHPS) project, so the new survey will be called Hospital CAHPS (H–CAHPS) and will help consumers make more informed choices about the hospitals they use and create further incentives for hospitals to improve the quality of care they provide.

More recently, provisions in the MMA will further enhance CMS's quality-improvement activities. MMA, includes provisions designed to encourage the delivery of high-quality care, especially through demonstration projects focused on improving care for people with chronic illness, where we provide the worst care and spend the most money, as well as identifying effective approaches for rewarding superlative performance. We are particularly excited by provisions in the MMA to improve chronic illness care through disease management care and pay for performance demonstrations, and AHRQ is working very closely with CMS on these initiatives.

It is important to note that as significant as all of these Federal efforts are, the public sector can't improve quality of care on its own. I am very pleased to report that the private sector is very involved and, in some cases, leading the way on the issue of health care quality, particularly in hospitals. We are working closely with them to make sure that our efforts are synergistic and complementary. We have attempted to further these private-sector initiatives through grants and other kinds of support. For example, AHRQ sponsors a program called Partnerships for Quality, which includes a grant to the Leapfrog Group, a consortium of more than 135 large health care purchasers that buy benefits for more than 35 million Americans. Our support is helping the Leapfrog Group continue exploring how purchasers can create incentives for quality improvement through their contracts with providers and plans.

We have also recently developed a partnership with the American Hospital Association and the American Medical Association to distribute evidence-based information on what patients and their families can do to help improve patient safety of care right now while we are waiting for better information. I have brought you copies of posters that describe the five steps to safer health care. Again, I want to thank you for inviting me to discuss with you today the important issue of health care quality and the initiatives that HHS has underway to improve quality of care. I look forward to answering any questions.

[The prepared statement of Dr. Clancy follows:]

Statement of Carolyn Clancy, M.D., Director, Agency for Healthcare Research and Quality, U.S. Department of Health and Human Services

Chairman Johnson, Congressman Stark, distinguished Subcommittee members, thank you for inviting me to this important hearing on initiatives to improve the quality of health care in America. Quality health care for all people is a high priority for President Bush and the Department of Health and Human Services (HHS).

Quality health care is a statutory responsibility for my agency, the Agency for Healthcare Research and Quality (AHRQ), and it is a key area of emphasis for the Centers for Medicare & Medicaid Services (CMS).

My testimony today will address three areas: first, current activities of the Department to improve the quality of care, including the use of health information technology; second, the significant provisions of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) that both build upon and advance our efforts to improve the quality of health care; and finally, I will provide a brief overview of private sector quality initiatives.

I. THE DEPARTMENT'S QUALITY INITIATIVES

Under Secretary Thompson's leadership, the Department has developed a variety of quality initiatives involving hospitals, doctors, skilled nursing facilities, and other providers. The Secretary has also placed great emphasis on our different agencies functioning as "one Department"; as my testimony will outline, this has meant that AHRQ is increasingly serving as a science partner to CMS in its many quality initiatives.

AHRQ QUALITY OF CARE INITIATIVES

AHRQ's specific mission is to improve the quality, safety, and effectiveness of health care for all Americans. To fulfill our role as a science partner for CMS and State initiatives to improve quality, I believe that AHRQ must become a true "problem solver." We must marshall existing and develop new scientific evidence that targets the critical challenges these programs face in improving the quality of health care they provide and the efficiency with which they operate. My goal as Director is to ensure that AHRQ's work is useful to those who manage these programs so that the taxpayers receive true value for their tax dollars and to those who rely upon these programs so that they receive appropriate, high quality care. There are four aspects of AHRQ's work that I will discuss: research to support evidence-based decisionmaking, using data to drive quality, accelerating the pace of quality improvement, and improving the infrastructure for quality health care.

Research to Support Evidence-based Decisionmaking

AHRQ's research seeks to improve quality by developing and synthesizing scientific evidence regarding two aspects of health care: the effectiveness and quality of clinical services and the effectiveness and efficiency of the ways in which we organize, manage, deliver and finance health care. With respect to clinical services, we assess the effectiveness of health care interventions; for example, do Medicare beneficiaries with multiple chronic illnesses benefit as much in daily practice from a new intervention or drug as those in the clinical trial who usually have only one problem? We also look at comparative effectiveness: how effective is a given intervention versus the alternatives and what are the comparative risks and side effects? These are critical issues for physicians making treatment recommendations and for patients who are in the best position to assess the risks they are willing to take. For example, cholesterol lowering drugs—commonly called "statins"—have different safety and effectiveness profiles. Comparative studies with statins could have revealed that some are more likely to cause a serious life threatening adverse event instead of relying upon adverse event reports that eventually caused one of them to be taken off the market.

In addition, every aspect of the financing and delivery systems for health care can matter. Our research asks similar questions in those areas: what is effective, how does it compare with other strategies, what is most efficient and what are the risks of unintended consequences. Currently, we are completing two research syntheses that focus on what research tells us needs to be taken into account in implementing an insurance drug benefit and how employers have responded and could respond to increases in health insurance costs.

Our work in patient safety is an excellent example of how improving the quality and safety of health care involves both health care services and the systems through which care is received. Our research is addressing key unanswered questions about when and how medical errors occur and how science-based information can make the health care system safer. We know, for example, that medication errors are a major issue and have made research on the safe and appropriate use of pharmaceuticals a significant focus of our research agenda. For example, a recent research finding has identified a disturbingly large number of pregnant patients receiving prescriptions for drugs that are contra-indicated during pregnancy. We are working with the FDA and other HHS agencies to develop collaborative strategies for addressing this problem. At the same time, medication errors also result from faulty work flow procedures or unnecessarily complicated equipment. Once again, we are working closely with the FDA on research on the processes related to medication

prescribing and delivery, the use of information technology, development of an effective bar coding system, and "human factors research." This is a field of science that can inform the design of health care equipment, like infusion pumps, to ensure that busy, distracted, and tired health care workers are less likely to make an error in entering the information for delivery of an intravenous drug.

Health care decisionmakers need a synthesis of the best evidence that is understandable, objective, and places the ever-increasing number of scientific studies in context. AHRQ is committed to accelerating the adoption of science into practice so that all Americans benefit from advances in biomedical science. An example in the patient safety area is our evidence report, titled *Making Health Care Safer, A Critical Analysis of Patient Safety Practices*. This report highlighted 73 proven patient safety practices which would help health care administrators, medical directors, clinicians, and others improve quality by reducing medical errors. Specifically, the report identified 11 practices that are proven to work but not used routinely in the Nation's hospitals and nursing homes.

It is also critical that we foster ongoing learning from experts in the field to expedite quality improvement. For example, a critical challenge in making health care safer is that providers do not share lessons learned from errors and near misses due to fear of liability. To help health care professionals benefit from insights beyond their home institutions, AHRQ is sponsoring a monthly, Web-based medical journal that showcases patient safety lessons drawn from actual cases of near-errors. This unique online journal allows health care professionals to learn about avoidable errors made in other institutions, as well as effective strategies for preventing their recurrence. One case each month is expanded into a "Spotlight Case" that includes an interactive learning module that features readers' polls, quizzes, and other multimedia elements. Practicing physicians may obtain continuing medical education credit by successfully completing the spotlight case and its questions, and trainees can receive certification credits for doing so.

Using Data to Drive Quality

To improve quality, you need strong measures, good data, and somebody with strong reason to use them. Responding to user needs, AHRQ has played a fundamental role in creating the measures and the data. I'll give you two examples. The first focuses on hospital care. In response to requests by state hospital associations, state data organizations and others, AHRQ developed a set of Quality Indicators which can be used in conjunction with any hospital discharge data to let a hospital know how it is doing in terms of safety and quality. A subset of these indicators also lets us use information about hospital admissions to assess the performance of the health system of the community. At the same time, employers, CMS and others who wish to reward good-quality hospitals can use these measures with data from particular hospitals or regions. Or they can use the module on preventable admissions to target and launch major health improvement efforts on a community-wide scale. These indicators have been used by a number of states and communities to improve care and to determine how their own hospital or health system's performance compares to other hospitals in key areas. We have a support contract to make this easy for all users.

A second example has to do with improving the patient experience of care, a widely recognized component of overall quality. Several years ago, AHRQ created a survey, CAHPS, which health plans could use to question patients about their care experience. CAHPS is now an easy to use kit of survey and reporting tools that provides reliable information to help consumers and purchasers assess and choose among health plans, providers and other health facilities. The first CAHPS surveys, which assessed consumers' perceptions of the quality of health plans, are used by more than 100 million Americans, including those in Medicare managed care plans, enrollees in the Federal Employees Health Benefits Program, and participants in the Department of Defense's health programs.

An H–CAHPS survey built on AHRQ's earlier work in establishing surveys and will measure the hospital care of those patients' involved in the pilot. The survey is being considered by CMS as part of the National Voluntary Hospital Reporting Initiative. CMS has received comments and has lessons learned from the pilots, which could be helpful in working with AHRQ to develop a standardized H–CAHPS.

AHRQ is stepping up its efforts to provide assistance, often web-based, for those who are seeking to improve the quality of patient care. For example:

- AHRQ recently launched a web-based clearinghouse [*QualityTools™.gov*] providing practical tools for assessing, measuring, promoting and improving the quality Americans' health care. The site's purpose is to provide health care providers, policymakers, purchasers, patients, and consumers an accessible mecha-

nism to implement quality improvement recommendations and easily educate individuals regarding their own health care needs.

- In addition, AHRQ is helping patients and their families improve the quality of the health care they receive and play an important role in preventing medical errors. AHRQ and CMS collaborated on a campaign to promote new "5 Steps to Safer Health Care" posters. In addition, campaigns with the American Hospital Association, the American Academy of Pediatrics, American Medical Association, and AARP are working to implement evidence-based information that help patients know how talk to clinicians about safe health care.
- While the text of AHRQ's recent reports, *National Healthcare Quality Report* and the *National Healthcare Disparities Report*, are currently available on the web, AHRQ is developing a more sophisticated search engine that will enable those seeking to improve the quality of care at the local or state level to link to the myriad of charts and data that are summarized in the report. Over time we expect this to be an indispensable tool for those seeking to develop a "road map" for their own quality improvement efforts.

Accelerating the Pace of Quality Improvement

To accelerate the pace of quality improvement, AHRQ has launched a program called *Partnerships for Quality*. The purpose of the Partnerships program is to support models or prototypes of change led by organizations or groups with the immediate capacity to influence the organization and delivery of health care as well as measure and evaluate the impact of their improvement efforts. For example, AHRQ has awarded a grant to The Leapfrog Group, which is a consortium of more than 135 large private and public health care purchasers buying health benefits for more than 33 million Americans. Leapfrog has devised a plan for conducting and rigorously evaluating financial incentive or reward pilots in up to 6 U.S. healthcare markets in two waves over the next three years.

Another approach to accelerating quality improvement is to involve health care system leaders in the research enterprise itself from the outset. AHRQ currently has three delivery-based networks that follow this approach. The Primary Care-Based Research Network is a group of 19 primary care networks across the country that do research collaboratively on ways to improve preventive care and other issues of interest to primary care providers. The HIV Research Network is a network of 22 large and sophisticated HIV care providers around the country who share information and data so that they can learn from each other what can work to improve quality. They also provide timely aggregate information to policymakers and other providers interested in improving quality and answering other questions about access and cost of care for people with HIV. Through the work of this network and other large HIV care providers, for example, AHRQ is looking to identify and remedy major causes of prescribing errors for patients with HIV.

A third network, the Integrated Delivery System Research Network (IDSRN), is a field-based research network that tests ways to improve quality within some of the most sophisticated health plans, systems, hospitals, nursing homes, and other provider sites in the country. In the past year for example, provider-researcher teams have been working on ways to reduce falls in nursing homes, and ways to limit medication errors. Often we partner with others in the Department on these efforts. For example, CMS asked us for a handbook on ways to improve cultural competency of health care providers, and is now using this handbook as the key part of their training for Medicare and Medicaid providers. One of our contractors developed a tool to help hospitals prepare for bioterrorist events and other emergencies, and the American Hospital Association has since shared this tool with all of their members and in fact provide technical assistance on how to use it.

Improving the Infrastructure for Quality Health Care

Two critical elements for improving the quality and safety of patient care are expanding the use of information technology (IT) and investing in human capital. The most recent report from the Institute of Medicine's quality chasm series emphasizes the need for improved information at the point of care and the deployment of the still developing National Health Information Infrastructure (NHII) to improve patient safety and quality of care, for which HHS has the lead Federal role working with the private sector. Both AHRQ and ASPE have several initiatives underway to advance the adoption and appropriate use of IT tools and enable the secure and private exchange of information within and across communities.

In FY 2004, AHRQ has launched a new initiative to improve health care quality and reduce medical errors through the use of information technology. AHRQ will award $50 million to help hospitals and other health care providers invest in information technology designed to improve patient safety, with an emphasis on small

communities and rural hospitals and systems, which don't often have the resources or information needed to implement cutting-edge technology. An important aspect of this program is that it will foster the implementation of proven technology through the health care system and establish important building blocks for the NHII.

As the NHII is developed, it will enable appropriate access to important patient information and evidence to assist clinicians in making diagnostic and treatment decisions that are based on the best available science. If a Medicare beneficiary typically receives care from an internist and specialist in Connecticut for 6 months of the year but has different physicians in Florida during the winter, their medications, labs, x-rays and other important health information would be available to all their physicians at any point in time. This will allow clinicians to provide continuous high quality of care regardless of where a beneficiary accesses the health care system. While the intention of HHS is to facilitate the development of the NHII, we recognize that the most realistic strategy is to foster and support community-based health information exchanges with the ability to share information within and across communities nationally over time. In addition, the FY 2005 Budget requests a new $50 million within the Office of the Secretary to support communities with the development of these health information exchanges in FY 2005 and disseminating lessons learned to ensure the success and long-term viability of these local efforts across the country.

Another infrastructure issue is the ability to share health information in ways that enable us to make significant strides towards improving patient safety, reducing error rates, lowering administrative costs, and strengthening national public health and disaster preparedness. To share health data, agencies need to adopt the same clinical vocabularies and the same ways of transmitting that information. This sharing information within and between agencies establishes "interoperability." Public and private groups have emphasized how interoperability through standards will enable us to share a common electronic patient medical record and in turn greatly improve the quality of health care. The Consolidated Health Informatics (CHI) initiative will establish a portfolio of existing clinical vocabularies and messaging standards enabling Federal agencies to build interoperable Federal health data systems. This commonality will enable all Federal agencies to "speak the same language" and share that information without the high cost of translation or data re-entry. Federal agencies could then pursue projects meeting their individual business needs aimed at initiatives such as sharing electronic medical records and electronic patient identification. CHI standards will work in conjunction with the Health Insurance Portability and Accountability Act (HIPAA) transaction records and code sets and HIPAA security and privacy provisions. Many departments and agencies including HHS, VA, DOD, SSA, GSA, and NIST are active in the CHI governance process.

Even when the best tools available are used appropriately, achieving consistent high quality care requires a solid understanding of the delivery process and inherent risks in the system that will never be mitigated through automation. In recognizing the importance of intellectual component of quality improvement, AHRQ recently established the AHRQ–VA Patient Safety Improvement Corps, a training program for state health officials and their selected hospital partners. During the first annual program, 50 participants will complete coursework in three 1-week sessions at AHRQ's offices in Rockville, MD. Participants will analyze adverse medical events and close calls—sometimes known as "near misses"—to identify the root causes of these events and correct and prevent them. Anticipating that the growing demand for patient safety expertise will exceed the capacity of this intensive program, one aspect of this initiative will be to develop web-based training modules. These will be in the public domain and could be used independently or by private sector training programs that would provide additional "hands on" experiences.

CMS QUALITY OF CARE INITIATIVES

In November 2001, Secretary Thompson announced the Quality Initiative, a commitment to assure quality health care for all Americans through published consumer information coupled with health care quality improvement support through Medicare's Quality Improvement Organizations (QIOs). The Quality Initiative was launched nationally in 2002 as the Nursing Home Quality Initiative and expanded in 2003 with the Home Health Quality Initiative and the National Voluntary Hospital Quality Reporting Initiative. The CMS Physician Focused Quality Initiative (PFQI) began its implementation this year. Most leaders in health care recognize that achieving the safest and highest quality of care will require significant enhancements in the use of health information technology and strategies to permit sharing of patient data within communities. In FY04 and FY05 the Department will

invest $150 million. In addition, the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) includes a variety of provisions designed to encourage the delivery of quality care, including demonstrations to focus effort on improving chronic illness care and identifying effective approaches for rewarding superlative performance.

Nursing Homes

About 3 million elderly and disabled Americans received care in our nation's nearly 17,000 Medicare and Medicaid-certified nursing homes in 2001. Slightly more than half of these were long-term nursing home residents, but nearly as many had shorter stays for rehabilitation care after an acute hospitalization. About 75 percent were age 75 or older. As part of an effort to improve nursing home quality nationwide, the Administration has taken a number of steps, including the Nursing Home Quality Initiative. Working with measurement experts, the National Quality Forum, and a broad group of nursing home industry stakeholders—consumer groups, unions, patient groups and nursing homes—CMS adopted a set of nursing home quality measures and launched a six-state pilot. Encouraged by the success of the pilot, CMS expanded the Nursing Home Quality Initiative to all 50 States in November 2002. This quality initiative is a four-pronged effort including, regulation and enforcement efforts conducted by CMS and state survey agencies; continual, community-based quality improvement programs; collaboration and partnership with stakeholders to leverage knowledge and resources; and improved consumer information on the quality of care in nursing homes.

As part of the effort, consumers may compare quality data, deficiency survey results and staffing information about the nation's Medicare and Medicaid-certified nursing homes through the Nursing Home Compare website, which is updated quarterly. The quality measures included on the site help consumers make informed decisions involving nursing homes. The Nursing Home Compare tool received 9.3 million page views in 2003 and was the most popular tool on www.medicare.gov.

Home Health

In 2001, about 3.5 million Americans received care from nearly 7,000 Medicare certified home health agencies. These agencies offer health care and personal care to patients in their own home, often teaching them to care for themselves. Launched nationwide in November 2003, the Home Health Quality Initiative aims to further improve the quality of care given to the millions of Americans who use home health care services. The initiative combines new information for consumers about the quality of care provided by home health agencies with important resources available to improve the quality of home health care. Like the Nursing Home Quality Initiative, the Home Health Quality Initiative uses the same "four-pronged" approach to regulate the industry, ensure consumers have improved access to information, utilize community-based quality improvement programs, and collaborate with the relevant stakeholders to access resources and knowledge for home health agencies. CMS' regulation and enforcement activities will assure that home health agencies comply with Federal standards for patient health, safety, and quality of care. In March 2004, CMS updated the eleven home health quality measures on every Medicare-certified home health agency to give consumers the ability to compare the quality of care provided by the agencies. To access the information, consumers can call 1–800–Medicare or use the Home Health Compare tool at www.medicare.gov. Over the past six months, the tool has been viewed about 780,000 times.

Hospitals

The Hospital Quality Initiative consists of the National Voluntary Hospital Reporting Initiative (NVHRI), a public-private collaboration that reports hospital quality performance information, a three state pilot of the Hospital Patient Perspectives on Care Survey (HCAHPS), and the Premier Hospital Quality Incentive Demonstration. The Hospital Quality Initiative, is more complex, and consists of more developmental parts than the nursing home and home heath quality initiatives. The initiative uses a variety of tools to stimulate and support a significant improvement in the quality of hospital care. The initiative aims to refine and standardize hospital data, data transmission, and performance measures in order to construct a single robust, prioritized and standard quality measure set for hospitals. The ultimate goal is that all private and public purchasers, oversight and accrediting entities, and payers and providers of hospital care would use the same measures in their public reporting activities. The initiative is intended to make critical information about hospital performance accessible to the public and to inform and invigorate efforts to improve quality. Among the tools used to achieve this objective are collaborations with providers, purchasers and consumers, technical support from Quality Improve-

ment Organizations, research and development of standardized measures, and commitment to assuring compliance with our conditions of participation.

National Voluntary Hospital Reporting Initiative

The National Voluntary Hospital Reporting Initiative (NVRI) was launched in 2003 in conjunction with the American Hospital Association, Federation of American Hospitals, American Association of Medical Colleges, and other stakeholders (AARP, AFL–CIO). The NVRI was established to provide useful and valid information about hospital quality to the public, standardize data and data collection, and foster hospital quality improvement. For the previous initiatives, CMS had well-studied and validated clinical data sets and standardized data transmission infrastructure from which to draw a number of pertinent quality measures for public reporting. Hospitals do not have a similar comprehensive data set from which to develop the pertinent quality measures. Thus, the American Hospital Association, the Federation of American Hospitals and the Association of American Medical Colleges approached the Joint Commission on Accreditation of Healthcare Organizations, the Agency for Healthcare Research and Quality, the National Quality Forum and CMS to explore voluntary public reporting of hospital performance measures. CMS contracted with the National Quality Forum (NQF) to develop such a consensus-derived set of hospital quality measures appropriate for public reporting. We selected 10 measures from the NQF consensus-derived set as a starter set for public reporting and quality improvement efforts and an additional 24 measures from the set for the hospital quality incentive demonstration. CMS has worked with the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) and the QIOs to align their hospital quality measures to ease the data transmission process for hospitals. This information is currently displayed on the CMSI website and updated quarterly.

Hospital Patient Perspectives on Care Survey (HCAHPS)

Although many hospitals already collect information on their patients' satisfaction with care, there currently is no national standard for measuring and collecting such information that would allow consumers to compare patient perspectives at different hospitals. CMS worked with the Agency for Healthcare Research and Quality (AHRQ) to pilot test Hospital Patient Perspectives on Care Survey, known as HCAHPS. The HCAHPS survey built on AHRQ's success in establishing surveys measuring patient perspectives on care in the United States health care system through the development of CAHPS for health plans. CMS has received comments and has lessons learned from the pilots, which could be helpful in working with AHRQ to develop a standardized H–CAHPS.

Premier Hospital Quality Incentive

The Premier Hospital Quality Incentive demonstration project also is part of the Hospital Quality Initiative. This three-year demonstration project recognizes and provides financial rewards to hospitals that demonstrate high quality performance in a number of areas of acute care. The demonstration involves a CMS partnership with Premier Inc., a nationwide purchasing alliance of not-for-profit hospitals, and rewards the hospitals with the best performance by increasing their payment for Medicare patients. There are approximately 280 hospitals participating in the project. Under the demonstration, top performing hospitals will receive bonuses based on their performance on evidence-based quality measures for inpatients with heart attacks, heart failure, pneumonia, coronary artery bypass graft, and hip and knee replacements. The 34 quality measures used in the demonstration have an extensive record of validation through research.

Using these measures, CMS will identify hospitals in the demonstration with the highest clinical quality performance for each of the five clinical areas. Hospitals in the top 20 percent of quality for those clinical areas will be given a financial payment as a reward for the quality of their care. Hospitals in the top decile of hospitals for a given diagnosis will be provided a 2 percent bonus for the measured condition, while hospitals in the second decile will be paid a 1 percent bonus. In year three, hospitals that do not achieve performance improvements above the demonstration baseline will have their payment reduced. The demonstration baseline is set during the first year of the demonstration. Hospitals will receive a 1 percent reduction in their DRG payment for clinical conditions that score below the ninth decile baseline level and 2 percent less if they score below the tenth decile baseline level.

Physician Focused Quality Initiative

Similar to the Hospital Quality Initiative, the CMS Physician Focused Quality Initiative (PFQI) has several components with multiple approaches to stimulating the adoption of quality strategies and potentially reporting quality measures for

physician services. The Physician Focused Quality Initiative builds upon ongoing CMS strategies and programs in other health care settings in order to: (1) assess the quality of care for key illnesses and clinical conditions that affect many Medicare beneficiaries, (2) support clinicians in providing appropriate treatment of the conditions identified, (3) prevent health problems that are avoidable, and (4) investigate the concept of payment for performance.

Doctors' Office Quality (DOQ) Project

The DOQ Project is designed to develop and test a comprehensive, integrated approach to measuring and improving the quality of care for chronic diseases and preventive services in the outpatient setting. CMS is working closely with key stakeholders such as nationally recognized physicians associations, consumer advocacy groups, philanthropic foundations, purchasers, and quality accreditation or quality assessment organizations to develop and test the DOQ measurement set. The DOQ measurement set has three components including a clinical performance measurement set, a practice system assessment survey, and a patient experience of care survey.

Doctors' Office Quality—Information Technology (DOQ–IT) Project

CMS recognizes the potential for information technology to improve the quality, safety and efficiency of health care services. Through the DOQ–IT project, CMS is working to support the adoption and effective use of information technology by physicians' offices to improve the quality and safety for Medicare beneficiaries. DOQ–IT seeks to accomplish this by promoting greater availability of high quality affordable health information technology and by providing assistance to physician offices in adopting and using such technology.

Payment Demonstration Projects

CMS continues to examine financial incentives for physicians that demonstrate higher quality performance. This approach includes the Physician Group Practice demonstration that tests a hybrid methodology for paying physician-driven organizations that combine Medicare fee-for-service payments with a bonus pool derived from savings achieved through improvements in the management of care and services.

ESRD Quality Activities

BBA required CMS to develop and implement, by January 1, 2000, a method to measure and report the quality of renal dialysis services provided under the Medicare program. To implement this legislation, CMS funded the development of clinical performance measures (CPMs) based on the National Kidney Foundation's Dialysis Outcome Quality Initiative Clinical Practice Guidelines. Sixteen ESRD CPMs (five for hemodialysis adequacy, three for peritoneal dialysis adequacy, and four for anemia management) were developed and are used for quality improvement purposes through the ESRD Networks.

II. QUALITY PROVISIONS UNDER THE MMA

The Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) includes a variety of provisions designed to encourage the delivery of quality care, including demonstrations to focus effort on improving chronic illness care and identifying effective approaches for rewarding superlative performance. The law includes a number of quality provisions such as demonstrations, electronic-prescribing, medication therapy management, and background-checks on long-term care facility employees. In addition, the law expands the responsibilities of QIOs and develops a closer working relationship between AHRQ and the Medicare, Medicaid, and SCHIP programs.

Medicare Health Care Quality Demonstration Programs

The MMA authorizes a 5-year demonstration program that expands CMS' current Physician Group Practice (PGP) demonstration and evaluates the effect of various factors such as the appropriate use of culturally and ethnically sensitive health care delivery, on quality of patient care. This demonstration defines "health care groups" as regional coalitions, integrated delivery systems, and physician groups and allows "health care groups" to incorporate approved alternative payment systems and modifications to the Medicare FFS and Medicare Advantage benefit packages. This demonstration covers both FFS and Medicare Advantage eligible individuals and must be budget neutral.

Medicare Care Management Performance Demonstration

The MMA also authorizes a Care Management Performance Demonstration Program in Medicare FFS. Eligible Medicare beneficiaries will include those enrolled

in Medicare Parts A and B who have one or more chronic medical conditions, to be specified by CMS (one of which may be a cognitive impairment). The goals of this demonstration are to promote continuity of care, help stabilize medical conditions, prevent or minimize acute exacerbations of chronic conditions, and reduce adverse health outcomes, such as adverse drug interactions. This is a pay-for-performance 3-year demonstration program with physicians. Physicians will be required to use information technology (such as email and clinical alerts and reminders) and evidence-based medicine to meet beneficiaries' needs. Physicians who meet or exceed performance standards established by CMS will receive a per beneficiary payment. This payment amount can vary based on different levels of performance. CMS will designate no more than 4 sites for this demonstration program, which must also be budget neutral.

Voluntary Chronic Care Improvement under Traditional FFS

The MMA requires that CMS phase-in chronic care improvement programs in Medicare FFS. These programs must begin no later than 1 year after enactment of MMA. Eligible beneficiaries will be those with chronic diseases such as congestive heart failure and diabetes. Chronic care improvement programs will help beneficiaries manage their self-care and will provide physicians and other providers with technical support to manage beneficiaries' clinical care. The goal of these programs is to improve quality of life and quality of care for beneficiaries without increasing Medicare program costs. This program will be particularly valuable in rural areas and among populations who encounter barriers to care by ensuring that nurses and other professionals will be available to help chronically ill beneficiaries manage their illnesses between office visits. CMS will identify beneficiaries who may benefit from these programs, but participation will be voluntary. Participating organizations must meet performance standards and will be required to refund fees CMS paid to them if these fees exceed estimated savings.

Incentives for Reporting

MMA provides a strong incentive for eligible hospitals to submit data for 10 clinical quality measures. For fiscal years 2005 through 2007, hospitals will receive the full market basket payment update if they submit the 10 hospital quality measures to CMS. If hospitals do not submit the 10 quality measures, then they receive an update of market basket minus 0.4 percentage points.

Electronic Prescribing

Medication errors caused by poor handwriting and other mishaps will be sharply reduced by the electronic prescribing provisions in the MMA. Under MMA, the Secretary of Health and Human Services is directed to develop a national standard for electronic prescriptions with the National Committee on Vital and Health Statistics and in consultation with health care providers including hospitals, physicians, pharmacists and other experts. With a national standard in place, doctors, hospitals, and pharmacies nationwide can be sure their computer systems are compatible. This will allow providers to share information on what medications a patient is taking and to be alerted for possible adverse drug interactions. A seamless computer system also will provide information about a patient's drug plan and any prescription formularies. This information would let the doctor know whether a therapeutically appropriate switch to a different drug might save the patient some money.

A one-year pilot project in 2006 will test how well the proposed national standard works, and the Secretary may revise the standard based on the industry's experience. Once the final standard is set (and no later than April 2008), any prescriptions that are written electronically for Medicare beneficiaries will have to conform to the standard. There is, however, no requirement that prescriptions be written electronically. Electronic prescribing is entirely voluntary for doctors. However, MMA authorizes the federal government to give grants to doctors to help them buy computers, software, and training to get ready for electronic prescribing. The grants will cover up to half of the doctor's cost of converting to electronic prescribing, and they may be targeted to rural physicians and those who treat a large share of Medicare patients. The first public meeting on this initiative will take place next week.

Medicare Therapy Management

MMA requires plans offering the new Medicare drug benefit to have a program that will ensure the appropriate use of prescription drugs in order to improve outcomes and reduce adverse drug interactions. MMA also contains a provision that allows plans to pay pharmacists to spend time counseling patients and will be targeted at patients who have multiple chronic conditions (such as asthma, diabetes, hypertension, high cholesterol and congestive heart failure), are taking multiple medications, and are likely to have high drug expenses. The therapy management

program also will be coordinated with other chronic care management and disease management programs operating in other parts of Medicare. Medication management was identified by the Institute of Medicine as one of 20 priority areas for transforming the health care system.

Medication therapy management will be a new service for Medicare plans. In Medicare, the amount and structure of payment will be set by the plans offering the new Medicare Part D, according to requirements established by the Secretary of Health and Human Services in the coming years.

Research on Health Care Items and Services

The bill requires AHRQ to serve as a science partner for the Medicare, Medicaid, and S–CHIP programs. The Secretary is required to establish a priority-setting process to identify the most critical information needs of these three programs regarding health care items or services (including prescription drugs). An initial list of priority research is required by early June with the initial research completed 18 months later.

III. QUALITY INITIATIVES IN THE PRIVATE SECTOR

In the past few years, the private sector has become very involved in the issue of healthcare quality, particularly for hospitals. Several well-publicized landmark studies identify significant gaps and variations in the quality and safety of health care, at a time of rapidly escalating health costs. These reports have accelerated efforts by accrediting bodies, large purchasers and employer coalitions, and others to track quality at the national, state, and provider level, publish comparative quality reports, launch quality improvement efforts, and use public and private purchasing power to reward better quality.

AHRQ has been an important partner in these efforts, providing tools and data, lending technical assistance, and helping all of the players learn from these efforts. For example, with respect to accreditation, our research and tools have provided the basis for measures used by HEDIS and JCAHO.

To facilitate internal quality improvement, AHRQ's Quality Indicators (QIs) have been used by hospitals and state hospital associations for benchmarking. Statewide hospital associations run the indicators for all hospitals in their state and then share the information with hospitals that can not only track their own performance but also compare it with that of their peers. This use of our indicators takes place in New York, Georgia, Montana, Missouri, West Virginia, Illinois, Kentucky, Oregon, and Wisconsin. In Texas, the Dallas-Fort Worth Hospital Council uses our indicators to target and direct interventions to improve care diabetes in the community and thereby prevent the need for many hospitalizations. In Illinois, Blue Cross Blue Shield profiles hospitals uses 10 of our measures and expects to add more shortly.

A major change in the past several years has been an acceleration of public reporting efforts, particularly for hospitals, and this has brought a tremendous amount of interest in AHRQ's Quality Indicators. Two large states now have comparative quality data for all hospitals using AHRQ's Inpatient Quality Indicators. In New York, the Niagara Business Coalition has published statewide comparative data for two consecutive years. The Texas Health Care Information Council also published public scores for all 400 Texas hospitals using all 25 of AHRQ's Inpatient Quality Indicators. The reports are posted on their web site and a Readers' Guide is available to help consumers understand the information. This is a new use of the Quality Indicators—one we had not even anticipated in our original work, which was more focused on quality improvement. To inform these public reporting efforts, AHRQ is finalizing a guidance document for states, purchasing coalitions and others wishing to use AHRQ's Quality Indicators for this purpose.

Another way we facilitate the private sector's reporting efforts is to work with those using the data to find ways we can improve it. For example, many in the private sector favor use of administrative data because it is readily available and inexpensive. But the value of this information can be improved by selectively linking in clinical data. For example, the Pennsylvania Health Care Cost Containment Council already requires that hospitals collect and submit selected clinical data elements to supplement the administrative data and the UB–02 committee is considering adding some of these to the minimum data set. AHRQ has funded a project to describe the value of administrative data and is anticipating future projects focused on integrating clinical data elements into administrative data.

Several private sector organizations are already using quality information to guide their provider selection and payments. For example, an increasing number of large employers and coalitions are using a common Request for Information (eValue8) to solicit information about quality from health plans seeking to do busi-

ness with them. Through the Leapfrog Initiative, alliances of large employers and business coalitions are asking hospitals to provide data on three safety practices: computer physician order entry, evidence-based hospital referral and ICU physician staffing. In addition, both private and public purchasers are establishing programs basing payment amounts and/or contractual referral relationships on provider quality information. In some cases payment is linked to mere provision of the quality data, whereas in others it is linked to the score itself. For example, Anthem Blue Cross in Virginia rewards hospitals for reporting performance on several indicators, including AHRQ's Patient safety measures. Several of AHRQ's Patient Safety measures are being used in the CMS demonstration with Premier and, in fact, Premier is now tracking their performance against all of these indicators as part of an overall quality improvement effort.

AHRQ also is working closely with employers, business coalitions and others involved in pay-for-performance initiatives. For example, at the suggestion of Alliance Healthcare Coalition in Wisconsin, we have done a review of what the evidence shows about the impact of financial incentives on quality. In addition, AHRQ is doing an evaluation of seven large pay-for-performance demonstrations involved in the Robert Wood Johnson's Rewarding Results program, which should help purchasers and others in the future as they design pay-for-performance schemes.

CONCLUSION

Chairwoman Johnson, Congressman Stark, distinguished Subcommittee Members, thank you again for inviting me to discuss the health quality initiatives that the Department of Health and Human Services is undertaking to improve the quality of care delivered by the health care systems across the nation. This Administration is committed to working with the health care industry and the various stakeholders to improve the quality of care, while also ensuring patients have access to the information they need to make educated decisions involving their health care. Thank you again for this opportunity, and I look forward to answering any questions you may have.

Chairman JOHNSON. Thank you very much, Dr. Clancy, for that speedy review of, really, an enormous amount of work on behalf of the Executive Branch. I have never seen the Executive Branch involved in so many aspects—and leadership—in so many areas on health care technology, information systems, best practices and so on. I really am excited about the base we have laid down for action. Mr. Hackbarth, if you will continue now with MedPAC's role in all of this?

STATEMENT OF GLENN M. HACKBARTH, CHAIRMAN, MEDICARE PAYMENT ADVISORY COMMISSION

Mr. HACKBARTH. Thank you very much, Chairman, Mr. Stark, other Members of the Subcommittee, and I want to add what you just said, AHRQ and CMS, others in the Department and outside the Department have created some tremendous tools that have allowed MedPAC and others to begin evaluating the quality of care provided to Medicare beneficiaries and the population at large. What we did in our March 2004 report is examine care provided to Medicare beneficiaries over a period of time using these measures developed by AHRQ and CMS. For most of the measures, the period of time examined was 1995 to 2002. On some of the measures, it was 1998 to 2001. We looked at quality applying a framework developed by the Institute of Medicine, namely that quality of care should be effective care safely delivered in a timely fashion, in a patient-centered manner.

We selected measures that would allow us to get at these various component parts of quality. The measures we looked at included hospital mortality, adverse events that occurred during the hospital

stay, adherence to standards of effective care, both inside and outside the hospital, potentially avoidable hospital admissions and patient satisfaction. On some of these measures, we were able to compare care in the traditional fee-for-service program against care in the managed-care portion of Medicare. Our findings, as has been true of other research on quality, were mixed. We found that patient satisfaction was high and stable over the whole period we examined. Hospital mortality improved in most instances as did adherence to effective standards—standards of effective care. However, we found that even after improvement in adherence to standards of effective care, many Medicare beneficiaries, often 20, 30 percent or more, are not receiving care proven to be effective.

In addition, we found that adverse events within the hospital increased for 9 out of 13 measures that we examined. We also found that avoidable hospital admissions increased in 7 out of 12 measures that we examined. So, in sum, of course Medicare beneficiaries receive technologically advanced care for the most part. They usually receive a lot of care. However, as others have found, we found significant quality gaps. To help improve quality, in our view, we must attack the problem with multiple tools. Of course, there are the traditional Medicare tools of conditions of participation and accreditation. More recently, CMS has added quality-improvement targets and efforts and public disclosure of data to the arsenal. What we are advocating in our March report is that we take now the next logical step, which is to link payment for service to the quality of care delivered. We do this with the simple conviction that you get what you pay for. Right now, we pay more for volume. We pay more for technological advancement. The payment system, as currently constructed, is at best neutral toward quality and, arguably, in some instances, hostile to quality.

What we propose in our report is that we begin to apply quality standards and payment in areas where there are clearly defined consensus measures of quality with existing methods of data collection in place. As we look at the Medicare program, we see two noteworthy examples of that. One is in dialysis care for patients with end-stage renal disease, and the other is in care provided by private plans to Medicare beneficiaries. Our recommended approach is that we take the existing payments to those at work in the sectors, and set aside a small portion of those payments to be redistributed based on performance against quality measures. It would be a budget-neutral program. The intent of our recommendation is that all of the dollars put into the quality pool would be paid. We further recommend that the dollars be distributed in two ways: one piece of it going to the organizations with the highest absolute level of quality, and then another piece delivered to organizations that show large improvement in their quality. We believe in using this two-pronged approach, because it will distribute dollars in a way that provides maximum opportunity and incentive to improve quality.

This is a complicated endeavor, a challenging endeavor. It would be less than candid to say it is not without its complications and, therefore, potential risk. The potential risks that I am most concerned about are, one, creating an incentive for health care providers to avoid the most difficult patients, the most challenging

cases, because it might make them look bad on quality measures. A second concern is that you might, in effect, put teaching to the test with providers focused exclusively on improving what is measured and paid for as opposed to other opportunities for improving quality. Those are real risks. We think that they need to be looked at in context. The risks of the status quo, in our judgment, are even greater. Continuing as we are with the payment system that is neutral or even negative towards quality is costing us a great deal, not just in dollars but in terms of health for Medicare beneficiaries. Thank you very much.

[The prepared statement of Mr. Hackbarth follows:]

Statement of Glenn M. Hackbarth, J.D., Chairman, Medicare Payment Advisory Commission

Chairman Johnson, Congressman Stark, distinguished Subcommittee members, I am Glenn Hackbarth, chairman of the Medicare Payment Advisory Commission (MedPAC). I appreciate the opportunity to be here with you this morning to discuss improving quality in the Medicare program through Medicare payment policy, a subject that has been of particular interest to the Commission.

The Quality of Care for Medicare Beneficiaries Needs to Be Improved

Ensuring that Medicare beneficiaries have access to high quality care is the principal objective of the Medicare program. Yet Medicare beneficiaries receive care from a system known to have quality problems. While care is improving in several settings, as RAND, Jencks and others have reported, significant gaps remain between what is known to be good care and the care delivered. Studies documenting the gap between high-quality care and the care currently delivered have called attention to the need for improvement. As the Institute of Medicine reported, the safety of patients, particularly in hospital settings, is also of concern.

In our March report to the Congress, we document aspects of the quality of care for the Medicare population using quality indicators developed by the Agency for Healthcare Research and Quality (AHRQ) and results from CMS using other measures. We find that although some measures of quality show improvement over the last decade, many do not and improvement is possible in many more.

We find quality varies based on the indicators used. Hospital mortality rates are improving (table 1). The rate of in-hospital mortality—an indicator of effectiveness—generally decreased between 1995 and 2002 on all conditions and procedures measured. At the same time, many beneficiaries experience adverse events in hospitals. Measures of the safety of patients in the hospital reveal that 9 out of the 13 rates of adverse events we tracked for hospitalized Medicare beneficiaries increased between 1995 and 2002 (table 2). Beneficiaries are being admitted to hospitals for conditions that might have been prevented in ambulatory settings (table 3). Seven out of 12 indicators show increases in admissions between 1995 and 2002 for potentially avoidable admissions. For beneficiaries who are hospitalized, measures used by CMS's quality improvement organization program show improvement. Fourteen out of 16 measures of appropriate provision of care in hospitals improved between the periods 1998 to 1999 and 2000 to 2001 as reported by Jencks. Although improving, gaps still exist between care delivered and optimum care.

Simply providing more care does not necessarily lead to improving quality. The amount of care Medicare beneficiaries receive varies widely across the nation. Yet, as noted in our June 2003 report to the Congress, higher use of care does not appear to lead to higher quality care; in fact it appears that states with the highest use tend to have lower quality than states with the lowest use. Wennberg, Cooper, Fisher and other researchers have found similar phenomena in smaller geographic areas—areas with the highest service use tend to have lower, not higher quality.

An Approach to Improving Quality

Quality varies from low to high among providers. This implies both that high quality is achievable, and that a multi-faceted approach to quality is needed to account for the differing starting points of providers. For example, conditions for participating in the program can assure that all providers meet minimum standards but encouraging high-quality providers to maintain or improve their quality requires a different approach. The ultimate goal is to find ways to continually improve quality delivered by all providers. As a first step, quality has to be measured and evaluated.

Measures of quality and guidelines for appropriate care are becoming increasingly available. The Medicare program has been a leading force in these efforts to develop and use quality measures often leading initiatives to publicly disclose quality information, standardize data collection tools, and give feedback to providers for improvement. CMS has also revised its regulatory standards to require that providers, such as hospitals, home health agencies, and health plans, have quality improvement systems in place. By offering technical assistance to providers, the Quality Improvement Organizations have been a critical part of these efforts. In some sectors, these steps are showing results. The Commission views CMS's focus on quality as an important contribution and an excellent foundation for future initiatives.

The private sector also has taken steps to improve quality. In our June 2003 report, we document that most private sector organizations began their quality improvement efforts by developing quality measures and then providing feedback to providers followed by public disclosure. This helped establish credibility and acceptance of the measures used as well as developed the process for data collection. But many organizations found that those steps alone did not achieve sufficient improvement and began designing financial incentives to tie payment to quality. Early experience has shown improved quality and in some cases cost savings.

Medicare payment systems do not incorporate financial incentives tying payment directly to quality. Current payment systems in Medicare are at best neutral and at worst negative toward quality. All providers meeting basic requirements are paid the same regardless of the quality of service provided. At times providers are paid even more when quality is worse, such as when complications occur as a result of error. It is time for Medicare to take the next step in quality improvement and put financial incentives for quality directly into its payment systems. Linking payment to quality holds providers accountable for the care they furnish. In addition, financial rewards would accrue to providers investing in the processes that improve care encouraging investment in such improvements. Through its actions Medicare can act as a catalyst for improvement throughout the health delivery system.

In our June 2003 report to the Congress, the Commission recommended that CMS move toward using financial incentives for all types of providers and plans participating in Medicare. We also developed the following criteria for choosing the most promising settings for introducing payment for quality performance:

- To be credible, measures must be evidence-based to the extent possible, broadly understood, and accepted.
- Most providers and plans must be able to improve upon the measures; otherwise care may be improved for only a few beneficiaries.
- Incentives should not discourage providers from taking riskier or more complex patients.
- Information to measure the quality of a plan or provider should be collected in a standardized format without excessive burden on the parties involved.

Building on this analysis, in our March 2004 report to the Congress, we develop as a general design principle that a system linking payments to quality should:

- reward providers based on both improving the care they furnish and exceeding thresholds,
- be funded by setting aside a small proportion of total payments, and
- be budget neutral and distribute all payments that are set aside for quality to providers achieving the quality criteria.

We also analyze and make specific recommendations on linking payment to quality for two sectors judged the most ready for financial incentives: providers of dialysis services, and private plans in Medicare.

Using payment incentives to improve dialysis quality. The Commission recommends that the Congress establish a quality incentive payment policy for physicians and facilities providing outpatient dialysis services. Although quality of outpatient dialysis services has improved for some measures, it has not for others. Despite some improvement in dialysis adequacy and anemia status, patients and policymakers remain concerned about the unchanged rates of hospitalization during the past 10 years and the poor long-term survival of dialysis patients. By directly rewarding quality, Medicare will encourage investments in quality and improve the care beneficiaries receive. The recommendation would reward both the dialysis facilities and physicians who are paid a monthly capitated payment to treat dialysis patients. Physicians are responsible for prescribing dialysis care and facilities are responsible for delivering it; only together can they improve quality in the long term.

The outpatient dialysis sector is a ready environment for linking payment to quality. It meets all of our criteria. Credible measures are available that are broadly understood and accepted. All dialysis facilities and physicians should be able to improve upon the measures. Obtaining information to measure quality will not pose an excessive burden on dialysis facilities and physicians, and measures can be adjusted for case mix so that dialysis facilities and physicians are not discouraged from taking riskier or more complex patients.

In keeping with our general design, MedPAC recommends a system linking payments to quality that would:

- reward facilities and physicians based on both improving the care they furnish and meeting thresholds,
- be funded by setting aside a small proportion of total payments, and
- distribute all payments that are set aside for quality to facilities and physicians achieving the quality criteria.

Measuring the quality of care and holding providers financially accountable will take on additional importance if Medicare broadens the dialysis payment bundle to include commonly used injectable drugs and laboratory services.

CMS is already planning to use quality incentives in the agency's new end-stage renal disease management demonstration. Medicare will pay program participants—dialysis facilities and private health plans—an incentive payment if they improve quality of care and if they demonstrate high levels of care compared with the national average. We applaud CMS for linking payment to quality in the demonstration. Quality incentives should not, however, be limited to demonstration efforts, but rather should apply to all fee-for-service dialysis providers so care for as many patients as possible will improve. In addition, when using quality incentives only in a demonstration, bidders may primarily consist of high-quality facilities and not be representative of all facilities. By contrast, we recommend incentives that are part of the outpatient dialysis payment system and will affect both low- and high-quality providers.

Using payment incentives to improve the quality of care in private plans. To reward improvements in quality for beneficiaries enrolled in private plans we recommend that the Congress establish a quality incentive payment policy for all private Medicare plans. This program is a promising sector for applying payment incentives to provide high-quality care because it meets the criteria for successful implementation. Private Medicare plans already report to CMS on a host of well-accepted quality measures. Plans vary in performance on the reported quality measures and room for improvement exists on almost all measures. Because plans are responsible for the whole spectrum of Medicare benefits, they have unique incentives to coordinate care among providers which is an important aspect of quality.

Although CMS would have work to do before it would be ready to administer any incentive program, in keeping with our general design principles we recommend creating a reward pool from a small percentage of current plan payments and redistributing it based on plans' performance on quality indicators. To reach the most beneficiaries, Medicare should reward plans that meet a certain threshold on the relevant performance measures and plans that improve their scores. The program should be budget neutral and CMS would need to create a mechanism that insured budget neutrality.

Next Steps to Link Payment to Quality

The Commission seeks opportunities to improve the quality of care all Medicare beneficiaries receive. As we have discussed, beginning in 2005 we recommend paying for quality in two sectors where there is consensus on measures and they are regularly collected—outpatient dialysis and Medicare private plans. We anticipate expanding recommendations on payment for quality to other sectors in the future as better measures become available.

To help target quality improvement initiatives, we will continue to analyze the quality of care in hospitals, ambulatory settings, post-acute care settings, and private plans using a range of available indicators. The hospital and ambulatory settings affect a large number of beneficiaries and thus quality in those settings is critical to the program. This work will raise questions for further research, but may also point to where payment incentives are most needed. The Commission will also investigate the relationship between cost and quality. Work in the dialysis sector showed no correlation between cost and quality for services paid prospectively under the composite payment. It also found a negative correlation under the fee-for-service payment for the sector—beneficiaries' outcomes were poorer for facilities with higher than average costs. This correlation could, to some extent, be a reflection of unmeasured case mix complexity.

We will also investigate how care coordination and rewarding improvements in quality across settings can be addressed given the fragmented nature of the current health care system. In fee-for-service Medicare, rewarding the providers in one sector when savings from their actions accrue in other sectors is a challenge. It is also difficult to provide incentives to coordinate care across settings, for example, through mechanisms such as disease management, when no single provider is responsible. Such considerations have led many private purchasers and plans to target their incentive initiatives at organizations—either group practices, networks, or health plans that use some form of risk sharing—that they believe are more effective at improving quality. Finding effective approaches to these issues will be a major challenge for the Medicare program.

Conclusion, The Time Is Now

The Medicare program can no longer afford for its payment systems to be neutral or negative to quality. Although there are risks in paying for quality—providers avoiding high-risk patients and concentrating on the measured quality elements to the exclusion of others—good design can ameliorate them. The risk from maintaining the status quo is much greater. No beneficiary should be fearful for her safety going into a hospital because of medical errors. No beneficiary should be hospitalized when it could have been avoided through better ambulatory care. It would be impossible to reduce medical errors or preventable hospitalizations to zero, but evidence suggests we are far from a tolerable level now and many improvements are possible and needed.

In June 2003, MedPAC expressed an urgent need to improve quality in fee-for-service Medicare and in care furnished by private plans. In our March report we have recommended two sectors where the Congress can act now—rewarding quality care in outpatient dialysis and Medicare Advantage. Linking payment to quality in other sectors could encourage broader use of best practices and thus, improve the quality of care for more beneficiaries. A Medicare program that rewards quality would send the strong message that it cares about the value of care beneficiaries receive and encourages investments in improving care.

Table 1. Effectiveness of care: Hospital mortality decreased from 1995–2002

Diagnosis or procedure	Risk-adjusted rate per 10,000 discharges				Percent change 1995–2002	Observed deaths in 2000
	1995	1998	2000	2002		
In-hospital mortality						
Pneumonia	1,122	1,032	1,012	949	−15.4	78,999
AMI	1,670	1,477	1,414	1,309	−21.6	43,750
Stroke	1,357	1,240	1,212	1,159	−14.6	39,099
CHF	689	585	541	474	−31.2	38,828
GI hemorrhage	504	434	400	355	−29.5	11,155
CABG	580	522	482	427	−26.3	8,669
Craniotomy	1,033	963	986	931	−9.9	3,216
AAA repair	1,258	1,178	1,161	1,130	−10.2	2,632
30-day mortality						
Pneumonia	1,525	1,531	1,377	1,557	2.1	107,502
CHF	1,063	1,006	818	907	−14.6	58,678
Stroke	1,816	1,808	1,620	1,807	−0.5	52,263
AMI	1,899	1,792	1,627	1,690	−11.0	50,367
GI hemorrhage	757	718	590	649	−14.3	16,438
CABG	532	496	441	412	−22.5	7,932
Craniotomy	1,164	1,158	1,123	1,182	1.6	3,666
AAA repair	1,158	1,116	1,069	1,072	−7.4	2,423

Note: AMI (acute myocardial infarction), CHF (congestive heart failure), GI (gastrointestinal), CABG (coronary artery bypass graft), AAA (abdominal aortic aneurysm). Rate is for discharges eligible to be considered in the measure.

Source: MedPAC analysis of 100 percent of MEDPAR data using Agency for Healthcare Research and Quality indicators and methods.

Table 2. Safety of care: Adverse events affect many beneficiaries

Patient safety indicator	Risk-adjusted rate per 10,000 discharges eligible				Change in rate 1995–2002	Percent change 1995–2002	Observed adverse events 2000
	1995	1998	2000	2002			
Decubitus ulcer	237	273	297	319	82	34.5	128,774
Failure to rescue	1,772	1,683	1,652	1,511	−261	−14.7	57,491
Postoperative PE or DVT	98	108	120	123	25	24.5	36,795
Accidental puncture/laceration	28	31	32	36	8	30.7	134,171
Infection due to medical care	24	27	28	30	6	28.5	24,524
Iatrogenic pneumothorax	10	12	11	11	1	4.8	10,985
Postoperative respiratory failure	43	66	75	87	44	99.6[b]	8,184
Postoperative hemorrhage or hematoma	N/A	27	26	24	−3[a]	−11.2	8,056
Postoperative sepsis	89	112	127	135	46	50.7	6,739
Postoperative hip fracture	18	18	18	13	−5	−24.2	3,707
Death in low-mortality DRGs	39	30	31	30	−9	−23.6[c]	3,453
Postoperative wound dehiscence	38	41	37	38	0	0.4	2,043
Postoperative physiologic and metabolic derangement	11	12	13	14	3	31.8	1,952

Note: PE (pulmonary embolism), DVT (deep vein thrombosis), N/A (not available), DRG (diagnosis related group).

[a] Change from 1998–2002.

[b] Some of this increase may be due to the introduction of a new code in 1998 for acute and respiratory failure.

[c] Agency for Healthcare Research and Quality researchers identified low-mortality DRGs for all-payers, not Medicare beneficiaries only.

Source: MedPAC analysis of 100 percent of MEDPAR data using Agency for Healthcare Research and Quality indicators and methods.

Table 3. Effectiveness and timeliness of care outside the hospital: The change in the rate of potentially avoidable hospital admissions is mixed, 1995–2002

Conditions	Risk-adjusted rate per 10,000 beneficiaries				Percent change 1995–2002	Observed admissions in 2000
	1995	1998	2000	2002		
Congestive heart failure	241	257	244	238	−1.0	703,012
Bacterial pneumonia	154	182	193	192	24.1	567,995
COPD	104	121	122	118	13.6	368,674
Urinary infection	60	64	67	66	9.4	209,550
Dehydration	50	55	58	65	30.2	181,785
Diabetes long-term complication	35	38	39	41	18.5	125,053
Adult asthma	24	21	20	23	−6.3	65,680
Angina without procedure	50	24	19	14	−71.4	59,983
Hypertension	9	10	11	13	38.3	37,334
Lower extremity amputation	15	16	15	14	−2.1	24,224
Diabetes short-term complication	7	7	7	7	2.1	22,425

Table 3. Effectiveness and timeliness of care outside the hospital: The change in the rate of potentially avoidable hospital admissions is mixed, 1995–2002—Continued

Conditions	Risk-adjusted rate per 10,000 beneficiaries				Percent change 1995–2002	Observed admissions in 2000
	1995	1998	2000	2002		
Diabetes uncontrolled	10	8	7	6	−38.1	22,416

Note: COPD (chronic obstructive pulmonary disease).
Source: MedPAC analysis of 100 percent of MEDPAR data using Agency for Healthcare Research and Quality indicators and methods.

Chairman JOHNSON. Thank you very much. I am glad that you mentioned this problem, penalizing providers for taking higher costs, more complex, more difficult and more costly patients. I think that is something we have to be very careful about as we think about pay for performance. We already have that problem in many hospitals as we have allowed surgicenters and boutique hospitals to take the paying patients out from under community hospitals, leaving the community hospitals with the more complex patients and the nonpaying patients. Now, I am drawing a very simplistic picture. We are going to be looking at whether that is true or not. We do need to understand the problems inherent in our current system that may be concentrating the most difficult patients in the hospitals at the very time we are imposing heavier standards on them and going to attach payments. The other concern is that you will underpay those who have the biggest problem in financing the efforts to improve quality. So, I think on both of those scores, we do have to proceed carefully. I wanted to ask a couple of questions and then go on to the other Members and maybe come back.

This issue of the health record, I mean, we have had people into my office—they are doing this in England. Why can't we position ourselves to have electronic health records at least for those coming into Medicare under the Welcome to Medicare Physical Provision in 2006? There are Health Insurance Portability and Accountability Act of 1996 (HIPAA) (P.L. 104–191) compliance systems; existing technology takes it. Can you work with us? Do you think that is an achievable goal, or can we just work as if it is an achievable goal and see how far we get? If we could combine the provisions in the MMA that provide a "Welcome to Medicare Physical," that press forward on technology, that provide disease management and, therefore, can identify the early symptoms of disease management with an electronic health care record, we would really move the system forward in terms of ability to deliver quality care to people with multiple illnesses dramatically. So, I look at what people are showing me in the technology, and I say to myself, what are the barriers; $50 million isn't going to do it. Between your two resources, why can't we get there in 2 years?

Dr. CLANCY. I think, as you know, Mrs. Johnson, Secretary Thompson shares your passion and asks us the same question about every 48 hours. He is away for a couple of days, so we are getting a brief break. We are focused right now—in addition to learning from the investments that AHRQ will be making in the

Department as well—we are trying to look at all opportunities in the MMA for accelerating the adoption of electronic health records, and we would be pleased to work with you on that.

Mr. HACKBARTH. I, personally, am a true believer in computerized medical records, and I base that on personal experience. When I was in Boston, I worked for Harvard Community Health Plan and then subsequently Harvard Vanguard Medical Associates. Harvard Community Health Plan had, I think, the very first ambulatory computerized medical record beginning in 1969. Then when I was Chief Executive Officer of Harvard Vanguard, we implemented the Epicare System, which is one of the more advanced computerized systems available. I was able to see, in my firsthand experience, the capability that that computerized technology gave us compared to other providers in Boston who did not have access to it.

I believe passionately that the gains are potentially huge for the health care system and for our patients. Having said that, it is not inexpensive. You mentioned the $50 million allocated. That is roughly the amount that we spent for our 600-physician group to implement the Epicare System. Once you count the software, all of the infrastructure, the training required, it is a very complicated endeavor. The reason it is not more widely available is that there is no return on the investment or at least not a readily discernible return on investment. If you go out and buy a new magnetic resonance imaging, you can see the dollars that are going to flow in. You can see how the machine is going to pay for itself. When you invest large sums in a computerized medical record system, you can't look at the immediate financial returns.

Chairman JOHNSON. Let me ask you another unrelated question, and then we will get back to costs. My colleague, Mr. Stark has rightly acknowledged the reluctance of some on my side to regulate. There is an equal problem on his side in regard to the word privatization. I don't know how you can achieve these advances in quality without technology and the systems that come with it. Those systems integrate provider communities in a collaborative fashion. While, in this bill, I was very careful to learn how to pay for disease management and fee-for-service medicine, personally, I think there is a limit to how far the individual independent practitioner can go in meeting quality standards without being part of an integrated system. I want to try to get us over, through better understanding technology and its power and the challenge of quality, to get over this issue of privatization.

It is a different way of delivering medical care, and it is going to require a different partnership between providers and between the public and private payers. To me, technology is absolutely essential to the next round of quality improvements. If we let this word privatization cut us off from the very systems that can deliver higher quality care to people with chronic illnesses, we will destroy for Medicare recipients the care they urgently need. I would like your input on this issue, on the relationship between technology systems and the word privatization, because we have to do something to lay it aside because it is a barrier now to public understanding of how we are trying to improve the quality of the public programs, not just Medicare. The Secretary did put out this initiative just a week ago, saying we will pay half if the States will pay

the other half to put disease management into Medicaid. We know that will pay us back, and it will be budget neutral in 3 years. I need your help on this issue. What does the word privatization have to do, either as a barrier or as an incentive, to move us toward higher quality health care?

Dr. CLANCY. Let me start and just say that I think most leaders in health care and health care quality agree with you that IT alone won't solve the problems, but we can't solve them without IT for all the reasons you and Mr. Stark and others have very clearly articulated. The fact is that most medical care is delivered in a "Marcus Welby" world where you have paper charts and it is very hard to track information when patients go to different settings or see different doctors and so forth. For that reason, the Department has two sets of investments. One is focused on making sure that the components of health IT actually do improve quality and safety within organizations, whether that IT is hospitals, physician practices and so forth.

That is going to be complemented by some support for these community or state information exchanges so that all components of the health care sector within a community can share data in a way that is private and confidential. We think that that is going to be an important payoff. Dr. Hackbarth is right. Our total investment here is fairly modest. As we are struggling to figure out how to make the most out of the opportunities in the current and next year's budget, we are working very hard to identify the right incentives that would actually begin to move the adoption of electronic medical records by physicians from its current low of somewhere in the ballpark between 10 and 15 percent of physician practices, depending on which survey you read. It is a huge hurdle.

Chairman JOHNSON. I would add that you are going to add $14 billion as well as the $50 million, and the $14 billion is explicitly in the bill to try to do—a few years ago, the Congress and the Rural Caucus insisted upon this, arbitrarily increase the floor of payments for rural areas to try to get plans out there. In this bill, we gave you $15 billion in money so you can put the technology out there so that rural health can be linked into medical centers and others, and those doctors practicing out there solo can have the specialist consult with them and the patient on the spot and then do the followup. It would be a revolution in rural health care, and it would save rural health care by keeping doctors out there. There is a lot of money in this bill for technology if we can figure out how to use it right. It is an opportunity to insert not medical records, because that is a much bigger problem, but electronic health records into those rural areas. If you do that, then that fosters this linking and the ability to deliver far higher quality care through specialist consultation in the rural areas across America, and it is the only thing that will do it. If we let this word privatization get between us and these systems that have to be built to link urban and rural care and are going to demand expensive technology and nobody out there makes enough to buy it, I mean, you are not going to be able to do that.

Often what has been described pejoratively as a slush fund in this is probably one of the most enlightened components, and it is imperative that we try to figure out how we can get health records

into the system by 2006 because, at that time, these plans will be setting up in big regions, and we have to make sure they are powered by the technology that drives quality. I put that challenge out for all of us. I wanted to put it out publicly. We have absolutely got to meet this challenge because that will realize the tremendous vision of the legislation, but also will enable us to bring to fruition and into the practical reality of Americans throughout the country what the knowledge base in health care already knows. Let me move on to my other colleagues here. My colleague, Mr. Stark.

Mr. STARK. Well, Madam Chairman, I am all for that technology stuff, and if I could sell you some of the stocks that I bought in echinacea companies and jojoba bean schemes which I thought was the technology of the days back, I would be glad to give them to you. If I could mention what I have left, maybe it would go up, but then maybe I would make Martha Stewart look like a Sunday school teacher. I have no quarrel with technology. Really, I am excited by it and intrigued by it and I am a believer. I think I am concerned and what I would like to direct witnesses about establishing single quality standards. I don't think we can do that. I get back to an old saw horse that we have been beating in this Committee, and that is basically doing some research in outcomes. While there must be 15 different kinds of equipment that surgeons can use to deal with my prostate or a woman's breast cancer, and there may be 80 different kinds of drugs that oncologists can use and protocols all over the place, patients, and I suspect physicians, do not have very much evidence about which ones work over a period of 5 and 10 years. We may know how many people lived through the operation in recent trials and did not die in the hospital or shortly after, but comparing what happens to you 5 and 10 years out after some of these major illnesses is an area of which we have precious little information.

I would ask the witnesses whether, first of all, the physician community would be more receptive to receiving details on outcomes, which they could relay to the patients, then they would be getting a standard. I have always heard the doctors say, don't give us cookbook medicine. There is an art to practicing medicine and it takes information. So, then I guess, rather than just blindly saying any technology, ought we not to be focusing first on gathering data which won't be available at least for 5 or 10 years to see what happens to folks? I would ask both of the witnesses whether they see building this base that will give us outcomes and the results of various protocols in treating disease as important? Or would you rather see us start to establish quality standards, even though I don't know quite what they would be? A specific better treatment for prostate cancer. I don't think there is just one, but maybe the witnesses could comment on my dilemma. Dr. Clancy or Dr. Hackbarth?

Dr. CLANCY. The capacity to follow what happens to patients who have received different interventions and to follow them out to some period of time, I think, is going to be a very important byproduct of building an information infrastructure very similar to what Representative Johnson has been describing. I think most doctors would welcome that. I do not think it necessarily replaces or eliminates the need for standards in some areas. For example,

delivering preventive care or making sure that people with diabetes get all tests we know to be efficacious is still a good idea.

Mr. STARK. What you are suggesting? If someone is diagnosed with diabetes, there ought to be a standard screen that they have to go through in terms of tests. The treatment alternatives would be something for which you might use for outcomes research.

Dr. CLANCY. That would be one way. There are some areas where the evidence is very clear about what is the best path. There are many other areas—which is, really, again a byproduct of our investments in biomedical science—where we have different options, and that is wonderful. What would be equally wonderful is if doctors, patients and others could make informed decisions based on evidence about what happens to people like me confronting a similar decision, and that will take some time to develop.

Mr. HACKBARTH. Due to work over the last 15, 20 years, in fact, the database of knowledge about what works and what doesn't work has grown tremendously through the work of AHRQ and many other organizations. We need to continue that. It is an ongoing process and a long-term process as you point out, Mr. Stark. There are things, however that we know today work. What concerns us is, too often, they are not done. They perhaps cover only a small fraction of the care delivered to Medicare beneficiaries. So, you know, we are nowhere near the end of solving this problem and saying we know exactly what works in every case and what you ought to do. From our perspective, for us in a broad way not to apply known effective treatment for different types of patients is a problem, and we see that shortcoming not in a few cases but on a large scale in the treatment of Medicare beneficiaries. We have to do something about that, and hence our recommendation that we begin moving toward payment associated with providing appropriate, proven effective care.

Chairman JOHNSON. Thank you. We will have a chance to pursue that with the second panel. That is an extremely important question. Mr. McCrery?

Mr. MCCRERY. Dr. Clancy, let's talk about the Hospital Quality Initiative for a second and the indicators. You have 10 clinical quality indicators. Then you have another 24 indicators that will be used for the quality incentive demonstration that will reward hospital performance. Those 34 indicators address treatment methods that have been well established for some time now. Once hospitals begin reporting those indicators, won't it be important to expand the indicators to cover other critical treatment areas that are not as well established but offer maybe greater potential for improving quality and saving lives?

Dr. CLANCY. Without question. I think you have hit on an important challenge in terms of developing indicators and measures of quality and performance and that it has been incremental. You start with a small menu and then build out from there. Those are the ones that are linked to hospital payment update in the MMA; they are the starter set. All partners in this initiative recognize that is a starter set. In addition to those within the construct of the CMS demonstration with the premier system, there is an additional 34 measures. Even those 34 measures actually cover only 5 broad areas. The CMS and AHRQ in conjunction with our partners

throughout this hospital reporting initiative are about to launch a series of activities to try to develop what we are calling a robust measurement set that covers all aspects of quality of care for people in the hospital. We will be getting input from stakeholders, the public and many others. So, a series of townhall meetings will start in April combined with some other activities. That is just the beginning. All indicators are only useful and credible if they are based on the latest scientific evidence about what is the right treatment and what is the right thing to do. The AHRQ is committed to making sure that those indicators are indeed as evidence-based and up-to-date as possible or else they will have no meaning.

Mr. MCCRERY. You are about to start that process of examining additional indicators that could be added?

Dr. CLANCY. Yes.

Mr. MCCRERY. In my home State of Louisiana, the American College of Cardiology just held their annual meeting, and they released data from a new private quality initiative called CRUSADE being conducted by Duke University. It is interesting because it is looking at patients who are at high risk for heart attack but never had a heart attack. That is one of the examples I think of indicators that we may want to look at to treat patients that have not gone into the hospital for acute heart attack but may be at risk and then thereby prevent that. The CRUSADE program is a private initiative. You talked in your testimony about the possibility of joining efforts between the private sector and your efforts. Could you expound on that a little bit? How will you identify—and how can something like CRUSADE and Duke University get entrance into your umbrella program?

Dr. CLANCY. Sure. I am not sure if CRUSADE is a hospital-based initiative or more broadly based than that. In general, every effort that has been made, certainly in the public sector and I think in the private sector, to develop indicators and measures, there is a very broad, public call and active seeking of input from organizations known to have expertise in this area. The example you use, the American College of Cardiology, I would say is one of the leading professional organizations. They have been leading others in terms of developing guidelines and measures and other strategies to improve quality of care. So, they will most definitely be consulted. I think the question we are going to confront after developing a robust measurement set, is what is the strategy for implementing those which are required, which are optional and so forth. That is the nature of a partnership between the public and private sector. I am very optimistic that this approach is the reasonable way to go.

Mr. MCCRERY. You said, when commenting on the Chairman's question about electronic medical records, that there is no obvious return on investment for the industry to make that investment and how expensive it is going to be. Why is there a return on investment on those kinds of technological improvements in every other sector of our economy but not health care? I mean, if a business converts all of its records to computer, they don't have any immediate return on that investment, but they might be able to do with fewer employees, which saves them money over the long term.

They compete on the basis of quality of their service or whatever. Why is it different in the health care field?

Mr. HACKBARTH. Well, first of all, in actually making this decision personally, among the things we looked at were potential administrative savings, that you don't need a large medical records department. There are certain savings that are clear and obvious, but they are not enough in and of themselves to justify the substantial investment. We made the decision to go ahead and make that investment because we believed it would change patterns of care, would change how we treated patients, and over the long run that would mean better quality and even some saving on cost. We were different than a lot of organizations, though. We were fully capitated. We had a lump sum payment for the full range of services provided to our patient population. So, if we could save money through better ambulatory care, reduce hospital cost, we gained from that. In the fragmented fee-for-service delivery system, often the gains from improvement accrue to somebody else, and so that is one of the reasons why the financial return isn't as immediate or apparent. Now, having said that, I think that there are some things that we can do to change that investment calculus. One would be to pay for quality. If in fact, by using computerized medical records, we can enhance quality, measure and pay for it, there starts to be a more immediate direct financial return for the investment.

In some instances, it may be necessary to go beyond that. This is actually an issue that MedPAC as a commission is taking up this week and will be in the future months, so here I am speaking for myself, as opposed to the commission as a whole, but, you know, it may be appropriate that we make loans available to institutions to make it easier to make this large investment. There are a number of financial options that we could use to change this investment calculus a little bit. I don't want the message that I deliver to be pessimistic about the potential. It is a challenge, but I think it is a challenge that we can overcome, and I think the gains from computerized medical records in clinical IT are very, very large.

Chairman JOHNSON. Just to clarify, I hear you saying that it pays off if you are paying for health care. It doesn't pay off in the fee-for-service system where you are simply paying for volume of actions, whether they are good health care or they are not good health care. So, it does pay off in a capitated system. It just doesn't pay off in our current system. Mr. McDermott.

Mr. MCDERMOTT. Thank you, Madam Chairman. I begin by saying I have nothing but the highest respect for you, Dr. Clancy, and your predecessor John Eisenberger. I think you run an agency that requires heroes to participate in it. In listening to some of the questioning, it seems to me that people have questions about why these organizations don't function better, but it is always politics that gets in the way. I am going to have a meeting in my office today at 1:30 with Dr. Javitz, who is the head of Ptech for the President. We were working on the problem of trying to get a seamless transfer of information between the Veterans—or between the military, the U.S. Department of Defense and the U.S. Department of Veterans Affairs. We have mandated it in the Congress, but the thing we run up against is they each have their own com-

puter system the veterans designed by themselves, and the military has a proprietary system, and somehow or other we can't seem to root out that proprietary system and make one system so that when somebody loses their leg in Iraq and they are discharged from the military, their records can be easily transferred from the Defense Department to the Department of Veterans Affairs.

I want to ask you a couple questions, Dr. Clancy, about this whole process, because we have been watching the Department dance around about things that they do studies on and that are politically correct. How do you select the processes that you are going to look at in quality? Is it done for you? Is it done by you and submitted upstairs and approved, or is it—or do they send the list on to you and say this is what we want you to study? I remember the study done about back surgery and what happened and all the flap about that. The agency did a good job and then got chewed up by the political process afterward. So, what is the process actually by which you select subjects that you are going to do anything related to quality?

Dr. CLANCY. We make investments in a number of areas. Where we make investments in data and tools such as those used in the MedPAC report, we are guided very much by the needs of those who are providing health care. We are not told from on high what subjects or areas to focus on. In some cases, investigators come to us with very creative ideas, particularly in the areas of how do we close the gap between evidence-based and actual care that is being provided. For a recent report that we produced, the National Health Care Quality Report, we actually turned to the Institute of Medicine for guidance on the six dimensions that Dr. Hackbarth walked through in his testimony, and also they helped us develop a framework for that. Then we worked with many, many partners across the Department and also with help from the private sector. So, it was a very open, transparent process in terms of where the measures came from and what the priorities were.

Mr. MCDERMOTT. Then after the report is written, then it is submitted upstairs and they put their signature on it or say whether it is going to go out? I mean, when professionals have looked at an issue like the Institute of Medicine and yourselves, the question then is, why does some bureaucrat or some political appointee make the decision about whether it goes out? Or does that happen?

Dr. CLANCY. No. No. No. The usual clearance process is a second level of review for technical issues. For the quality report, the vast majority of comments we got pointed out that tables were inadvertently mislabeled or that there had been some technical error, sometimes coming from the people who had given us the data. The clearance process is just one way to make sure that all the data contained in the report are impeccable and they challenge us to edit the document in terms of readability. That is really all that happened in the process for that report.

Mr. MCDERMOTT. We used to have a process in the Congress before the Republicans took over called the Technological Advisory Committee. Representative Amo Houghton and others sat on it with me, where any Member of Congress could submit something that you wanted to be technologically reviewed by this Committee. It was a bipartisan 50–50 kind of Committee, basically supposed to

be nonpartisan. We don't have any place to do that anymore, because it was considered not worthwhile. I wonder if I submitted a request to you to study the effectiveness of cardiac bypass surgery and the enormous amounts of money we spend on it or, for instance, the issue of renal dialysis—the Medicare Program has kind of a one-size-fits-all approach in many respects, although people's kidneys are not one-size-fits-all, and so there needs to be some variation—if I were to submit a request to you, what would happen to that?

Dr. CLANCY. It depends on the specific question and the state of the evidence and information available. In some cases, I might be able to tell you that we have a study ongoing or recently completed, and that would be great news. One of the mechanisms that we use a lot, we have 13 evidence-based practice centers across North America that do very rigorous reviews of existing literature, and in order to select the topics for that, we actually turn to people in the private and public sectors for nominations of topics. That is one way that we do that. We use that process, for example, to give CMS the best evidence to give to the Medicare Coverage Advisory Committee when they are debating whether to cover a new service. So, that would be another approach. In some cases, your question might lend itself to a question that, using one of our databases inhouse, we could easily do an internal analysis. To some extent, it would depend on the question, but you would get a response.

Mr. MCDERMOTT. Who would make the decision—I mean, so all 435 Members have questions. They could submit things to you that they think are good or bad or are not being covered or whatever by Medicare, and who would make the decision about whether or not these were subjects worthy of research?

Dr. CLANCY. If the question or subject required a large investment, we would need to be candid with you about that in terms of whether there were resources available to be able to support that. We certainly use that kind of input from a variety of stakeholders, including Members of the Congress, to feed into our priorities as we are planning our budget. Does that help?

Mr. MCDERMOTT. It tells me I need a little more political power to get done what I want to get done. Thank you very much.

Chairman JOHNSON. Mr. Ryan from the full Committee has joined us today.

Mr. RYAN. Thank you. Thank you for allowing me to participate in this as well, Mrs. Chairman. I want to start by addressing something that Mr. Stark said earlier. He said people to the right of this side of the gavel don't like regulating. That is typically true, but in this instance it is not necessarily so. The concern that some of us have is if we put too much of a command-and-control, cookiecutter kind of regulatory system on technology, then we are going to stunt innovation and slow down new innovations. So, how you do that regulating so that you can capture constant improvements in technology and innovation is really important. So, there is probably somewhere where we can agree on this. We just don't want to have a heavy-handed, top-down, innovation-slowing process.

Mr. STARK. Will the gentleman yield?

Mr. RYAN. Sure.

Mr. STARK. What I look forward to in the regulatory world is getting it started. My feeling is nobody is going to do it unless somebody says this must be done by a certain date and everybody has got to participate, and that I think can only come from on top.

Mr. RYAN. Reclaiming my time, there is a lot of variables. My first question to the panelists, looking into this whole technology issue and the fact that there seems to be a lack of return on equity from some of the providers to purchase these hardware and software systems, is there not also a little bit of a problem with respect to the vendors of software and hardware between the issue of universal connectivity and interoperability? In the IT field you have people who have proprietary systems that don't talk to each other, that want to sell these systems and continue to carve this market niche. Does that not prevent a problem from having everybody talking to each other? Can you elaborate on that little friction we have in the marketplace? What will it take from this side, from Congress, to get this smoothed out and make sure that the IT system is selling to the marketplace when we get this Return on Equity fixed for the providers, when we get this out there, that they have universally connectible, interoperable systems?

Mr. HACKBARTH. I could easily get in way over my head in talking about the technical——

Mr. RYAN. I have already gone there.

Mr. HACKBARTH. I don't want to wade in too far, but certainly the ability to communicate across institutions is a critical problem, particularly given the nature of American health care, which tends to be somewhat fragmented. So, it is a barrier and one that needs to be overcome through standards about interoperability and the like.

Mr. RYAN. You see this barrier in the marketplace today?

Mr. HACKBARTH. Yes. It is a problem today, this ability to communicate. As to the solutions, that is where I am over my head. You know, in other industries we manage the ability to communicate across companies, and I can't imagine that there is an insuperable problem. So, yes, but we can do it. How we do it I will leave to somebody else.

Mr. RYAN. You think that that is something that has to be done by government?

Mr. HACKBARTH. I am not really well educated on the subject enough to know that. I don't think that it was necessarily done by government in other sectors.

Mr. RYAN. That is correct.

Dr. CLANCY. The development and diffusion of standards has been advanced over the past couple of years through the Consolidated Health Informatics Initiative for which HHS had the lead. There was an initial set adopted last year by HHS, the Department of Veteran Affairs, and the Department of Defense as a starting menu in order to have some of the standards that are required for interoperability. The MMA is forcing us to ramp up very quickly on the standards that are going to be needed for electronic prescribing. So, thank you. Some portion of our investment this year and next year is going to be focused on identifying additional standards that will be needed to enhance interoperability.

There are a couple of these communities in the country right now. The two that are cited a lot are Santa Barbara, California, and Indianapolis, where a mechanism has been set up for health care organizations to share data in a confidential fashion, and it seems to work pretty well. We have a little bit to learn about the financial sustainability of such a model. I don't think anyone thinks the government ought to go in and pay and just simply run this. I think we do believe that the government has an important role in convening the people who would need to take the lead in helping communities set up that sort of governance, because it will yield many, many benefits for all people in the community in terms of improved quality and efficiency. I would be happy to follow up with you on that. I don't want to get——

Mr. RYAN. No. I would like to come by and talk to you about that, if I may, because that was the goal, more than just cutting down on medical errors, was to get this system up in place through which quality and price data can go to the consumer. Do I have time for one more?

Chairman JOHNSON. I think we need to move on to the other panel, because we are going to have some votes and we may be able to get through all the other panels', at least, opening statements.

Mr. RYAN. Thank you very much.

Chairman JOHNSON. Thank you very much for being here. I would ask that you look at my legislation in regard to technology, because the Administration has provided very aggressive leadership, but it has tended to bring together the people in government. They aren't necessarily the ones on the cutting edge. While I know you talked about cutting-edge people, I do think, since it is going to be a 10-, 20-year, ongoing project, we need to have a clear public/private group that works on technology standards as a regular thing and knows all of the Medicaid issues as well as Medicare and private sector. I think also in HHS we need one office who is sort of the lead office in all of this, because right now the authority and opportunity to participate and go off in different directions is quite disparate. I mean, this, Mr. Secretary, has been brought together, but that is not an adequate, in my estimation, way to manage what is going to be a major aspect of not only quality care in health care but also cost containment in health care. So, if you take a look at that, both of you, I would appreciate it. Thank you very much for your input. I appreciate it.

Now we will turn to our second panel. We were supposed to have a vote about 11:00, so it was—glad we could get through this panel, but since the vote hasn't been called, it will be effectively a one-half hour hiatus. If we could start now with the second panel, that would be very useful. We will start with Dr. Milstein, then go to Dr. Ho, Dr. Crosson, Mr. Kahn and Ms. Burger. We thank you all for being here. The second panel has a lot of practical experience with technology and quality standards, and we hope to learn from you both what the private sector is doing and what thoughts you might have for applying your experience to Medicare and other public sector programs to enhance the quality of care available under those programs. Thank you for being here. Dr. Milstein, if

you would—well, if you are not—let's see. Dr. Milstein, if you will proceed.

STATEMENT OF ARNOLD MILSTEIN, MEDICAL DIRECTOR, PACIFIC BUSINESS GROUP ON HEALTH, SAN FRANCISCO, CALIFORNIA

Dr. MILSTEIN. Thank you for the opportunity to speak on behalf of large American employers. Employers, insurers and Medicare Program unintentionally contribute to today's poor health care industry performance. We do this via incentives that do not reward doctors or hospitals for quality or for superior total cost efficiency over the longitudinal course of an acute or chronic illness. We pay unintended bonuses for preventable complications and for more reserve-intensive clinical practice styles that are not improving patient health or patient satisfaction. Robust payment incentives that reward doctors and hospitals for excellence in quality and in longitudinal efficiency can improve clinical performance. Accordingly, many employers support health insurers' new efforts to apply such incentives.

Roughly 40 such incentive programs are currently operating. The largest of these is California's Integrated Healthcare Association initiative that is projected to pay approximately $100 million to medical groups with top scores in quality patient satisfaction and clinical information systems adoption during 2004. Payment incentives are not the only market levers for lifting clinical performance. Sunshine in the form of easily understood public performance comparisons has been shown to triple quality improvement efforts in poorly scoring hospitals and to raise performance scores. There are budget-neutral opportunities for Congress to more rigorously reinforce private sector momentum. These include: first, encourage CMS to speed up and significantly expand its current efforts to make publicly available quantified measures of hospital and physician quality and to coordinate its physician and hospital incentives with large private sector incentive programs such as the Leapfrog Group.

Second, within CMS and AHRQ efforts to compare and improve clinical performance, much more heavily prioritize measures of the cost-efficiency for doctors and hospitals over the duration of an episode of acute illness or a year of chronic illness. Given the crisis in health care affordability both in the private and public sectors and evidence of a roughly 40-percent uncaptured efficiencies in the American health care industry, this facet of performance measurement and incentivization deserves a higher priority. Third, while fully protecting Medicare beneficiary privacy rights under HIPAA and the Privacy Act, allow private sector health plans routine access to the beneficiary de-identified, full Medicare claims database. Almost no private sector purchasers or insurers have enough claims experience in any one location to measure precisely the longitudinal cost efficiency and quality of individual physicians and specific hospital service lines. Access to the full Medicare claims database would allow them to more precisely measure and therefore reward more robustly physicians and hospitals for superior quality and longitudinal efficiency.

Rapid improvement in performance measurement would emancipate America's doctors and hospitals from the irrationality of public and private health benefit plans that primarily reward the cheapest unit prices and often unintentionally punish improvements in quality and longitudinal efficiency. America's current movement to use consumer-directed health benefit plans to incentivize Americans to select more efficient, higher-quality health care options can provide about half the horsepower we need to achieve breakthroughs in the affordability and quality of our health care. The rest must come from reformed public and private sector payment systems that make an irresistible business case to our health care industry to take up modern tools of performance management and drive quality and longitudinal efficiency up to the levels that America needs and deserves. Thank you.

[The prepared statement of Dr. Milstein follows:]

Statement of Arnold Milstein, M.D., Medical Director, Pacific Business Group on Health, San Francisco, California

I am Dr. Arnold Milstein, a physician at Mercer Human Resource Consulting and Medical Director of the Pacific Business Group on Health (PBGH). PBGH is California's coalition of large employer health care purchasers and also supports the health benefits needs of more than 9,000 small California employers.

I have helped to develop, and currently participate in the governance of, three private sector programs to pay American doctors and/or hospitals for superior performance: the Leapfrog Group, Bridges to Excellence, and the Integrated Healthcare Association's (IHA) Pay-for-Performance Program. The IHA program is projected to pay over $100 million to better performing California physician groups in 2004. My comments today on health care pay-for-performance programs are not intended to represent these five organizations.

A more detailed review of U.S. health care pay-for-performance programs will be published on the Commonwealth Foundation's website in April. It is based on a paper commissioned by the Foundation that I prepared for the Foundation's International Health Care Leadership Colloquium at Bagshot, England in July of 2003.

1. **The American health care industry is severely underperforming.** Compared to other developed countries, we spend substantially more of our GDP on health care. In return, we get easier access to advanced biomedical innovations, but poor health care industry adherence to evidence-based treatment guidelines, patient safety standards, and efficient care delivery methods. Current scientific estimates (specified in my testimony to the Joint Economic Committee on February 25 and Senate HELP Committee on January 28) by Rand, the Institute of Medicine, and nationally respected health services researchers at Dartmouth, Harvard and Intermountain Health Care, give us an approximately 50% national score on exposing Americans to substandard quality of care and preventable treatment complications and a 40% national score on wasting their health benefits spending via services with undetectable health benefit and/or inefficient service delivery methods. Though the health care industry is making efforts to improve, the level of effect is not yet scaled to the magnitude of the problem.
2. **One root cause of this unintended equilibrium is toxic payment incentives that do not reward doctors, hospitals, managed care organizations, or treatment innovators for superior quality and superior total cost efficiency over the longitudinal course of an acute or chronic illness.** As Tom Scully frequently observed, it is insanity to pay the same price for any service without regard to differences in performance. Others such as Dr. Brent James at Intermountain Health Care have detailed how improvements in longitudinal cost-efficiency and quality are often penalized under today's *performance-insensitive* payment systems. Why would we expect that quality and longitudinal cost efficiency would flourish under such an incentive system?
3. **Payment incentives can be effective in improving health industry performance.** While the evidence to support this statement is based as much on anecdote as on scientific evidence, most private sector purchasers regard it as self-evident, based on all other American markets for products and services.

I've attached a thoughtful recent synopsis by researchers at the Harvard School of Public Health of experience to date in 37 recent U.S. programs to pay doctors and/or hospitals for higher performance. Its most important conclusion is that it will be difficult to measure or maximize the effectiveness of doctor and hospital pay-for-performance programs, until they affect a much larger fraction of physician and hospital total income.

4. **Performance-based payment incentives for doctors, hospitals, and managed care organizations are an increasing private sector trend.** Few of the 36 private sector incentive programs included in the Harvard study existed five years ago.
5. **Payment incentives are not the only market levers for lifting clinical performance.** "Sunlight" created by the public release of easily understandable, credible, and comparable performance measures on important measures of quality such as death rates, complication rates, and rates of adherence to clinical guidelines, has been shown to motivate a 3X increase in provider improvement effort (J. Hibbard, *Health Affairs*, January 2003) and improved clinical results (E. Hannan, *Medical Care*, January 2004). Other powerful private sector market levers on performance include substantial loss of patient volume from insurance plans that exclude or reduce insurance coverage for less well performing physicians, hospitals, and/or treatment options.
6. **Market based payment incentives are more effective when combined with other performance drivers.** Among the most important are physician and hospital access to and training in two generic tools of modern performance management of complex, high risk consumer service industries such as commercial airlines: (1) electronic, interoperable information systems that allow continuous prompting of professionals and/or service users whenever opportunities exist to improve a plan of services or prevent service implementation errors; and (2) greater use of operations engineering expertise in managing performance over the entire course of a consumer's period of service need. Almost sixty years of post World War II progress in biomedical technology has transformed American health care from a relatively simple, ineffective, low-risk, and inexpensive service menu of services to a highly complex, potentially very effective, dangerous, and expensive service menu. However, our clinical information systems continue to depend on handwriting, paper documents, and highly fallible human memory; and advanced expertise in operations engineering is wholly absent in the clinical work of most hospitals and physician offices. Early performance exemplars such as Intermountain Health Care in Salt Lake City and Theta Care in Appleton, Wisconsin have shown that insertion of these two modern industrial tools into the DNA of American health care delivery can generate very large quality increases and/or efficiency capture. Multiple new private sector programs to incentivize physician and/or hospital performance breakthrough (such as the Leapfrog Group, the Integrated Health Care Association, and Bridges to Excellence) recognize the importance of these two ingredients and have directed a substantial fraction of their incentives at provider adoption of them, in addition to incentivizing high performance.
7. **There are budget-neutral opportunities for Congress to much more vigorously reinforce private sector momentum to incentivize longitudinal cost-efficiency and quality among doctors and hospitals.** These include:
   A. **Encourage CMS to speed and significantly expand its current, laudable efforts to (1) make publicly available quantified measures of hospital and physician quality, clinical information system adoption, and clinical management capabilities (for example, achieving NCQA's certification in physician office systems); and (2) coordinate its physician and hospital incentives with large national private sector incentive programs such as the Leapfrog Group; and (3) prepare to implement promptly recommendations for CMS provider incentives, expected in 2005 from the Institute of Medicine.**
   B. **Reprioritize NIH spending in favor of AHRQ, especially for efforts to (a) test and refine comparable measures of performance of physicians, hospitals, and treatment options; and (b) accelerate physician and hospital use of clinical information systems and operations engineering tools to improve their performance.** NIH biomedical research is America's health care muscle; AHRQ health services research is America's health care brain. We currently allocate NIH funds in an approximate ratio of 99% muscle to 1% brain. The result is an American A+ on treatment discovery and an American C− on efficient, high quality delivery of these treatments.

C. **Within CMS and AHRQ efforts to compare and improve American clinical performance, much more heavily prioritize measures of longitudinal cost-efficiency for doctors, hospitals, and treatment options.** Given the crisis of health care affordability in both the private and public sectors and evidence of roughly 40% uncaptured efficiencies in the American health industry, this facet of performance measurement and incentivization deserves higher prioritization within CMS and AHRQ. Recently enacted Medicare demonstration projects are directionally favorable, but more broadly applicable near-term incentives for longitudinal cost-efficiency are warranted.

D. **While fully protecting Medicare beneficiary privacy rights under the Privacy Act and HIPAA, allow private sector health plans continuous access to the beneficiary de-identified, full Medicare claims database.** Almost no private sector purchasers have enough claims experience in any one location to measure precisely the longitudinal cost-efficiency and quality of most individual physicians and specific hospital service lines, such as knee replacement surgery. Access to the Medicare claims database would allow them to identify more precisely measure and therefore reward more robustly physicians and hospitals for superior quality and longitudinal cost-efficiency. In addition, expansion of billing data required for Medicare payment would greatly improve the cost and precision of performance measurement. Such an expansion is illustrated by recent recommendations of the Quality Work Group of the National Committee on Vital and Health Statistics. Rapid improvement in performance measurement would emancipate America's doctors, hospitals, and treatment innovators from the tyranny and irrationality of public and private health benefit plans that primarily reward the cheapest unit prices and often unintentionally punish them for improvements in quality and longitudinal cost efficiency.

America's current movement to use consumer-directed health benefit plans to incentivize Americans to select more efficient, higher quality health care options, including improved health behaviors, can provide half of the horsepower we need to achieve breakthroughs in the affordability and quality of our health care. The rest must come from reformed public and private sector payment systems that make an irresistible business case to our health care industry to take up modern tools of performance management and use them to continuously optimize quality and longitudinal cost-efficiency.

Chairman JOHNSON. Thank you very much, Dr. Milstein. Dr. Ho.

STATEMENT OF SAMUEL HO, SENIOR VICE PRESIDENT AND CHIEF MEDICAL OFFICER, PACIFICARE HEALTH SYSTEMS, INC., CYPRESS, CALIFORNIA

Dr. HO. Good morning. My name is Sam Ho. I am the Chief Medical Officer of PacifiCare Health Systems, Inc., and I thank you for the opportunity to share PacifiCare's experiences and results on the health care quality improvement. Today I will be providing you an overview of the comprehensive and integrated strategy that PacifiCare has developed around quality initiatives. Some of these programs I knew. Others reflect years of effort. For example, since 1998, we have engaged in sophisticated provider profiling, as reflected in our Quality Index. In 2002, we began provider payment incentives, as exemplified by our quality incentive program. We also created value or tiered networks in 2002, and 7 years ago we initiated what I believe are noteworthy disease management programs. Most recently, we have implemented consumer incentive programs intended to reward consumers who engage in healthier behaviors. I will briefly touch on each of these. Taken together, we

believe this integrated suite of programs has shown remarkable results in improving quality health care delivered to our members.

First, the Quality Index Profile has been a powerful tool to help close what the Institute of Medicine has characterized as the quality chasm. This consumer-oriented, publicly disclosed report card of provider performance has been published semiannually since 1998. Encompassing 55 measures of clinical and service quality, this profile has proven to be a credible and relevant information tool for consumers and providers. Over the past 5 years, 65 percent of the Quality Index measures have demonstrated annual improvement in cancer screening rates, treatment of diabetes, coronary disease, congestive heart failure, asthma and acute infections as well as improvement in patient satisfaction and specialty referrals.

Providers have effectively responded to the Quality Index by competing and moving the needle on quality. Conversely, our members have also emphatically responded. Over 30,000 members have gravitated to better performing providers each year, averaging over a 6-percent increase in membership to these providers on an annual basis. This is a statistically significant response. The second component of our Quality Index strategy is the Quality Incentive Program. Begun in 2002, this program has incorporated 10 measures from the Quality Index well as other measures of patient safety and patient satisfaction. After establishing an incentive pool of $14 million and requiring performance levels by providers over the 75th percentile for each indicator, over 140 medical groups in California have been rewarded with quality bonuses on a quarterly basis since last July. As a result, we have seen 12 of the 16 measures demonstrating significant improvement; and the average relative increase exceeds 30 percent, which is a remarkable achievement in so short a time.

Currently, we are expanding our 2004 initiative to include 21 measures, increasing the thresholds to the 85th percentile and increasing the overall incentive pool to $21 million. We have demonstrated that both report cards and incentives work in improving quality and benefiting both patients and doctors. The third component in our strategy is the development of a value network and a value insurance product. Derived from our Quality Index profiles, we defined a subnetwork of providers who have demonstrated greater efficiency and effectiveness in managing health care. Employers such as Wells Fargo Bank, Lockheed Martin Corporation and Xerox have purchased our value health plan product, where costs in general are approximately 20-percent lower and quality is approximately 20-percent higher than our standard plan.

Furthermore, health care cost trends are 14-percent lower in the value network. Such an insurance product benefits both employers looking for relief from health care cost inflation as well as consumers who are rewarded with higher quality. Briefly, the fourth component of our Quality Index strategy is our comprehensive suite of programs geared to addressing our members' health and disease status. Applying evidence-based medicine, we have demonstrated significant improvements in many areas of preventive health and chronic diseases. Four such examples of our results include increasing appropriate medication use in patients with congestive heart failure by 26 percent, thereby reducing hospitaliza-

tions by 50 percent and saving over $69 million cumulatively; improving the use of life-saving medication with patients with coronary disease to 98 percent when recent studies show that the national average is 45 percent; for patients with chronic lung disease, improving symptoms by 29 percent and quit-smoking rates by 30 percent; and for diabetics we have improved blood sugar and cholesterol control levels by 25 to 30 percent.

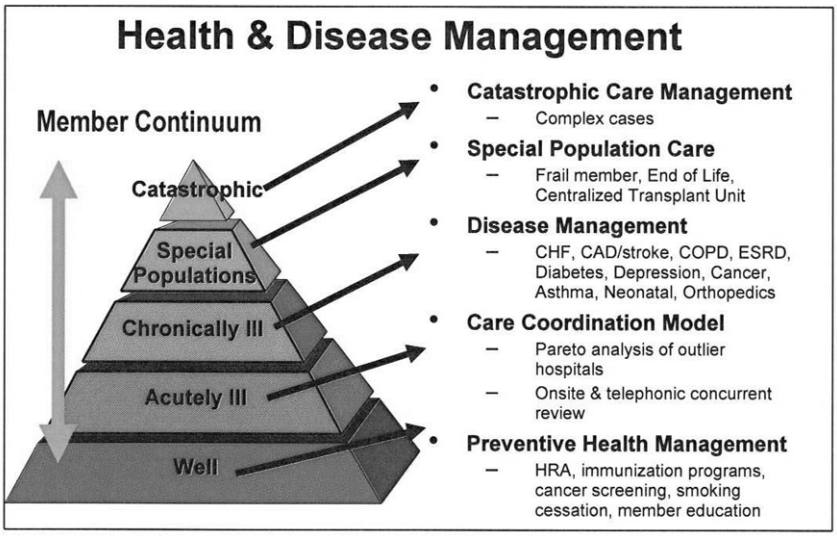
The last component of our QI strategy is our newly launched Health Credits, which is a rewards and report card program customized for Members. In this program, consumers can earn credits by participating in any of 16 health and disease management programs around diabetes, for example, or heart disease and improving their health via better diet, exercise and lifestyle choices. Also available is an online health risk assessment to help members gauge their current health status, as well as to receive tips on how to improve their health. In summary, I feel that PacifiCare has demonstrated health care initiatives and report cards as well as incentives that work for both consumers and physicians. Again, I thank you for allowing me this opportunity. I would be happy to answer any questions.

[The prepared statement of Dr. Ho follows:]

Statement of Samuel Ho, M.D., Senior Vice President and Chief Medical Officer, PacifiCare Health Systems, Inc., Cypress, California

Good Morning, Chairman Johnson and members of the Subcommittee. I am Dr. Sam Ho, Senior Vice President and Chief Medical Officer of PacifiCare Health Systems, and I appreciate the opportunity to discuss PacifiCare's experience with health quality initiatives. PacifiCare Health Systems (PHS) serves more than 3 million health plan members and approximately 9 million specialty plan members nationwide and has annual revenues of nearly $11 billion. PacifiCare offers individuals, employers, and Medicare beneficiaries a variety of consumer-driven health care and life insurance products including HMO, Value HMO, PPO, self insured and fully insured consumer-directed health plans, EPO, and Medicare+Choice (now Medicare Advantage) plans. Specialty operations include behavioral health, dental, vision, and complete pharmacy benefits management.

PacifiCare believes that a quality-driven, consumer-centric health plan should focus on improving and maintaining the health of its members in every stage of their life—whether they are sick, well, or in-between. We have developed a broad array of programs across the continuum of health care services built upon scientifically proven criteria and evidence-based medicine, with a focus on improving members' quality of life and enhancing providers' practice of evidence-based medicine, as illustrated by the following simple diagram.



NCQA (National Committee on Quality Assurance) Accreditation

PacifiCare has a demonstrated interest and experience in improving the quality and affordability of care provided to our members, as exemplified by consistent NCQA Excellent Accreditation awards, award-winning disease management programs and quality improvement initiatives, and industry-leading medical management techniques.

Starting in 1991, PacifiCare has demonstrated effective programmatic structure, processes and outcomes in quality improvement, as reflected in continuous NCQA accreditation, at the "Excellent" level. For example, PacifiCare of California was the first statewide managed care organization to have earned NCQA's highest level of accreditation, an Excellent status. Our most recent survey results include four 'stars' in the five categories surveyed: Access and Service, Qualified Providers, Staying Healthy, Getting Better, and Living with Illness. This recognition highlights our proven strengths in quality improvement, comprehensive chronic condition management and development of clinical practice guidelines and the extensive array of education materials we make available to our members.

HEDIS (Health Plan Employer Data and Information Set) Performance

Across PacifiCare commercial health plans, HEDIS 2003 results improved 4.3 percent from 2002, across 14 of the 15 measures with stable NCQA definitions, meeting or exceeding prior year performance. Performance, as compared to the national 90th percentile published by NCQA, was noteworthy in several areas:

- All PacifiCare plans met the national 90th percentile for Beta Blocker Treatment Following a Heart Attack.
- Among the measures pertaining to women's health, the national 90th percentile was met by 75 percent of PacifiCare plans for cervical cancer screening.
- Among the measures pertaining to Comprehensive Diabetes Care, the 90th percentile was met by 63 percent of PacifiCare plans for HgA1c Testing, 75 percent of PacifiCare plans for Eye Exams and Monitoring for nephropathy and 100 percent of PacifiCare plans for LDL–C Screening.

Health and Disease Management Programs

Our cutting edge Health and Disease Management programs and services include educational and screening guidelines and programs available through a member's primary care physicians and health-related information and programs accessible on our Internet site at www.pacificare.com. We also have a direct mail reminder program for healthy members who appear to be missing recommended periodic preventive health screenings. PacifiCare's population-based health management programs include: Taking Charge of Diabetes®, Taking Charge of Your Heart Health®, Taking

Charge of Depression®, StopSmoking, Taking Charge of Asthma®, Pregnancy to Preschool and Health AtoZ.

We have also developed case-based disease management programs, addressing the most-at-risk patients with coronary artery disease, stroke, congestive heart failure, chronic obstructive pulmonary disease, end stage renal disease, cancer, orthopedics, and neonatal ICU care, to improve the quality of the care received by our members with chronic diseases.

These programs enable PacifiCare to offer the appropriate level of care at the right time and place at no additional cost to its members. By extension, these programs help to improve or stabilize the healthcare cost inflation trend and reduce the demand on provider services by complementing other programs we offer to members. Since 1997, PacifiCare has earned many national distinctions for its impact on improving clinical outcomes amongst these cohorts.

Results from our disease management programs have been notable. For example, life-saving medication use, such as beta-blocker therapy for patients with coronary artery disease or ACE-inhibitor use for our patients with congestive heart failure, have increased by 20–30 percent and those rates are double the national average reported in FFS medicine. Also, case management and disease management proactively manage outcomes by preventing inappropriate hospitalizations from occurring. Rather than wait for a hospital admission to signal eligibility in these programs, we employ advanced analytics and identify patients earlier.

Four examples of our results include:

- Increasing appropriate medication in patients with Congestive Heart Failure by 26 percent and thereby reducing hospitalizations by 50 percent and saving over $75 million cumulatively.
- Improving the use of life-saving medications for patients with coronary artery disease to 98 percent when recent studies show that the national average is 45 percent.
- For patients with chronic lung disease, improving symptoms by 29 percent and decreasing smoking rates by 30 percent.
- For diabetics, we've improved blood sugar and cholesterol control by 25–30 percent.

To date, documented savings have exceeded $185 million in these programs. Although 90 percent of those savings are attributed to Medicare+Choice patients (due to the high prevalence of chronic disease among seniors), commercial patients have been similarly and favorably impacted as well.

Focused Medical Management

PacifiCare has developed industry-leading Medical Management programs to ensure each member receives all the appropriate care. Our Medical Management programs focus on reducing variation, improving the quality of care provided and assuring cost effectiveness. We base medical decisions on scientific evidence, and all of our medical management services include physician leadership and input. PacifiCare has developed online, science-based and objective Utilization Management criteria as well as technology-based clinical decision support systems related to case/utilization/disease management. Our extensive suite of programs includes:

- prior authorization
- on-site concurrent review
- telephonic concurrent review
- post service review
- case management
- disease management
- advanced care management

Disease management, demand management and case management are all primarily geared toward reducing preventable admissions to hospitals, whereas our medical management programs are primarily focused on assuring appropriate lengths of stay during hospital admissions. PacifiCare's medical management programs include: rigorous data analysis, identification of outlier groups of physicians and hospitals, collaborative physician education and assistance, expedited care coordination involving multi-disciplinary approaches and the incorporation of "high-touch" contact with "high-tech" monitoring.

Incorporating the above components, PacifiCare introduced Care Coordination, a program for managing inpatient care that combines the skills and experience of its centralized team with the effectiveness of the field staff. Pacificare has taken its extensive on-site and telephonic medical management experience and produced a re-

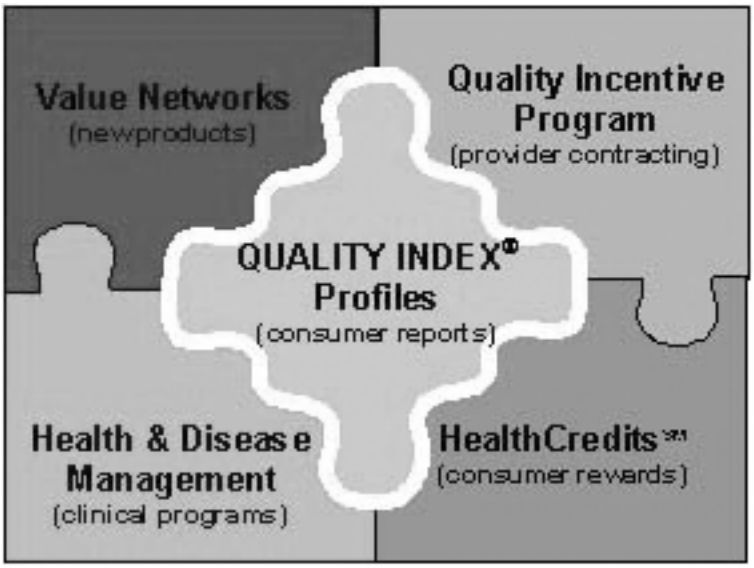
fined program that assures patients receive the appropriate care at the right time and place.

Our care coordination model focuses resources on the 20 percent of hospitals in every market, which are responsible for 85 percent of the variant or outlier bed days. In this way, we can impact bed day management in a focused manner, rather than micro-management, which is unnecessary and inefficient.

Quality Improvement Initiatives

PacifiCare has demonstrated successful results in improving the quality and affordability of care provided to our members through a comprehensive and integrated strategy. For example, we have engaged in sophisticated provider profiling leading to the development of our Quality Index® program in 1998; in 2002, we began provider payment incentives as exemplified by our Quality Incentive Program; we also created value, or tiered, networks in 2002; seven years ago, we created and implemented what I believe are noteworthy disease management programs; and, most recently, we have implemented consumer incentive programs intended to reward consumers who engage in healthier behaviors. Taken together, we believe this integrated suite of programs has shown remarkable results in improving the quality health care delivered to our members.

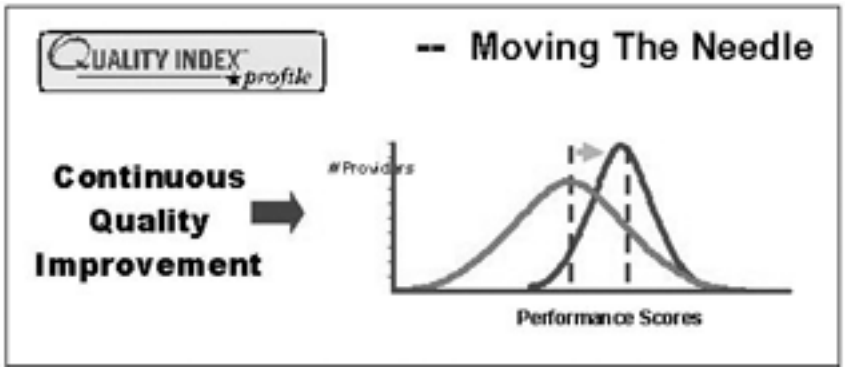
PacifiCare's Integrated Strategy



As a cornerstone, PacifiCare introduced comprehensive provider profiling in 1994 as an effective management tool to improve provider behavior and clinical results. When combined with health and disease management programs, focused medical and utilization management programs, and care management programs, these profiles have represented leading-edge analyses and measurements to assist contracting providers to better manage clinical quality, as well as healthcare costs.

Building on provider profiling, in 1998 PacifiCare released its QUALITY INDEX® Profile of Physician Organizations. This unique report provides consumer information on provider group performance in selected areas of clinical and service quality and affordability. The QUALITY INDEX® Profile provides consumers with an effective tool to make informed health care decisions, including the quality, affordability and value of the services they receive from our contracted network of providers. Ongoing measures range from preventive health screenings and clinical treatment of chronic diseases to frequency of member complaints and overall satisfaction with the level of service. Physician groups ranking in the 90th percentile or above in any of the measures receive a "best practice" designation, which is also included in PacifiCare's provider directory. This semi-annual, award-winning report has been expanded and enhanced since its first release, and now features the relative performance achieved by provider groups on 58 credible and relevant measures.

Providers have responded by competing and improving average mean performance in 65 percent of clinical and service measures. Also, members have 'voted with their feet' by changing to better performing providers, which, in turn, represents $18 million in additional annual capitation payments to those providers. Both results, 'voting with their feet' and providers 'moving the needle' on performance, represent a significant impact on the quality of health care delivered to our members and rewards given to our providers and these results have been sustained annually since 1998 and are unprecedented in the health care industry.



In 2001, PacifiCare of California introduced the first edition of the QUALITY INDEX® Profile for Women. This unique report is comprised of data specific to female patients from providers in our contracted network. It measures relative provider group performance on 14 selected areas of clinical and service quality. The charts within the QUALITY INDEX® Profile for Women illustrate how provider groups address the needs of their female patients and also how satisfied the female patients are with the care they receive from their providers. In 2003, PacifiCare took a further step and published the QUALITY INDEX® of Hospitals, a report card on the relative performance of hospitals in our contracted network on 56 measures of risk-adjusted complication rates and mortality rates, hospital patient safety measures, utilization and patient satisfaction related to common medical, surgical, obstetrical, orthopedic and pediatric conditions.

These profiles are shared on PacifiCare's public website, summarized in our Provider Directory and are mailed annually to commercial members through our member newsletter/magazine.

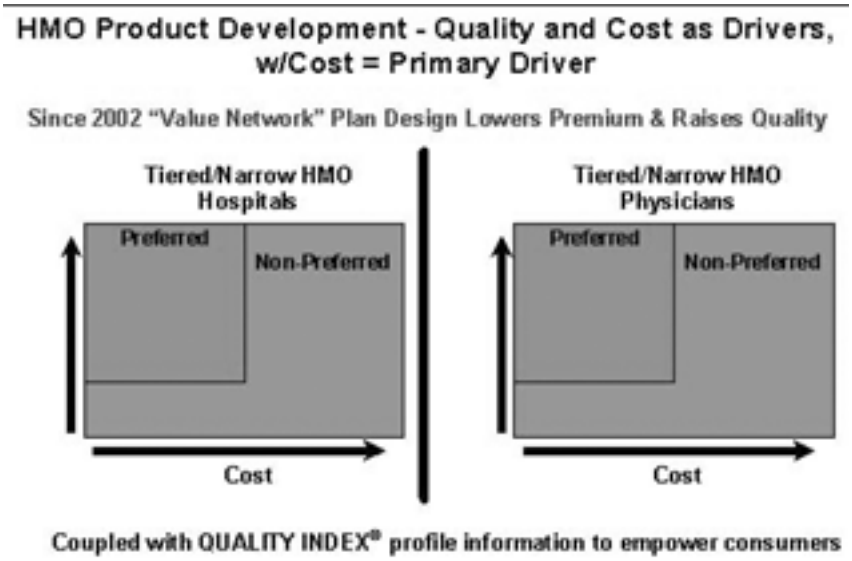
Tiering Benefits Based on Quality and Cost

Based on the success of member migration to best performing groups, as well as the impact of competition on unnecessary variation in quality and cost outcomes amongst provider delivery systems, PacifiCare was the first plan in the country to develop tiered benefits based on the performance of providers selected. In 2002, PacifiCare initiated the first tiered hospital network in the country, based on underlying costs of hospitals within California. In 2002–2003, PacifiCare developed and launched the first-ever value network product (PacifiCare SignatureValue℠ Advantage), based on the quality and costs of providers selected. The foundation for such product development has been the QUALITY INDEX® profiles. In PacifiCare's value health plan network, the participating medical groups have been selected using 17 measures of both medical group and hospital performance.

In order to qualify for the value health plan network, providers must meet established cost and quality targets. Health care cost measures link physician costs, pharmacy costs, and the costs of hospitals to which primary admissions are directed. In 2002, quality measures included 10 indicators of physician group performance and 6 measures of hospital performance. Physician performance included 5 clinical measures (breast cancer and cervical cancer screening rates, childhood immunization rates, diabetic and coronary artery disease care metrics) and 5 service/satisfaction measures (all derived from CAHPS). Hospital performance was based on a subset of patient safety measures and 1 patient satisfaction measure based on PEP–C (hospital-derived CAHPS survey). In 2003, the 5 patient safety measures have been incorporated into 3 general indicators from PacifiCare's QUALITY INDEX® profile of Hospitals, which represent aggregates of 48 measures.

Approximately 70 percent of PacifiCare's standard HMO network participates in the value HMO network in the counties where this is offered, and PacifiCare SignatureValue℠ Advantage is offered in conjunction with PacifiCare's standard HMO product.

By driving market share to cost-effective providers and hospitals, based on differential premium contributions and/or co-pays tied to differential performance of providers, healthcare costs are approximately 20 percent lower and quality is approximately 20 percent higher than our standard plan. Furthermore, health care cost trends are 14 percent lower in the value network.



Quality Incentive Program (Paying for Performance)

PacifiCare's Provider Quality Incentive Program (QIP) was initiated in 2002 aligning the identical measures used to determine value network eligibility with a pay-for-performance program. After the first 12 months of the QIP program, over 140 medical groups performed at or above the 75 percentile level in at least one of 16 indicators, and were rewarded from an incentive pool of $14 million. In 12 of the 16 measures, improvement occurred throughout the network, and averaged over 30 percent. In the second year of the QIP, 5 more measures have been added, thresholds have been raised to the 85 percentile per indicator, and the incentive pool has been increased to $21 million. By aligning our Quality Index® profile with an insurance product design and a quality incentive program, PacifiCare has begun to optimize provider, member, and purchaser behavior to focus on value-based choices and actions.

Consumer Rewards—HealthCredits℠

In 2003, PacifiCare launched it HealthCredits℠ program to encourage and reward consumers in practicing healthier lifestyles and behavior. For example, points, or credits, will be earned after documentation of healthier activities, such as completion of a health risk assessment, sustained enrollment in a disease management program, consistent attendance in weight management programs or consistent completion of on-line nutrition and exercise plans through PacifiCare's VirtualHealthClub℠. After an established threshold of credits has been reached, members are eligible for prizes and discounts on health promoting products.

Additionally, employers may introduce richer benefits, such as reduced copays, or increased employer contribution, or perhaps additional personal time off/vacation days. Such an approach leverages the automobile or homeowners insurance model, where lower premiums are offered to subscribers who wear seat belts, avoid traffic violations, or purchase fire/security alarm systems.

Information, Integration and Innovation

PacifiCare has developed a well-integrated strategy to exploit its core competency in health and disease management programs, focused medical management and quality improvement initiatives. Such a strategy includes innovative and industry-leading programs such as our QUALITY INDEX® Profile of Physician Organizations, of Hospitals, and for Women; our Value Network plan, our Quality Incentive Program and our HealthCredits℠ program. Such programs represent the leading edge in helping to close the "quality chasm" and help manage healthcare costs, largely through the activation and engagement of consumers through information, incentives and informed choices.

In conclusion, I would like to thank the Members of this Subcommittee for their interest in health care quality innovation and for the opportunity to present PacifiCare's views on this important topic. Thank you.

Chairman JOHNSON. Thank you very much, Dr. Ho. Dr. Crosson.

STATEMENT OF FRANCIS J. CROSSON, EXECUTIVE DIRECTOR, PERMANENTE FOUNDATION, OAKLAND, CALIFORNIA

Dr. CROSSON. Madam Chairman, Members of the Subcommittee, my name is Dr. Francis J. Crosson. I am the Executive Director of the Permanente Federation, a national organization of Permanente medical groups. Thank you very much for inviting me to testify on this vitally important topic. I would ask that my written testimony be included in the record. Today, I am speaking on behalf of Kaiser Permanente. I want to share some observations about the key reasons for our six decades of success in delivering high-quality, cost-effective health care. We hope that these observations might help point the way to better, more efficient health care for all Americans. First, at Kaiser Permanente integration is more than a promise. It is a reality. Our delivery system is based on physicians organized into large multispecialty group practices. The group practice culture stresses a coordinated team approach to the delivery of care. Also, integrated care is greatly facilitated, because physicians in group practice share a unified medical record for every patient, a powerful engine of quality and safety.

Second, the multispecialty group practice model enables us to integrate the entire continuum of care. As our members move from one stage of life to another, their needs change. We meet these needs best through a single system that delivers care through primary care physicians, specialists in hospitals, home health programs, health education programs, pharmacies and clinical laboratories. Finally, at Kaiser Permanente, the entire organization is aligned in the pursuit of improved quality. In addition, to clinical integration, the delivery system operates in a close partnership with the insurance operations, especially those that affect care delivery such as benefit design and the uses of capital. Why does all this integration and collaboration matter to health care consumers or purchasers? Let me cite just three examples.

The multispecialty group model is uncommonly capable of coordinating care for patients with multiple chronic conditions, an already large population that is growing rapidly with the aging of America. For example, one in four Kaiser Permanente members with diabetes also suffers from coronary artery disease or heart failure. Because we can coordinate care across specialties in a sin-

gle setting, we can meet virtually all of our patients' needs in a tightly coordinated way. Our success at doing so is evident in our chronic disease prevention and management quality measures as rated by the National Committee for Quality Assurance and others. Integration from patient education to early intervention to critical care is evident in the way we address the problem of heart disease. In our Northern California region, thanks to more than a decade-long program to implement systematic, evidence-based programs of chronic condition management, heart disease is no longer the leading cause of death for that region's 3.5 million members, although it remains so for the non Kaiser Permanente population.

Finally, our integrated delivery model is an ideal environment for reaping the extraordinary benefits of clinical IT. We are convinced that IT is the key to dramatic improvements in patient safety, health outcomes and health care resource utilization. This is why we are investing more than $3 billion over the next few years to implement a state-of-the-art clinical information system everywhere that our patients are treated throughout our program. So, how can the Federal Government help transfer the lessons we have learned at Kaiser Permanente about improving care to other delivery systems and providers?

First, the Federal Government can play a key leadership role in promoting the development of more sophisticated, evidence-based quality measures, widely adopted measures against which plans and providers can be held accountable. Such accountability, we believe, promotes integration. Second, the Federal Government can further promote a quality-driven health care market by using and encouraging other public and private purchasers to employ financial incentives related to performance on the same measures. Third, widespread use of state-of-the-art IT is vital to the kind of transformation of the health care delivery system envisioned by the Institute of Medicine in its 2001 report, Crossing the Quality Chasm. Both public and private purchasers need to support that transformation through provider and delivery system incentives. Finally, recognizing the importance of expanding the science base of medicine, last year's MMA included a provision to authorize the AHRQ to initiate a research agenda to compare the relative effectiveness of prescription drugs and other interventions designed to treat the same condition, a valuable step toward better quality in efficiency. I want to urge the Congress this year to make at least $75 million in fiscal year 2005 available for that effort. Thank you for the opportunity to address you.

[The prepared statement of Dr. Crosson follows:]

Statement of Francis J. Crosson, M.D., Executive Director, Permanente Foundation, Oakland, California

Madame Chairwoman, Representative Stark, members of the Subcommittee, I am honored to be here today to testify before you on health care quality, an issue that is sure to grow in significance as the nation grapples with the challenges of the uninsured, the growth of health care costs, and delivery system reform. My name is Dr. Francis J. Crosson. I am the Executive Director of the Permanente Federation, the national organization of the Permanente Medical Groups. Today, I am speaking on behalf of Kaiser Permanente, one of the nation's leading health plans and its largest private-sector health care delivery system. Kaiser Permanente provides health care coverage and medical care to more than 8.3 million members in nine states and the District of Columbia. The Permanente Medical Groups include more

than 12,000 physicians, who are supported by approximately 125,000 professional and administrative employees.

In my remarks today, I want to share some information and observations about what we at Kaiser Permanente believe are the key challenges to improving American health care. I will also discuss how Kaiser Permanente is responding to these challenges through our integrated, team-based care delivery model, innovative care processes, state-of-the-art information technology, evidence-based provision of pharmaceuticals, and an overarching focus on preventive care and the achievement of health, in addition to the improvement in quality of life for those with chronic conditions. I will conclude my remarks with some suggestions for ways in which we believe health care policymakers—not only the government but the large purchasers of health care, as well—could contribute to the goal of creating a stronger, more effective and more efficient health care delivery system for all Americans.

The Institute of Medicine's (IOM) 2001 report, *Crossing the Quality Chasm*, provides a very useful review of many of the shortfalls of the American health care delivery system. As the "Chasm" report states, "If we want safer, higher-quality care, we will need to have redesigned systems of care, including the use of information technology to support clinical and administrative processes. . . . The current care systems cannot do the job. Trying harder will not work. Changing systems of care will."

Improved systems of care, strengthened by the power of information technology: That, in a nutshell, is the IOM's prescription for crossing the great "quality chasm" that persists in American health care.

Across America, there are a number of models of systematic health care delivery systems, based on multispecialty group practice, that are producing encouraging results and warrant close attention. For more than half a century, Kaiser Permanente has systematically promoted the dynamic integration of patients, physicians and other clinicians across the entire delivery system, along with a commitment to evidence-based medicine. Today, I am pleased to tell you, we are leveraging the power of that integration by investing more than two billion dollars in a state-of-the-art clinical and administrative information system. Within three to four years, virtually all of our 8.3 million members, and all of our physicians and ancillary staff—nurses, lab technicians, pharmacists, radiologists, care managers and others—will have access to a comprehensive electronic medical record system with powerful decision support capabilities.

A New Care Paradigm

But new systems of care, even those leveraged by powerful IT systems, will not be enough to keep pace with the changing, accelerating demands of today's and tomorrow's health care consumers. To meet those demands—especially the needs of an aging population beset with multiple chronic conditions—a new paradigm of care is required. Tomorrow's systems of care must be held accountable, through widely endorsed standards of quality and efficiency, not only for the "sick care" they provide—the treatment of heart attacks, strokes, fractures, infections and other acute, episodic events—but even more importantly for the way in which such systems are focused on the cost-efficient promotion of overall health and quality of life. There is now compelling scientific evidence that, through concerted, systematic action, chronic conditions such as diabetes and heart disease need not result in an inevitable progression to debility and death. In the health care system of the future, even the very near future, the valid metric of accountability must be expressed not merely in units of health care provided, but most importantly in terms of the overall dimensions of health.

Kaiser Permanente has made significant strides toward the realization of the kind of IT-enhanced, integrated care system envisioned by the IOM. In addition, because of our more than half a century of experience with population-based care, we have continually sought ways to move the focus of care from the downstream demands of acute, invasive—and increasingly costly—episodic care to the rich, upstream potential of prevention, care management, and strategies to maintain the health and quality of life of our members. I would like to share with you some examples of Kaiser Permanente's innovative approaches to improving quality and the results we have achieved. Today, I will focus on the areas of chronic care management, the use of clinical information systems, pharmaceutical use management, and elder care. In addition, I would like to offer some observations about how our integrated system of care has enabled us to achieve dramatic strides in these areas.

Chronic Care Management: The Challenge of Our Era

As you know, chronic and complex conditions are now the leading cause of disability, acute illness, and death. As the IOM has noted, they affect nearly 1 in 2

Americans, and they consume the lion's share of all health care expenditures (Hoffman et al., 1996; The Robert Wood Johnson Foundation, 1996). Among Kaiser Permanente's non-Medicare members in our Northern California region, individuals with chronic conditions account for two-thirds of all costs, and the share is significantly higher for our Medicare members. For Kaiser Permanente, as for almost any other health care organization offering comprehensive benefits, the ability to deliver high-quality care efficiently to this population is an imperative.

To meet that imperative, in 1997 we created the Kaiser Permanente Care Management Institute, a program-wide resource that works with regional experts to identify, disseminate and support the adoption of evidence-based best practices. Tools provided to physicians and members include evidence-based care guidelines, medication protocols, participation in interdisciplinary care teams that identify ways to manage patients who have more than one chronic condition, and "beyond the exam room" support for members to make and sustain lifestyle changes that can reduce their burden of illness, such as smoking cessation, weight management, increased physical activity, and dietary counseling.

Comprehensive, team-based programs are being developed for the 20 most common, high-impact conditions identified as priorities by the IOM. By facilitating the development and diffusion of this knowledge base throughout our organization, we have moved the average performance of all eight KP regions on many key metrics of quality to a level that significantly exceeds what had been the peak performance level of the very best KP region just three to six years ago. Each year brings further advances at the leading edge of performance. For example:

- Coronary artery disease (CAD)—Unlike the rest of the United States, heart disease is no longer the leading cause of death for members in Kaiser Permanente's Northern California region. Focused efforts in managing heart disease over more than a decade have reduced mortality from heart disease for these 3.5 million Americans by 30 percent, so that it is now the second leading cause of death, behind cancer.
- Diabetes—Control of blood sugar in members with diabetes has increased steadily since 1996. Between 1996 and 2002, 37,000 more members with diabetes achieved a good level of control. This will translate into significantly fewer complications. For example, if these same 37,000 members maintain a good blood glucose (sugar) level over the next 10 years, at least 875 of them would greatly reduce their risk of blindness. The rates of stroke and of amputations would also decrease.
- Heart failure hospitalizations—The rate for heart failure hospitalization declined by 18 percent between 1998 and 2002, to 2.3 per 1,000 KP members.
- Asthma—Since 1997, rates of hospitalization and emergency room visits for asthma have fallen 21.1 and 48.8 percent respectively.

The IOM has set the goal—research and pilot studies will help lead the way—but true success for Americans needs to be defined as getting the whole population across the quality chasm through organized, efficient systems of care. There is growing evidence that broad systematic pursuit of such performance improvements results in enhanced value (quality as a function of cost) to whole populations of consumers and health care purchasers:

- While the cost of caring for a KP member with heart failure is on average four times as much as caring for a similar member without heart failure, pursuit of improved care management significantly improves overall quality for *all members in this population*. At the same time, this relative marginal cost for the entire population of KP members with heart failure has remained steady or gone down slightly.
- Similarly, the relative cost of caring for all members with diabetes, coronary artery disease, depression, and asthma, compared with caring for similar members without these conditions, has remained steady or declined as substantial improvements in quality measures and health outcomes have been achieved.

Information Technology: The Electronic Medical Record and More

We are convinced that the achievements we have already realized in chronic care management will be significantly accelerated by the ongoing implementation of what we call KP HealthConnect, a large, integrated suite of clinical and administrative information systems that is being deployed across all KP regions. KP HealthConnect (like similar IT systems at other organizations) is the vital lynchpin of care improvement efforts in virtually all areas of sub-optimal quality: underuse, overuse, and misuse. A few examples:

- Reducing underuse: Whenever diabetes patients come to our pharmacies for supplies in our Colorado region, where an automated clinical information system has been deployed for more than five years, KP pharmacists are able to review an electronic diabetes flow sheet that indicates which patients are due for required lab tests and then order them electronically at the same time the supplies are dispensed.
- Reducing Overuse: Evidence indicates that when care guidelines are embedded in automated systems, patients spend less time on ventilators and are discharged sooner from ICUs. In ambulatory settings, the use of antibiotics for patients with viral upper respiratory infections has significantly declined in our Colorado region, and unnecessary imaging procedures have been reduced in our Northwest region, which piloted an early version of KP HealthConnect.
- Reducing misuse: Data from our Northwest region shows virtual elimination of preventable drug/drug interactions and a significant decline in adverse drug reactions by using automated drug order entry in our clinical information system.

Perhaps the greatest power of KP HealthConnect, or any such system, is its ability to help move the primary locus of care beyond the confines of the exam room or hospital and into members' homes and workplaces. The average KP member may spend only 1–2 hours each year in KP facilities (a few office visits and no hospitalizations). The remainder of the time, they oversee their own care or receive care from family members and friends. A clinical information system with web-based access enables them to "visit," or interact with, the KP health care system whenever they want and for whatever length of time is required.

Ubiquitous Care Via Web-Accessed Electronic Medical Records

In short, web-accessed clinical information systems will touch patients wherever they are, whenever they need it, enabling far greater patient engagement in their own health care. It will not only link patients to their health records and their care teams, but it will enable care teams to work more efficiently and productively, even remotely. Importantly, it will link all health care practitioners and patients to the continuously expanding body of medical knowledge, and help process that knowledge into clinician- and patient-usable information at the point of care, promoting greater patient involvement and shared decisionmaking. Finally, it will continuously monitor the efficiency and outcomes of care processes, target interventions to improve processes where necessary, and measure outcomes again following the interventions—the real-time transfer of research into practice.

This broad array of performance improvement activities requires much more than a simple electronic medical chart. KP HealthConnect also enables ambulatory and inpatient scheduling, registration, admission, discharge, transfer systems, and billing and claims management. It greatly enhances inpatient pharmacy management, and it includes specialized modules for emergency department and operating room management and documentation. With a web-based "front end," it can be used by any physician with Internet access and appropriate authorizations anywhere in the world. All personal health records will be fully protected in our secure network and fully compliant with all HIPAA regulations. A web-based front end for members, tailored to their specific needs based on their age, sex, and medical problems, enables them to review their own medical records, see their laboratory and x-ray results (once reviewed by their physician), make appointments, see a list of their current and past medications, refill their prescriptions, review all instructions given to them by their physician, make notes in their medical record, and communicate via secure email with members of their health care team. All of these systems are available 24 hours a day, 7 days a week, and they are available in multiple locations simultaneously.

When fully deployed, a KP member will be able to seek care in any region and know that all of their medical information is available to the practitioner they are seeing. In addition to member's health information, practitioners will be provided a wide variety of decision support tools at every moment they are caring for our members. This will include automatic prevention alerts and reminders, health and wellness reminders, automatic alerts related to all allergies, including drug allergies, and notification about drug interactions—all initiated as prescribing occurs. Evidence-based guidance for care related to common and serious conditions, including chronic conditions, will be instantly available.

Clinical information systems such as KP HealthConnect represent the launching pad from which health care will be propelled across the quality chasm and into a healthier future. I am proud that my own organization is a leader among those multispecialty group practiced-based organizations that are in the vanguard of this endeavor, but it is vitally important that the rest of American health care following this lead.

Putting Data in the Driver's Seat for Pharmacy Services

Quality problems related to overuse, underuse and misuse are nowhere more challenging than in the area of prescription drug utilization, where clinicians must contend with a constantly expanding armamentarium of new pharmaceuticals. New drugs account for billions of dollars in added costs to total health care spending every year, and while some represent valuable, less invasive alternatives to existing products or procedures, many others offer only marginally enhanced benefit, if at all.

Integrated health care systems, enhanced by clinical information systems, can serve as a powerful antidote to the costly problems of drug overuse, underuse and misuse. In Kaiser Permanente, the linkage of prescription data with diagnosis and encounter data has enabled our Pharmacy Outcomes Research Group to continually evaluate pharmaceutical manufacturers' claims regarding the efficacy and cost-effectiveness of pharmaceuticals.

Example: Beta Agonist Inhalers

A good example of our use of computerized data to improve outcomes for our patients and control overall health care spending is a program that evaluates asthma patients and compares their use of beta agonist inhalers that provide quick relief but no real improvement in the underlying disease as opposed to inhaled corticosteroids that improve the patient's health by addressing the cause of the symptoms. Physicians are able to monitor the pattern of use for each patient, and they can address misunderstandings and other potential adherence issues with patients who do not appear to be following the prescribed regimen. In addition to improving our members' health, these interventions can save money by eliminating the need to change a patient to a more expensive agent when the reason for treatment failure is non-compliance rather than ineffectiveness of the medication.

Available information technologies can be particularly useful in assuring that pharmaceuticals are prescribed in the highest quality and most cost-effective manner in the first instance. A wide variety of prescription drug therapies are available for many chronic medical conditions. Information systems have the ability to translate the best available medical evidence into support tools for physicians faced with making complex prescribing decisions for patients with differing health needs. If best practices based on both the individual patient and drug characteristics can be identified, information technology accessing all available clinical data can provide the physician with the relevant and timely data needed to make a quality decision. Systems have already been developed in the group practice environment to provide this information in the physician's office at the time of the patient encounter to make it easier for physicians to do the right thing at the right time when prescribing drugs.

Example: Cox–2 Inhibitors

An excellent example of this is the development of a scoring tool to assist physicians in targeting the use of the Cox–2 inhibitor drugs in the class of nonsteroidal anti-inflammatory drugs ("NSAIDs") used for treatment of osteoarthritis. Many excellent NSAIDs have long been on the market and are now generically available. Medicines in the newer Cox–2 inhibitor group of NSAIDs are now widely prescribed. Medical evidence indicates that these drugs, which are no more effective than older NSAIDs at relieving pain and inflammation, have a somewhat lower incidence of gastrointestinal side-effects, and as a result reduce the likelihood of severe gastrointestinal bleeding in patients who are at high-risk of such bleeding. But only about 3–4 percent of NSAID users are at high risk of this bleeding, while nationally, outside of KP, Cox–2 inhibitors are currently prescribed more than 50 percent of the time for new NSAID users. There is virtually no advantage in using these drugs outside of the high-risk population.

Researchers at Stanford University, collaborating with Kaiser Permanente physicians, developed a scoring tool to identify high-risk patients prospectively, based on a series of research-defined and validated risk factors, to assure that these patients are treated with Cox–2s or other lower-risk alternatives, and to promote the use of traditional anti-inflammatory agents in patients for whom Cox–2s provide no advantage. Initially established as a manual questionnaire, Kaiser Permanente's pharmacy operations team in California developed information systems to automatically query Kaiser Permanente's enrollment systems, laboratory systems, pharmacy systems and hospital systems to automatically score all California KP patients for gastrointestinal risk each night. A score, based on up-to-date data, is provided to physicians at the time of seeing a patient to support appropriate prescribing, if an NSAID is called for during the patient's visit. This has resulted in a Cox–2 prescribing rate within KP of approximately 6 percent, very close to the expected target for optimal

prescribing, assuring both the patients at high-risk and those at lower-than-high risk for gastrointestinal bleeding are appropriately treated.

Even this single example has major implications for the health care system. Cox–2 inhibitors are prescribed nationally 10 times more often than is medically necessary, at a per-prescription cost 10 times that of the available generic alternatives. Cox–2 inhibitors alone consume more than $5 billion annually across the United States. More appropriate prescribing in this single class could reduce unnecessary U.S. drug spending by more than $4 billion annually—money that could be better used for other health care purposes.

Caring for Our Senior Members

Almost 900,000 of Kaiser Permanente's members are 65 years of age or older, and 70,000 KP members are over 85. Most are Medicare beneficiaries who have been with Kaiser Permanente for decades. We know these numbers will increase dramatically in the years ahead, both for Kaiser Permanente and across the entire landscape of American health care. How are we to deal with what we know will be monumental challenges in the care of the elderly, especially those with multiple chronic conditions?

Again, we believe that integrated systems of care, enhanced by information technology, will provide a critically important part of the answer.

The challenges in care for the aging already are enormous. There are well documented quality problems in the care for the common age-related conditions that greatly affect older adults' independence and quality of life—conditions such as falls, Alzheimer's disease and other dementias, incontinence, and depression. As anyone responsible for a seriously ill, older relative knows, there are failures in continuity of care when older adults move from one site of care to another, such as from hospital to home or skilled nursing care facility.

To assess the extent of the problem, RAND's ACOVE project (Assessing Care of Vulnerable Elders), using evidence in the literature and the consensus of nationally recognized experts, developed minimal standards or quality indicators for the care of those older adults who are at a four-fold risk of death or functional decline within two years. Thirty percent of elders are in this "at risk" category.

ACOVE also developed quality indicators for the care of 22 conditions at a system level, not individual patient level. The conditions included the care of diseases like diabetes, heart failure and high blood pressure, but also age-related or geriatric problems such as falling, incontinence, dementia, continuity of care, hospital care, chronic pain and end-of-life care. The quality measures covered four aspects of care—prevention, diagnosis, treatment and followup.

As part of the study, the medical records of over 400 vulnerable older adults were reviewed to evaluate the quality of care they received. The findings are startling. Only 52 percent of the time did vulnerable elders receive recommended care for common medical conditions like diabetes mellitus, high blood pressure, and heart failure. They received recommended care for the age-related conditions such as dementia, falling and incontinence only 31 percent of the time.

Kaiser Permanente firmly believes that our integrated program and our systematic approach to care is an exemplary model for the provision of quality care to older adults. We are currently investing significant resources to build and test even better ways to care for these members.

Kaiser Permanente's Aging Network

The cornerstone of our elder care program is the Kaiser Permanente Aging Network (KPAN). It is made up of physicians, nurses, outside business people and many others, including community-based organizations and academic geriatric experts. This group is charged with recommending strategies and developing specific tactics to improve the quality of care to our older members. KPAN works in close cooperation with Kaiser Permanente's Care Management Institute (CMI) (see above), which has established the elderly as a priority population. CMI develops guidelines and identifies model approaches to improving care. CMI's Elder Care work includes population screening and appropriate follow up, chronic care, dementia care, care for people with advanced illnesses, care in nursing homes, reducing the use of medications considered high risk in older adults, care at transitions and care at the end of life.

Following are just a few examples of accomplishments in this area:

- Dementia is a condition that afflicts one in ten people over 65 and nearly half of people over 85. There are quality deficits in the early detection and diagnosis of dementia as well as in the education, support and followup care that is required once the diagnosis is made. Kaiser Permanente has collaborated with local Alzheimer's Association chapters to develop model approaches and systems

of care to ensure that our members with dementia and their families reliably are linked with community resources. The collaboration is the result of both Kaiser Permanente and the Alzheimer's Association recognizing that most people with Alzheimer's and other dementias are not receiving appropriate care, from proper diagnosis and treatment to information about their condition and referrals to vital community services. New programs are growing throughout Kaiser Permanente to make the entire care process for people with dementia reliable and not subject to chance. A study among Alzheimer's disease patients in our Ohio region found that if patients were reliably referred to the Alzheimer's Association there was higher family satisfaction and less use of emergency and hospital services. The Alzheimer's Association has hailed Kaiser Permanente's work and programs as "a 21st century model for the nation's health care system."

- Kaiser Permanente's Care Management Institute has identified as a priority the reduction in the use of medications that present high risk to older adults because of the presence of multiple medical conditions, slower metabolism, and greater sensitivity to side effects. Examples are medications that can cause confusion, falls, gastric hemorrhage and very low blood sugar. Some of these medications are categorized as being acceptable for short-term use but others are in an "always avoid" category. Targeted educational efforts have been instituted. Reminders are electronically generated and placed on medical records to prompt physicians to consider discontinuing risky medication. There has been progress throughout the program in reducing these medications. The most dramatic results have been in the Northwest Region where an electronic medical record has been is use for years. There, the use of "always avoid" medications is the lowest within Kaiser Permanente and improvement continues. Computers immediately prompt physicians and suggest safer alternatives if a risky medication is being ordered. This means that fewer older adult members are being exposed to risky medications.

In conclusion, I must again quote from the IOM's outstanding 2001 report, Crossing the Quality Chasm: "What is perhaps most disturbing (in the present health care environment) is the absence of real progress toward restructuring health care systems to address both quality and cost concerns, or toward applying advances in information technology to improve administrative and clinical processes." Kaiser Permanente could not agree more: Restructuring health care delivery into genuine *systems* of care, and supercharging those systems through the widespread use of information technology, is the right prescription for getting America across the quality chasm. It is the route that Kaiser Permanente has pursued, and we strongly encourage all others to join in leading the way to IOM's vision of a safer, more timely, more effective, more efficient, more equitable, and more patient-centered health care system for all Americans.

Recommendations

To promote the ideal health care delivery system envisioned in the IOM's "Crossing the Quality Chasm" report, all health care stakeholders—physicians, health plans, consumer groups, purchasers, and government agencies—need to become engaged in a broad array of quality and efficiency improvement efforts. In the interests of both brevity and focused impact, I will limit our recommendations for federal government leadership to four key areas:

- Federal agencies can play a key leadership role in promoting and facilitating the development of a set of widely endorsed, evidence-based health care quality standards and measures against which plans and providers can be held accountable by their payors and consumers.
- The Centers for Medicare and Medicaid Services could help promote the creation of a quality-driven health care market among both public and private purchasers by developing a financial incentive system tied to the kind of widely endorsed, evidence-based quality standards and measures suggested above. CMS could take a very valuable leadership role in bringing about financing reforms that finally link pay to performance.
- Information technology is a vital key to the kind of transformation of the health care delivery system promoted by the IOM. Both public and private purchasers need to support that transformation by creating incentives for providers and delivery systems to purchase and deploy clinical and administrative information systems. In addition, a vitally important role exists for the federal government to promote and facilitate the interoperability of information systems so that, in the not-too-distant future, the entire American health care system can communicate and share information through a common language.

- Evidence-based medicine is only as good as the science on which it is based. When deciding how best to treat a particular patient, physicians frequently have two or more options from which to chose. All too often, strong empirical evidence does not exist to help the physician make the right choice for the individual patient they are treating at that moment. Last year's Medicare Modernization Act included a provision to authorize the Agency for Health Care Research and Quality to undertake a research agenda designed to compare the relative effectiveness of different interventions designed to treat the same condition. This year, it is vital that the Congress make at least $75 million in FY 2005 available for this effort. Additionally, given the increasing importance of prescription drugs in treating patients and their rapidly rising costs, comparative effectiveness research on prescription drugs should be the first priority.

Chairman JOHNSON. Thank you very much, Dr. Crosson. Mr. Kahn.

STATEMENT OF CHARLES N. KAHN, III, PRESIDENT, FEDERATION OF AMERICAN HOSPITALS

Mr. KAHN. Thank you, Madam Chairman. It is my pleasure to testify today on behalf of the Federation of American Hospitals. Hospitals should act effectively, assertively and continuously to improve performance. One of the keys to improving performance is developing objective and comparable measurement of care and reporting that measurement. With reporting, clinicians and hospitals can improve services and patients can obtain information for making better informed medical decisions. Many third-party payers, employers, government entities and accrediting agencies have been developing quality measurements of hospital performance. The movement is both understandable and positive. However, the varied approaches taken by these groups are likely to produce mixed results and possibly even conflicting findings. Additionally, the potential new ask-fors for hospitals are myriad and will create new costs and unpredictable demands on an already pressed hospital system.

To assure success of these new efforts for measurement in reporting, the Federation took the lead with the American Hospital Association and the Association of American Medical Colleges to forge the Quality Initiative—a Public Resource on Hospital Performance. The CMS, AHRQ, Joint Commission on Accreditation of Healthcare Organizations, the AFL–CIO and the AARP joined us in initiating this program. The purpose of our collaborative voluntary effort is to establish a shared strategy for hospital quality measurement and public accountability. Together, the initial partners as well as other groups who have joined later are building a national uniform framework that provides valid and useful performance data. This framework will give us a dynamic process for continuously refining and adding data for collection and dissemination. It will contribute to improving hospital care and will provide the public with meaningful information for medical decisionmaking.

Beginning in May of 2003, we asked all hospitals in the country to submit data to CMS that will be used to compare performance on treatment for cardiac conditions and pneumonia. As of last month, almost 3,000 of the Nation's hospitals have pledged to participate in the Quality Initiative. This represents about 70 percent of all eligible hospitals and more than three-quarters of all admis-

sions to hospitals with a hundred beds or more. Currently, about 1,400 hospitals have posted on the CMS website at least 1 of the 10 measures, and almost 500 hospitals have reported all 10 quality measures. We expect later this year that there will be a significant increase in the number of hospitals reporting with the added incentive of receiving full market basket payment offered in the MMA for hospitals that report the current 10 measures.

These 10 measures are just the first step in building a national, standardized hospital quality measures database. Over the next year, our partnership will ask hospitals to submit additional performance measures. From there, based on meetings with key stakeholders and meetings across the country, CMS will identify other hospital performance measures that are feasible for hospitals to collect and report. I am pleased to report that virtually all of the Federation's acute care hospital members participate in the Quality Initiative. Even before the enactment of the MMA, our largest members had a 100 percent participation. We are proud of the Federation's role in advancing this ground-breaking initiative.

The Quality Initiative recognizes the patient's perception of their treatment is as important as the quality of the care they receive directly. The Quality Initiative will encourage hospitals to participate in the CMS patient experience survey that now is underdeveloped with AHRQ. We are all working together with the backing of consumers as well as providers to produce the best research tools to give the public objective and comparable information on the patient experience in hospitals. Obviously, hospitals are taking the initiative in other areas to improve performance. For example, one of our large systems is at the forefront of adopting bar coding and computerized physician order entry, both for administering and ordering drugs, but the successes and pitfalls of their experience illustrate opportunities and challenges of the critical path toward significantly improving the quality and safety of hospital care. First, with the impetus of the new Food and Drug Administration regulations and adoption of proven technology, this large system is adapting bar coding for all its hospitals. So, from the pharmacy to the bedside, the likelihood of error in dispensing of drugs is lowered significantly. Bar coding can be a success with the tools now available to hospitals.

Despite the strong case for computerized physician order entry, here the obstacles are undeniable and illustrative. There is no readily usable off-the-shelf technology. This is a problem that will resolve itself over time. However, there are also daunting IT questions. Computer physician order entry, to work as it should, depends on a medical record that is largely electronic. That is not a reality today. Finally, there is the issue of physician participation. Even if a hospital can solve all the technical and IT concerns, the initial ventures with computer physician order entry have generally met with insufficient physician cooperation. Hospitals have much control over the resources and technology so important to quality care, but the most important factor in improving patient care is a successful partnership between hospitals and medical staffs. To make the reporting initiative as well as our other efforts best serve the patients, hospitals and physicians must work together. Thank you.

[The prepared statement of Mr. Kahn follows:]

Statement of Charles N. Kahn, III, President, Federation of American Hospitals

On behalf of the Federation of American Hospitals (FAH), I am pleased to offer our views on new frontiers in health care quality. FAH is the national representative of investor-owned or managed community hospitals and health systems throughout the United States. Our members include general community hospitals and teaching hospitals in urban and rural America.

It is the mission of FAH member companies to provide high quality care to the patients we serve. It is the responsibility of hospitals to provide high quality care and safe environments, and we believe that informed consumers will make better personal health care choices. Today's hearing provides a good opportunity for us to describe what hospitals are doing to enhance the quality of medical care and to better inform American consumers of their health care choices.

Background

FAH has taken an active role in advancing policy initiatives to improve the safety and quality of hospital care in this country, and to promote the availability of patient information in a hospital setting. Our Board of Directors has adopted policies regarding principles for patient safety reporting systems; methods for reducing medication errors; requirements for creating effective quality measures; and most recently, the reporting of such measures to the public.

We are entering an important period in the evolution of quality performance measurement, improvement and reporting. There is a growing commitment to evidence-based care by clinicians. There is growing energy and momentum surrounding health care consumerism fueled by an increase in cost sharing and new insurance coverage alternatives like health savings accounts, and the Internet has made it possible to disseminate information about medical care services broadly for the first time.

By all accounts, the American public wants and needs more information about medical care. A public opinion survey conducted for FAH last fall found significant support for a website that evaluates hospitals about the treatment of certain diseases and new procedures. Almost half of survey respondents—48 percent—said that this information either could be the most significant factor, or an important factor, in helping them decide which hospital to choose for care.

A Myriad of Hospital Quality Information Exists Today

From our point of view there are two primary objectives for the collection of information about on hospital quality measures. First, and foremost, such information can serve as a critical tool for clinicians and hospitals to learn about their performance so that improvements in care can be made. And second, such information can enable consumers to make better health care decisions.

Despite the best of intentions, the myriad of hospital quality performance reporting efforts that exist today are working at cross-purposes regarding these two objectives. These varied approaches are producing incomplete, poorly analyzed, conflicting and even misleading information for clinicians, hospitals and consumers alike. They also are creating expensive, burdensome and unpredictable requirements on hospitals.

Individual states, insurers and other payers, the business community, consumer organizations, commercial enterprises, the Joint Commission on Accreditation of Health Care Organizations (JCAHO), and the National Quality Forum (NQF) all are advocating hospital reporting initiatives. However, many of these parties are proceeding on separate tracks. Clearly, we need a more rational and coordinated approach.

As an example, state programs in New York, Pennsylvania and California focus performance measurement on coronary artery bypass graft (CABG) surgery mortality rates. Maryland, Rhode Island, Connecticut, and Texas have implemented state-wide hospital quality reporting programs that measure performance on a number of medical conditions.

There are several private sector initiatives. For the last three years, The Leapfrog Group, representing several of the nation's largest employers, has advocated that employees consider hospital performance by using three safety indicators before selecting their choice for care. A fourth "leap"—a composite index of 27 individual safety measures endorsed by NQF—will be added later this year.

Health plan initiatives include PacifiCare, a managed care plan that began publishing reports on individual hospital performance across 56 quality measures, for 200 California hospitals. Commercial initiatives include J.D. Power and Associates and Health Grades, Inc. which have joined forces to develop a tool to measure and publicly recognize superior quality hospitals based on service and clinical excellence.

All of these efforts are attempting to empower consumers with information to make them better decisionmakers about their care. However, the proliferation of sources of information, and the uneven nature of that information, raises many questions as to whether or how this consumerism model actually will work in practice.

Clearly, hospitals and physicians must have valid and standardized information about their performance to allow them to assess areas where improvement is needed and compare their efforts to other hospitals. From today's myriad of hospital quality initiatives, there is no standardized information collected across all hospitals that can be used to compare and improve care.

We also do not know how consumers will use information about hospital performance in their decisionmaking since patients generally choose hospitals based on where their physicians have admitting privileges and where the hospital is located. None of the current hospital reporting programs has addressed whether, or how, information about hospital performance relates to physician-patient decisionmaking.

To begin a process to address these concerns, in 2003, FAH, along with the American Hospital Association and the Association of American Medical Colleges launched "The Quality Initiative—A Public Resource on Hospital Performance." Working in conjunction with several public and private sector organizations, our purpose is to forge a shared national strategy for hospital quality measurement and public accountability. Together, we want to build a national uniform framework, available to hospitals, physicians, public and private payers and the public that provides valid and useful performance data, contributes to improving hospital care, and that provides the public with meaningful information for making medical decisions.

In addition to the hospital groups, the initiating partners in the collaborative effort include the Centers for Medicare & Medicaid Services (CMS), the Agency for Healthcare Research and Quality (AHRQ), JCAHO, NQF, the AFL–CIO and AARP.

Beginning in May 2003, every hospital in the country was asked to submit data to CMS that would compare their performance related to the treatment of cardiac illness and pneumonia. Ten specific measures were selected because they are supported by evidence showing their effectiveness, because many hospitals already collecting these data, and because these measures were agreed upon universally by medical experts, including the National Quality Forum.

As of last month, almost 3,000 of the nation's hospitals had pledged to participate in The Quality Initiative. This represents about 70 percent of all eligible hospitals in the country and more than three-fourths of all admissions to hospitals with 100 beds or more. Currently, about 1,400 hospitals have posted on the CMS website data about at least one of the 10 measures, including almost 500 hospitals reporting all 10 quality measures. We expect that later this year that there will be a significant increase in the number of hospitals reporting with the added incentive of receiving full market basket payment offered in the Medicare Modernization Act for hospitals reporting the current measures.

These ten measures, however, are just the first step in building a national, standardized hospital quality measures database. Over the next year, our partnership will ask hospitals to submit additional performance measures related to cardiac illness and pneumonia. After that, hospitals will be asked to submit data assessing their performance on surgical infection prevention. From there, based on meetings with key stakeholders and experts across the country, CMS will identify additional high priority, evidence-based hospital performance measures that are feasible for hospitals to collect and report.

I am pleased to report that virtually all of FAH members' acute care hospitals participate in The Quality Initiative. Even before the enactment of the Medicare Modernization Act that includes the added payment incentive, our largest members had 100 percent of their hospitals participating in the program. We are proud of the Federation's role in advancing this groundbreaking initiative.

With the implementation of The Quality Initiative, we can begin to answer several questions, which, until now, have been academic. These questions include:

1. Will hospitals act on their reported results and implement changes to improve their performance? We certainly believe they will, that is why we have been proponents of this effort.
2. What will we learn about the role of physicians as the critical link between patients and hospitals? Hospitals and physicians must work collaboratively to

improve quality; the medical staff and individual physicians will need to take leadership in the change. Furthermore, will the availability of comparable data on performance move physicians? This is the key to the success of the quality performance reporting program.

3. Is the information on hospital performance that is meaningful to clinicians also meaningful to consumers? And how will that information best be used in the critical physician-patient relationship where consumer choice is so integrally related to care and decisionmaking?
4. Can a national infrastructure be created and maintained that identifies valid, evidence-based and standardized measures applicable to all hospitals?
5. Finally, once we identify the best indicators of performance, how can the information be used in payment systems to reward those hospitals that excel?

In addition to these "macro" questions, there also are a number of infrastructure issues that hospitals can address to improve their performance related to quality and patient safety.

Information Technology

Bar-coding medications—as promulgated in final regulations by the Food and Drug Administration last month—will go a long way toward reducing medication errors, especially because unit dose packages are included. Our largest member, HCA, Inc., has fully implemented bar-coded medications in 82 hospitals and is planning to have bar-coding in place in 186 hospitals by the end of the year. This relatively simple, low-cost technology has been extremely effective in virtually eliminating medication administration errors.

On the other hand, while computerized physician order entry (CPOE) holds great promise in reducing medication errors and improving patient care—especially when integrated with other clinical data bases—a range of issues challenge broad implementation at this time. Off-the-shelf software for CPOE just now is being developed, and presents significant cost and training requirements.

However, the ultimate key to successful CPOE implementation depends on physician cooperation, engagement and compliance. Physician engagement and compliance has been difficult for two reasons—many doctors do not want to use new technology, and secondly, the technology actually can be slower to use than old-fashioned pen and paper, taking more of their time, not less. Because of these difficulties, HCA, Inc. is choosing a deliberate and cautious approach in implementing CPOE, beginning with three hospitals and a small number of physicians in each. Their goal is to pilot test CPOE in 10 hospitals by the end of 2005.

Finally, for hospitals to implement widespread quality reporting, it will become essential to be able to extract data from electronic medical records, rather than from paper. The increasing burden on clinical staff time to collect and report data will not be sustainable otherwise. We are encouraged by the Administration's National Health Information Infrastructure initiative and are pleased to participate in this groundbreaking effort. In addition, FAH is working with eHealth Initiative, a collaborative effort which has brought together hospitals, clinicians, employers, health plans, public health agencies, and healthcare information technology suppliers to work with the public sector to address barriers related to using information technology to improve the quality, safety and efficiency of healthcare.

Definition of a "Good" Quality Measure

Another challenge to building a national framework is defining what constitutes a "good" quality performance measure. We believe that a "good" measure must be based on widely accepted evidence that the practice improves performance, that it is feasible to collect without inhibiting hospitals ability to fulfill their primary mission of providing patient care, and that it is meaningful to users—clinicians, payers and consumers. Finally, a "good" measure must be one that all hospitals can implement so that it can be adopted universally.

When evaluated against these criteria, many worthy ideas are just that—they do not yet and may never rise to the level of becoming standards for all hospitals. Examples of such efforts include the use of hospital intensivists and specific nurse staffing ratios. Neither is based on adequate or definitive evidence, nor would it be feasible for all hospitals to implement them.

Measuring Patient Experience of Care While Hospitalized

Although not a measure of the quality of clinical care per se, patient satisfaction or experience while hospitalized is viewed by many as an aspect of hospital quality. Therefore, conceptually, FAH supports the inclusion of such information in The Quality Initiative.

However, several issues need to be resolved before FAH can support the survey and its administration as currently proposed. The survey tool must be designed to provide consumers with useful information that has a demonstrated link to quality. Equally important, the survey should not repeat or duplicate current hospital survey efforts. Hospitals simply cannot afford to take on the additional cost of a redundant survey that does not lead to quality improvement in a hospital, especially given all the competing demands for the collection and reporting of other quality information. We are working with CMS and AHRQ to produce a process that is workable and practicable for hospitals.

A Coordinated and Cooperative Framework

As I indicated earlier, many different types of organizations, both public and private, have begun hospital quality reporting initiatives. We strongly believe that these fragmented and disjointed efforts must be united under a common and standardized infrastructure so that consumers have access to common information that applies to all hospitals.

Achieving this level of cooperation across so many players will not be easy. However, we believe that the greater good warrants that leaders of all stakeholder organizations support a single common approach. The three hospital associations, AHA, FAH and AAMC—along with CMS, AHRQ, JCAHO, and NQF—are working together to begin this process. FAH seeks to continue this collective effort, and we encourage others to join and strengthen our initiative, rather than begin or continue their own.

Conclusions

- Quality Initiative Will Provide Answers

The hospital Quality Initiative will give policy makers the opportunity to observe and evaluate a number of important questions, including whether such information will result in improved performance by hospitals, and what information about quality is actually useful to medical professionals and consumers. FAH supports this initiative and is working hard to make it successful.

- Build a Common National Framework

However, to achieve widespread hospital participation, there must be a coordinated and unified approach at the national level. All stakeholder organizations must support the use of the same measures or there will be mass confusion by the public, and an unreasonable burden placed on hospitals.

- Engage Physicians in Measuring Hospital Performance

Hospitals and physicians need to work together to improve patient care. Improving hospital performance, whether through improved clinical care or the use of new technology, is dependent upon physician cooperation and support.

- Continue to Research Linking Payment and Performance

It is good to provide incentives to participate in hospital reporting, but the reporting initiative is only one step toward improving performance. More testing and information is needed before an equitable, effective and efficient reimbursement system can be built. The first step is to determine if we are measuring quality correctly. After that, testing and demonstrations, such as the CMS demonstration project with Premier hospitals, are important and necessary second steps.

I hope our comments have been useful to your deliberations today. Thank you for the opportunity to share our views. I am happy to answer any questions that you might have.

Chairman JOHNSON. Thank you very much, Mr. Kahn. Ms. Burger.

STATEMENT OF SARAH G. BURGER, CONSULTANT, NATIONAL CITIZENS' COALITION FOR NURSING HOME REFORM

Ms. BURGER. Thank you. The National Citizens' Coalition for Nursing Home Reform (NCCNHR), is a 27-year-old consumer organization whose mission is to improve the quality of care and life

for nursing home residents. The Administration on Aging-funded National Long-Term Care Ombudsman Research Center, which supports 53 State ombudsmen and 1,000 paid local ombudsmen and 8,400 volunteers working to resolve resident complaints—is also at NCCNHR. Throughout its history, NCCNHR has had an active commitment to identifying and disseminating excellent care practices; and NCCNHR thanks the Subcommittee Chairman for this opportunity to present this part of our work. Every year a large part of our annual meeting is devoted to exposing long-term care ombudsmen, citizen advocates, residents and families to exemplary care practices that are replicable in their own communities across the Nation. One such opportunity presented itself in 1995 when we invited four providers who had previously not known each other to present their visionary ideas together on one panel. That event was the catalyst for the formation of the Pioneer Network of innovative practice providers in 1997.

Nursing home residents and their families know good care when they receive it. Nursing homes have followed a hospital care model. Imagine at 80 or 85 years of age adjusting to a hospital-like institution's scheduling for the rest of your life, sometimes 1 to 5 years, even having someone else decide when you will go to the bathroom. This toxic approach to care, physically and mentally, destroys both residents and staff. The Pioneer Network's new vision of nursing homes is that this is not a hospital but your home. The long nursing home corridors are divided into small neighborhoods or households. Staff are no longer organized hierarchically by departments but divided into interdisciplinary teams in the households. Staff do not rotate among units but remain permanently with the household, developing strong relationships with the residents and their families. Staff don't perform a list of tasks on people—bathing, eating, toileting, moving—but use residents' lifelong routines to guide care. A late riser gets to sleep in. Can you imagine trying to arouse a demented late rouser at 6:00 a.m.? It will take two people to do that wrenching work, which can be done easily by one aide using the resident's lifelong time of awakening in late morning. Food is not served hospital style on a tray but family style, and it is available whenever a resident wants it. How would you know if you were in this kind of a home? There is no urine smell, because people are toileted regularly. Residents don't cry out, because their needs are met—food, water, exercising, toileting, bathing and pain control. You see the same staff every day and know them. Administrators and directors of nursing have been there a long time. They know every resident and every staff member.

You and your family are welcomed as part of the household. Spontaneity drives activities, and people are engaged. Good care is good business. For instance: toileting people according to their own individual needs saves money on diapers. One home saved enough to pay for another nursing assistant around the clock. Physical and chemical restraint use and antidepressant use diminishes. Nursing staff turnover (45 percent nationwide), and a very expensive item, in the nursing homes decreases. The cost of replacing a single certified nursing assistant is about $4,000. Supplemental food costs plummet. Food waste is minimal. Census remains full. Pioneer Network practices are the vision for residents Congress had in

mind when it passed the Nursing Home Reform Act 1987 requiring facilities to provide nursing care and service to meet each resident's mental, physical and well-being. The CMS is so struck by this commonsense approach that they held a web cast on Pioneer Network practices on September 27, 2002; and I think there is another one coming up, by the way, this month at the end of March. This is a true partnership. Thank you.

Chairman JOHNSON. Thank you very much to the whole panel.

[The prepared statement of Ms. Burger follows:]

Statement of Sarah G. Burger, Consultant, National Citizens' Coalition for Nursing Home Reform

The National Citizens' Coalition for Nursing Home Reform (NCCNHR) is a twenty-seven year old consumer organization, founded by Elma Holder, whose mission is to improve the quality of care and life for nursing home residents. The Administration on Aging-funded National Long-Term Care Ombudsman Resource Center—which supports the 53 state ombudsmen, 1,000 paid local ombudsmen, and 8,400 volunteers working to resolve resident complaints—is also at NCCNHR.

Throughout its history, NCCNHR has had an active commitment to identifying and disseminating excellent care practices. NCCNHR thanks the Ways and Means Subcommittee Chairman, Congresswoman Nancy L. Johnson, and Members of the Subcommittee for the opportunity to spotlight this most rewarding part of NCCNHR's work.

Every year a large part of NCCNHR's annual meeting is devoted to exposing long-term care ombudsmen, citizen advocates, residents, and families to exemplary care practices that are replicable in their own communities across the nation. One such opportunity presented itself in 1995, when we invited four providers who had not previously known each other to present their visionary ideas together on one panel. That event was the catalyst for the formation of the Pioneer Network of innovative providers in 1997. The keys to the success of this story are: vision, stakeholder coalitions respectful of one another, including government, and commitment to change over time.

Nursing home residents and their families know good care when they receive it. Nursing homes follow a hospital care model, yet in 1999 about 75 percent of the residents lived in a nursing home from one to five years. Imagine at 80–85 years of age adjusting to a hospital-like institution's schedule for the rest of your life—even having someone else decide when you will go to the bathroom. This toxic approach to care and to life physically and mentally destroys both residents and the staff who care for them.

The Pioneer Network's new vision of nursing homes is that this is not a hospital but your home.

- The long nursing home corridors are divided into small "households."
- Staff are no longer organized hierarchically by departments, but divided into interdisciplinary teams in the households. Human resources are close to the residents.
- Staff are no longer rotated among units, but remain permanently with the household, so they develop good relationships with residents and families.
- Staff don't perform a list of tasks on people (bathing, eating, toileting, movement) but follow residents' lifelong routines in providing care. A later riser gets to sleep in, for example. Can you imagine trying to arouse a demented late-riser at six a.m.? It will take two people to do the work, which can be done by one later in the morning. The first experience is wrenching for all, the other is satisfying for both resident and staff.
- Staff don't make decisions for residents. Residents make their own decisions.
- Food is not served hospital-style on a tray, but family style, and it is available whenever a resident wants it.

How would you know if you are in this kind of home?

- There is no urine smell because people are toileted regularly.
- Residents don't cry out because their basic needs—food water, exercise, toileting, bathing, pain control—are met.
- You see the same staff every day and know them. Administrators and Directors of Nursing have been there a long time. They know every staff member and resident.

- You and your family are welcomed as part of the household. Householders are out in the community.
- Spontaneity drives activities and people are engaged.

Good care is good business. For instance:

- Toileting people according to their individual needs saves money on diapers. One home saved enough to pay for another nursing assistant around the clock.
- Physical and chemical restraint use diminishes.
- There is a decrease in the use of antidepressants.
- Staff turnover, which is about 45 percent nationwide, decreases. This is a tremendous savings when you consider that the cost of replacing a single certified nursing assistant is around $4,000.
- Supplemental food costs plummet. Food waste is minimal.
- Census remains full, increasing reimbursement.

Pioneer Network practices are the vision for residents Congress had when it passed the Nursing Home Reform Act of 1987 requiring facilities to provide care and services to preserve each residents' highest practicable mental, physical, and psychosocial well-being. The Centers for Medicare and Medicaid Services (CMS) is so struck with the common sense of this approach that it held a Webcast on Pioneer Network practices on September 27th of 2002. This is a true partnership.

Thank you Chairman Johnson and Members of the Subcommittee on Health for inviting NCCNHR to present the consumer view of good nursing home care and how to achieve it.

Chairman JOHNSON. Ms. Burger, I will be interested to hear after that meeting if you all could begin focusing on how the current survey and certification system is a barrier to the development of the kind of care you espouse and what are the new ways, reflecting what we have heard from the other programists in other areas, that we could use to set a different survey and certification process in place to encourage the quality of care that you clearly are committed to and are succeeding in delivering. It has always distressed me that the government is only interested in sometimes very minor ways in which a nursing home doesn't do precisely what we think they should do. I had one—a nursing home cited because a stack of things on the top shelf was 2 inches closer to the ceiling than it should have been. We are talking 8 to 10 inches rather than 10 to 12, really absurd. Yet never—our law never allowing citing for achievement. I think we couldn't be getting where we are in other areas if the systems that we have been talking about today didn't also reward positive achievement as opposed to simply faulting either major or minor defects. So, I look forward to working with you on that.

Ms. BURGER. Thank you very much.

Chairman JOHNSON. Dr. Ho, in your testimony, you cited that in your plan you were able to reduce costs by 20 percent. Health care costs are approximately 20-percent lower and quality is approximately 20-percent higher and that, furthermore, health care cost trends are 14-percent lower in the value network. That is extremely significant, particularly in today's arena. I know you all have these figures. I just happened to pull them out more specifically from Dr. Ho's testimony. You also do a lot of work with Medicare patients, so I wonder if you have been able to achieve any of those kinds of statistics in your Medicare networks.

Then you also make this comment on now page 4 that these programs enable PacifiCare to offer the appropriate level of care at the right—sorry, wrong paragraph—that their achievement rates—this

is in terms of ace inhibitor—will double the national average reported in fee-for-service medicine. Why are we having so much more trouble implementing quality standards? Are we, across the board, all of you, are we having more trouble implementing these new standards in sort of the fee-for-service setting than we are in the systems setting? Are we—for those of you who offer both, are we able to either improve quality and reduce costs in each setting equally, or do we need to know that one system is better than the other or they could both be handled equally?

Dr. Ho. Then anyone who wants to comment on that larger issue of to what extent does the system of delivery determine the outcome when in Medicare we do have two systems of delivery, fee-for-service and systems. Dr. Ho.

Dr. HO. Thank you. There are some similarities. For example, in the disease management programs that I summarized, we have comparable results for both the Medicare population and the Medicare Advantage plan that we offer as well as in the commercial plan that we offer. So, there is no discrepancy whatsoever in the disease management program nor in the results that we have been able to achieve with our Medicare Advantage beneficiaries as with our commercial or active—commercial or health plan beneficiaries. On the other hand, there have been quite a few challenges in implementing the full integrated strategy that I summarized for the Medicare beneficiaries. A lot of them have been challenges related to regulatory barriers. I will give you an example. In 1997, we went to CMS to request disclosure of our public report card, the Quality Index which was released in 1998. We never got that approval until 2002. So, Medicare beneficiaries have not been able to access or have accessible disclosure or provider performance, which, as I have summarized, has shown to be so effective in moving the needle in quality as well as helping members vote with their feet.

The value network has not been able to get the type of discussion around innovation nor the rewards for health plans like PacifiCare that have been willing to innovate and kind of push the edge of the envelope a little bit further from the regulators, either by reducing the barriers to innovate or the hassle factor, if you will, or actually increasing financial or nonfinancial incentives in terms of preferential marketing or collaboration on communication pieces to members and so forth. So, I would have to say that our overall quality improvement strategy has been suboptimized with the Medicare Advantage, with the notable exception of our disease management programs which have been actually implemented to the Medicare beneficiaries as well.

Chairman JOHNSON. Thank you very much. Dr. Crosson.

Dr. CROSSON. Thank you, Madam Chairman. I can't speak for the disaggregated fee-for-service world. I have spent 27 years now as a physician in Kaiser Permanente, and I can speak for that. I think it is absolutely correct that the structure of group practice, particularly prepaid group practice, as well as the culture that evolves among physicians makes it easier to take knowledge science constructed into guidelines or organized care processes and see that it is implemented. In fact, that is what we do; and some of the information I presented was a consequence of that. Furthermore, I think this issue is going to become more important rather

than less important in the future because Medicare is becoming more complex, not less complex, and it requires more coordination among doctors and among other care givers than it did a generation ago, for sure. Finally, I think it is going to become more important because I believe, as I said earlier, that the ability to use clinical IT is going to occur fastest and most effectively in organized systems of care, and that technology offers such a gigantic leap for health care delivery that it strongly influences me and has influenced our organization to make that investment. Thank you.

Chairman JOHNSON. Mr. Kahn.

Mr. KAHN. Yes, Mrs. Johnson. I believe that most hospitals want to participate in the Quality Initiative and would like to move as quickly as possible to more measures of their performance. One of the key issues here, though, is the technology. Every time a new measure is applied, that is more paper that has to be filtered through to produce the results so you can find out what is happening at the hospital. If we had the IT—if we had the medical record and it was a matter of just pushing a couple of buttons, it would make a big difference in terms of accumulating the information so we can understand much of what goes on in a hospital today. Let me also say, though, that if we look at Medicare, there are opportunities within Medicare for moving to more organized care and integrated care through managed care if Medicare Advantage takes off. Let me say, on the private sector side, I think the opposite could take place. We actually I think on the private sector side are finding more of a preference by consumers for preferred provider organization, for quasi fee-for-service products, and in some ways that actually may be the future there. So, I think we are going to have to find other means other than necessarily through the payment system to encourage the development of a kind of—at least record integration for patients, because I am not sure we are going to have for many patients ever the kind of organized system that would bring about integration like you can do in a Kaiser Permanente environment.

Chairman JOHNSON. Mr. McCrery.

Mr. MCCRERY. Dr. Crosson, what was the figure you used that described the level of your coming investment in technology improvements?

Dr. CROSSON. Yes, Congressman McCrery, it was $3 billion.

Mr. MCCRERY. $3 billion—with a "b"?

Dr. CROSSON. Yes, sir.

Mr. MCCRERY. Well, that is very impressive. Are you a competitor of PacifiCare?

Dr. CROSSON. Our organization and PacifiCare are both present predominantly in the State of California.

Mr. MCCRERY. So, that would be a yes?

Dr. CROSSON. That would be a yes.

Mr. MCCRERY. Well, it was interesting, because it was kind of like dueling plans there, the juxtaposition of Dr. Ho and Dr. Crosson. Dr. Ho's testimony was certainly impressive. So was yours. So, I could almost hear the advertisements and reading the pamphlets that you must be distributing about your quality improvements. That is very interesting and obviously very good, but it kind of goes against what I took from the first panel which was

that this is impossible to expect the private sector to do, to accomplish. I know that is not what they meant to convey, but somebody listening might have gotten that impression. It seems to me that you all at least are moving right ahead with quality improvements through technology improvements. You are making the investigation, and obviously you are paying for it or you expect to be able to pay for it through your operations—through income from your operations, right?

Dr. CROSSON. Yes, Congressman. I might on that note underscore what Mr. Hackbarth said because his experience at Harvard Community Health Plan was similar to ours, and that is because we are a prospectively paid organization. The business case, if you will, affects the way you look at it. The business case for this investment is much more robust than I think it is in the fee-for-service model because, as Mr. Hackbarth noted, to the extent we can use the systems effectively to not only improve quality but to manage costs, then we can reap those savings and then reinvest them in the system and that is not a characteristic of the dynamic that exists when the payment is based on fee-for-service payment.

Mr. MCCRERY. I understand that and we don't need to get into all of this, but it really concerns me that we are talking about the government basically underwriting these kinds of investments for fee-for-service delivery or disaggregated health care delivery as opposed to the kind of services that you all have and that Harvard plan has. It gets to the basic question of choice for consumers but also I think to the basic question of choosing to pay, and I am not sure that we can continue to underwrite at the government level everything that everybody wants and expect to have a good result in the end. So, I am not sure, Madam Chairman, if we ought not take from this a lesson. You know, depending on what the consumer wants, maybe they are going to have to choose a plan that is capitated or it is a managed care plan in order to get the kind of quality in terms of the technological improvements. If they want to stay in fee-for-service and they want that kind of improvement, they may have to pay for it. Yes, Mr. Kahn, I see you are anxiously awaiting.

Mr. KAHN. I think on the noncapitated side, and today really most providers are on the noncapitated side in terms of the way they receive their payments from, I think over time this problem will carry itself. I mean, obviously over time IT becomes less expensive. Over time there will be more products to buy off the shelf that hospitals can purchase to serve all these functions. I think, though, if we are pushed on the measurement and quality side, we can only meet so many expectations there, and I think if people are patient I would argue the private sector will solve the problem generally, but it is going to take a great deal of time and more than I think some policymakers may be willing to allow.

Mr. MCCRERY. If policymakers insist on certain benchmarks, certain measurements, we may have to pay for them in the short run?

Mr. KAHN. In the short run, unfunded mandates are unfunded mandates.

Chairman JOHNSON. Thank you very much. Yes, Dr. Ho.

Dr. HO. I would like to mention one thing that hasn't been raised this morning. The technology actually as a solution or an enabler to improve clinical decision support has been available for 10 to 15 years and who pays is obviously always a salient question, but I think there is a culture, a culture in the fee-for-service practitioner world that has to be raised as well, a culture that has historically not been in favor of accountability, but more in favor of autonomy and not necessarily in favor of a consumer-directed health delivery system versus a practitioner-directed delivery system. I think the issue here is—and we at PacifiCare firmly believe in technology and electronic health records. In fact, we spend millions of dollars in trying to pursue those objectives, but it is still difficult. It is a difficult sell when you have an intransigent practitioner community that is resistant to automation, resistant to accountability, resistant to outcomes and disclosing outcomes.

One comment, the RAND study that has been shown before that beta blocker use by people who have had a heart attack nationally is 45 percent. It is not because doctors don't know what to do. They are very familiar with the guidelines and some of them even have reminder systems. There has not been either an incentive program or a report card program to disclose what the results are or there is not a disincentive or a program that would maybe reduce their pay if they didn't do the right thing the first time. So, I think, not to belabor the topic, but I think it is a very complex subject. It is not just a matter of funding nor a matter of technology, it is really a matter of reeducating an entire practitioner community.

Chairman JOHNSON. Thank you for your comments. Did you want to comment, Dr. Milstein?

Dr. MILSTEIN. I think the perspective on the employer side is to keep incentives focused on performance with perhaps the single exception of adoption of information systems. I think the predominant purchaser sector view would be not necessarily to handout grants, government grants for IT, but to make the provider payments sensitive to the performance levels of doctors and hospitals, including adoption of information systems, longitudinal cost efficiency, and quality of care.

Chairman JOHNSON. I know some of the experiments in the private sector that look at pay for performance have been sensitive to the cost of technology and have encouraged the meeting of standards that you already know about, like beta blockers that you could do within your existing structure and use that as a way of earning higher payments so you can buy the technology. We will be having a hearing on paying for performance and specific systems that have worked, and I invite all of you to follow up with any specific, outside of the general payment structure of Medicare, but specific barriers. It is ridiculous that you wanted to reveal publicly quality information in 1998 and it took you 4 years for the right to do so for your own consumers.

So, we need to be more conscious of the specific barriers that exist in Medicare now to the development of higher-quality health care, and we need to hear that both from systems people and from fee-for-service providers as well. Then we will be looking at pay systems and a number of other aspects, the problems we face. I certainly appreciate your testifying and your leadership in challenging

the traditional health care delivery system to meet the future. It is not without significance that No Child Left Behind is also about accountability. It is about a system that works very, very well for a lot of people and is not working very well for others. So, I think there is a different culture, as you mentioned, Dr. Ho. I think there is a greater interest in accountability because technology can help us with that now, but there is also a greater interest in the individual consumer and their individual needs, whether it is the child in the school or the patient in the health system, and if we can use technology to achieve both greater accountability and more patient-centered care, then we will improve American health care in the next decade and reach a high of both cost effectiveness and quality. Thank you very much for your participation today.

[Whereupon, at 12:05 p.m., the hearing was adjourned.]

[Submissions for the record follow:]

Statement of American Academy of Family Physicians

Background

This statement is submitted for the record to the Ways and Means Health Subcommittee hearing entitled, "New Frontiers in Quality Initiatives" on behalf of the American Academy of Family Physicians representing more than 93,700 members throughout the United States.

This testimony includes an overview of the ongoing quality initiatives that the Academy has undertaken. In addition, it introduces as a necessary feature of Medicare quality improvement, a method of supporting the primary care infrastructure required to care for the 80 percent of Medicare beneficiaries with chronic conditions. Family physicians are integral to Medicare quality improvement efforts since the majority of Medicare beneficiaries who identify a physician as their usual source of care report that they have chosen a family physician.

Quality improvement efforts and medical errors research reveal the importance of navigating complex interactions across multiple care settings. Again, family physicians logically perform the role of integrating care for Medicare beneficiaries since they function as patients' usual, ongoing source of health care. Unless financing mechanisms specifically support the role of primary care in integrating care for beneficiaries with chronic diseases, patients' experiences in the current fragmented healthcare system are likely to grow worse. This is particularly true for the two-thirds of Medicare beneficiaries with multiple chronic conditions.

Chronic Care in the Medicare Population

The incidence and prevalence of chronic disease among Medicare beneficiaries, as well as the multiple challenges of treating and managing these diseases and the cost associated with doing so, are well documented. Medicare funds are increasingly directed toward beneficiaries with chronic illness. The Robert Wood Johnson Foundation's initiative entitled, *Partnership for Solutions*, estimates that about two-thirds of Medicare dollars go to participants with 5 or more longstanding conditions. This is a startling figure for a program that not only costs taxpayers billions of dollars, but also fosters fragmented care. Additional information from *Partnership for Solutions* reveals that 66 percent of Americans over the age of 65 currently have at least one chronic condition, and the majority go on to be afflicted with a number of illnesses. Data from the Medicare Standard Analytic File (1999) shows that beneficiaries without chronic conditions saw an average of 1.3 physicians in 1999. Beneficiaries with a single chronic illness saw an average of 3.5 physicians while those with two saw an average of 4.5 physicians. Seniors with six chronic conditions saw an average of 9.2 physicians in 1999. These figures argue for a single primary care physician who can provide cost-effective, integrated care for Medicare beneficiaries who have chosen to have a "personal physician" oversee their care.

The Link Between Systems Change and Quality Improvement

The Institute of Medicine (IOM) report, *Crossing the Quality Chasm*, has documented the performance gap between high quality health care and what is actually delivered in our current fragmented and costly system. The report is clear: "The current care systems cannot do the job. Trying harder will not work. Changing systems of care will." The report urges health payers, including Medicare, to create an infrastructure for evidence-based medicine; facilitate the use of information technology;

and align payment incentives around six priorities for care (i.e., safe, effective, patient-centered, timely, efficient, and equitable care). The current system of fragmented, costly and often substandard care is unacceptable for Medicare beneficiaries and financially unsustainable for the Medicare program.

America's family physicians are taking bold steps to change this inadequate system of care. These include major Academy initiatives to:

- improve chronic illness care within offices of family physicians by building on the Chronic Care Model that Edward Wagner, M.D. has developed,
- reinvent and redesign family physician practices to implement the IOM report, *Crossing the Quality Chasm*, which set out six aims and 10 simple rules for the 21st century health care system and to ensure that every American has a personal physician (*Future of Family Medicine* initiative),
- accelerate family physicians' adoption and utilization of electronic health records (EHRs) and other information technologies in the *Partners for Patients* initiative, and
- promote standards that improve the quality of care and patient safety, such as the *Continuity of Care Record*, a portable electronic format record of clinically relevant health care data.

Family physicians are trained to manage multiple chronic diseases using evidence-based guidelines, patient management tools and information technologies while engaging other specialists and community resources as appropriate. However, the current financing mechanism that supports office-based ambulatory care, including Medicare Part B, is outdated and does not foster optimal care for seniors beset by multiple chronic diseases. The current visit-based reimbursement system has compromised the ability of primary care physicians to serve in the role that they are trained and prepared to deliver. Rather than rewarding care that is more cost-effective, it rewards physicians for ordering tests and performing procedures. Family physicians are not currently reimbursed for the considerable time that they spend with patients in coordinating care and in behavioral counseling to improve patient self-care. There is no direct compensation to physicians nor any systemic incentive for assuring care is organized correctly and integrated in a way that makes sense to patients.

The IOM report, *Crossing the Quality Chasm*, stresses the need to realign incentives in health care delivery to the promotion of these functions. Providing a funding mechanism that encourages primary care physicians to build ongoing medical relationships with their patients also allows them to promote behavioral changes (i.e., eating right, exercising, quitting smoking and initiating other self-management behaviors). In this way, the earliest and best chronic care is based on sound behavior and lifestyle changes that primary care physicians can encourage.

Effective chronic care management involves:

- developing a partnership with each patient;
- developing a care plan;
- coordinating disparate systems to integrate their care; and
- providing patient education resources and delivery systems.

Performing these functions requires additional time and resources not currently recognized in the existing office-based reimbursement system. However, organizing care in this manner has proven worthwhile. For instance, thirty-nine studies have validated the Chronic Care Model developed by Ed Wagner, M.D., Director of Improving Chronic Illness Care (ICIC) at the MacColl Institute for Healthcare Innovation. Implementation of this model reduces unnecessary subspecialty referrals, contains costs, reduces duplicative care, improves patient satisfaction and results in better health outcomes. The six components of this model are:

- training patients in self-management;
- providing clinical decision support;
- redesigning the office-based medical practice;
- disseminating information technology systems;
- developing integrated systems of care; and
- linking physicians to community resources.

In fact, Bodenheimer et al. found that 18 of 27 studies concerning just three chronic conditions (congestive heart failure, asthma, and diabetes) demonstrated reduced costs or lower use of health care services when this Chronic Care Model was fully implemented, almost exclusively in primary care settings.

The AAFP is recommending the use of a chronic care management fee for primary care physicians that would support the implementation of this Chronic Care Model within the Medicare program.

Chronic Care Management Fee

The Academy recognizes the significance of Chairman Johnson's efforts to improve chronic care management through the development of the Section 721 chronic disease management pilot program. The Academy appreciates the Chairman's inclusion of primary care physicians as eligible providers under Section 721.

Sections 649 and 721 of the Medicare Prescription Drug Improvement and Modernization Act are designed to develop and test innovative and transformative models for chronic disease management. Section 721 is designed to test systems of care that improve health outcomes for Medicare beneficiaries with chronic illnesses. The more limited Section 649 provides the opportunity for CMS to work with physicians more directly through state-based Quality Improvement Organizations (QIO). The Doctors' Office Quality-Information Technology (DOQ–IT) project is an example of such collaboration.

The AAFP is working with CMS officials to ensure that implementation of the pilot project under Section 721 proactively enrolls primary care physicians and provides appropriate financial support to the creation of an integrated system of care based on the Chronic Care Model. In fact, the attendant benefits of the Chronic Care Model cannot be delivered without the inclusion of physician practices. The system of care that Section 721 seeks to create must establish primary care physician offices as the basis for creating systems of care for Medicare beneficiaries with chronic conditions.

The Academy supports a per-beneficiary chronic care management fee that is paid directly to the physician in addition to fee-for-service payments. This fee would be paid to whichever patient-selected physician, who is willing to perform the performing the following activities or functions as well as provide technology support:

- tracking and monitoring all aspects of patients' care;
- acting as a referral agent;
- coordinating clinical reports from others involved in patients' care;
- maintaining an electronic health record;
- providing greater time in the office visit as needed; and
- having appropriate staff and administrative abilities.

The implementation of a chronic care management fee, added to the regular Medicare fee-for-service reimbursement, would encourage the acquisition of medical information technology since the cost of this technology is the single biggest barrier to its implementation. This new reimbursement stream would also ensure that beneficiaries received coordinated, evidence-based medical care while the Medicare program would reap the resulting cost savings.

Conclusion

The Institute of Medicine has identified the improvements in a patient's health associated with a "usual source of care," also described as "a medical home." Care management models using this concept as a way to ensure the six quality characteristics have been successfully employed. For example, Medicaid primary care case management programs that pay primary care physician practices a monthly fee for care coordination responsibilities are meeting with success. Testing a similar model adapted to the needs of Medicare patients who characteristically possess several chronic conditions is a timely and appropriate innovation within the existing Medicare pilot and demonstration projects.

Statement of American Association of Homes and Services for the Aging

The American Association of Homes and Services for the Aging (AAHSA) appreciates the opportunity to submit this statement for the record of the Subcommittee's hearing on quality initiatives in health care. AAHSA represents more than 5,600 mission-driven, not-for-profit members providing affordable senior housing, assisted living, nursing home care, continuing care retirement communities, and community services. Every day, our members serve more than two million older persons across the country. AAHSA is committed to advancing the vision of healthy, affordable, and ethical aging services for America.

For the past forty-two years, AAHSA has been an advocate for elderly nursing home residents and has striven in the public policy arena to create a long-term care delivery system that assures the provision of quality care to every individual our members serve in a manner and environment that enhances his or her quality of life. Although we have been closely involved in the development of Federal nursing home quality standards, we recognize that continued efforts are needed to ensure

ongoing quality improvement. Long-term care providers themselves must do much of the work, but we believe that there are also opportunities for public policy changes to encourage continued improvement in the quality of care in our nation's nursing homes.

Quality First

AAHSA, partnering with the American Health Care Association and the Alliance for Quality Nursing Home Care, has embarked on a multi-year plan to ensure true excellence in aging services, going beyond simple compliance with government quality initiatives and taking the responsibility for raising the bar in our field. So far, close to 2,000 AAHSA members have signed a covenant that we view as a pact between providers, consumers, and government, and the number of AAHSA members who have signed is growing steadily. All of AAHSA's thirty-seven state affiliates have endorsed the covenant as well.

Covenant signors commit themselves to a process that is based on seven core principles: continuous quality improvement, public disclosure and accountability, consumer and family rights, workforce excellence, community involvement, ethical practices, and financial integrity. The goals for Quality First are continued improvements in compliance with regulatory requirements, progress in promoting fiscal integrity, prevention of abuse and neglect, demonstrable improvements in clinical outcomes, high scores on consumer satisfaction surveys, and higher employee retention rates and reduction in turnover.

To accomplish these goals, AAHSA is developing tools for members that give them the information they need on best practices in our field, how to evaluate their current strengths and weaknesses, and how to orient all of their operations toward quality care. We are emphasizing research into best practices, education and shared knowledge among our members, leading-edge care and services, codes of ethics, and fiscal and social accountability. We are committing ourselves to providing full and accessible information to consumers on facilities' services, policies, amenities, and rates. To address staffing issues, covenant signers promise to invest in staff training, competitive wages and benefits, and a supportive work environment for both paid caregivers and volunteers. Quality First emphasizes ongoing assessments of facilities' policies and practices to ensure a continuous process of quality improvement.

To measure and report on the success of this initiative, AAHSA and its partners have engaged the National Quality Forum to appoint a national commission made up of academic experts and leaders from the private sector who have no financial interest in or direct ties to our field. These impartial community representatives will keep nursing homes accountable for living up to the commitments we have made under the Quality First Covenant and will provide a credible resource for consumers, government, and other stakeholders.

Institute for the Future of Aging Services

Key to any improvement in the quality of nursing home care will be staff recruitment, training and retention. A number of well-documented challenges face health care and aging services providers across the spectrum of care, including the shrinkage of the working-age population in relation to the aging population, broader career opportunities for women who traditionally worked as caregivers, less attractive wages and benefits in the care giving field, and so on.

The Institute for the Future of Aging Services (IFAS), housed within AAHSA and under the leadership of Dr. Robyn Stone, is implementing several initiatives directed at finding creative solutions to these staffing challenges, including the following:

- **Better Jobs/Better Care (BJBC)**, a four-year research and demonstration program to achieve changes in long-term care policy and practice that help to reduce high vacancy and turnover rates among direct care staff across the spectrum of long-term care settings and contribute to improved workforce quality. Working in partnership with the Paraprofessional Healthcare Institute and with funding from the Robert Wood Johnson Foundation and Atlantic Philanthropies, BJBC has made grants for both demonstration projects and applied research and evaluation. Funding is going to teams of long-term care providers, workers, and consumers to work with state and local officials in developing and implementing changes in policy and provider practices to support recruitment and retention of a quality workforce. Other grants have also been awarded to study Federal and state policy changes, workplace management and culture, job preparation and training for long-term care workers, and innovative approaches to recruiting qualified workers.

- **Practice Profile Database**

The Institute for the Future of Aging Services and the Paraprofessional Healthcare Institute also have teamed up in putting on-line a database of successful direct-care worker recruitment, training and retention programs that aging services organizations can use to improve staffing. The database, at www.futureofaging.org, provides information on a variety of topics, including recruitment, career advancement, and training for both entry-level workers and management. Projects selected for the database were required to provide quantitative or qualitative evidence of results in the areas of staff satisfaction, successful completion of training programs, and employee-resident relations. Listings in the database include complete information on how the project was implemented and contact information for further discussion. This database provides proven, real-life solutions to staffing issues that confront all long-term care providers.

- **Wellspring Model Refinement, Replication, and Sustainability**

Almost ten years ago, a group of eleven AAHSA members in Wisconsin decided to pool their resources to accomplish two objectives: to improve clinical care for residents and to create a better working environment by giving employees needed skills, a voice in how their work should be accomplished, and the ability to work as a team toward common goals. The Wellspring alliance included clinical education by a geriatric nurse practitioner, shared staff training and data on resident outcomes, and culture change that empowered front-line workers to develop and implement care practices that they determined would be beneficial for residents.

A fifteen-month study and evaluation by IFAS and a team of leading academicians in the field of long-term care concluded that the Wellspring alliance had achieved its goals and had pioneered changes that could have broad implications for improving the quality of nursing home care. Positive outcomes noted in the evaluation included greatly reduced staff turnover, improved performance on Federal surveys, increased staff initiative to assess and act on care problems, better quality of life for residents, and improved relationships between staff and residents.

With a followup grant from the Commonwealth Fund, IFAS staff and a business consultant developed a business case statement for Wellspring to use with CEOs, upper management and boards of organizations interested in adopting this quality/culture change model. The team also developed a business plan for a new Wellspring Institute that would move beyond the "home-grown" organization that had been managing model replication and that could help bring the program to a greater scale. A full-time executive director of the new institute was recently hired (formerly the staff person from the California QIO who was responsible for implementing the Nursing Home Quality Initiative). Besides alliances in Wisconsin and Illinois, the Wellspring Institute just began a replication in Maryland and is exploring other alliances in North and South Carolina and California.

- **Real-time Care Plans for Nursing Home Quality Improvement**

IFAS is partnering as a subcontractor to the Institute for Clinical Outcomes Research on a study to design, support, and facilitate change that is likely to lead to documented improvements in health care quality and ensure that these improvements become part of the ongoing practice of health care providers and clinicians.

Working with nursing homes and state Quality Improvement Organizations (QIOs), this project will design, implement, and evaluate a process using automated standardized documentation forms and an IT tool to implement best practices. This project will make better use of staff time and improve resident outcomes by: focusing staff time on specific interventions associated with improved outcomes; incorporating evidence-based protocols developed through extensive research on pressure ulcer prevention (comprehensive database of 2,500 residents); ensuring protocol adherence by providing automated standardized tools for documenting and reporting information related to prevention of pressure ulcers; eliminating extra paper documentation and redundant data entry; facilitating clinical process redesign; and minimizing labor-intensive manual data abstraction process for MDS and quality indicators.

- **Measuring Long-Term Care Work: A Guide to Selected Instruments to Examine Direct Care Worker Experiences and Outcomes**

  IFAS has developed a guide to help LTC organizations improve their use of measurement tools to understand direct care workforce problems and to inform their solutions. The issues addressed by the instruments include: retention, turnover, vacancies, staff empowerment, job design, job satisfaction, organizational commitment, worker-supervisor relationships and workload. These tools are designed to help providers measure the quality of the job and the workplace for staff—an important and essential dimension of quality outcomes.

Policy Recommendations

Survey Improvement

Through the nursing home survey and enforcement process mandated by the Omnibus Budget Reconciliation Act of 1987 (OBRA), the federal government has sought to ensure that nursing homes meet minimal standards of quality. As noted previously, AAHSA was closely involved in the development of the OBRA standards, and we believe that the quality of care in nursing homes today generally is far above the level that prevailed prior to OBRA.

However, there continue to be serious issues with inconsistency in survey results and the imposition of remedies. We believe that improvements to the present system need to be considered objectively and with an unbiased view toward better ensuring quality care. OBRA was enacted sixteen years ago, and the system that it implemented was based on research that now is over twenty years old. Best practices in our field have advanced enormously since that time, and yet those in our field who want to provide innovative, high-quality care are sometimes hamstrung by a highly prescriptive Federal regulatory system that in many respects is out-of-date.

A number of states, including Minnesota, Washington and Wisconsin, have worked hard and thoughtfully to develop alternative approaches for measuring and ensuring quality nursing home care. They have sought waivers from CMS to use these alternatives in place of the OBRA-mandated system. Realistically, given the resources that states must now commit to the current survey system, they cannot carry out parallel survey processes. CMS has not granted any waiver requests from states, and may be precluded from doing so by the OBRA statute. We would recommend that Congress authorize a limited number of waivers under close supervision by CMS to give states greater flexibility to develop and explore innovative approaches to ensuring quality care. Ultimately, these state experiments could well lead to improvements in the present Federal survey system that would better ensure quality care nationwide.

Payment amd Quality

AAHSA firmly believes that a two-way commitment is essential to foster improvement in the quality of care and services provided in nursing homes. As the dominant payers for nursing home care, the Federal and state governments have an obligation to ensure that payments for nursing home care are adequate to allow for the provision of high quality clinical care in an atmosphere that also ensures quality of life for residents.

Nursing home providers, in turn, have an obligation to serve as responsible stewards of public funds by ensuring that they are delivering the high quality of care and services that Federal and state governments purchase for their residents through the Medicare and Medicaid programs. This is possible only by dedicating sufficient resources to the costs of direct care services.

AAHSA welcomes the growing focus of this Administration, Congress, and other interested parties on the question of how payment policies can be re-designed to foster and support the provision of the highest possible quality in health care. We were pleased with the recommendations of the Medicare Payment Advisory Commission (MedPAC) in their June 2003 report calling for demonstrations of "provider payment differentials and revised payment structures to improve quality." As MedPAC points out, "In the Medicare program, the payment system is largely neutral or negative towards quality. All providers meeting basic requirements are paid the same regardless of the quality of service provided. At times, providers are paid even more when quality is worse, such as when complications occur as the result of error." This is equally true of some state Medicaid payment systems, though a number have successfully implemented strategies to foster greater accountability and quality.

AAHSA is eager to work closely with the Administration and Congress to design and test alternative approaches to payment for long-term care services that will not be blind to quality.

Building on State Experience; Implementing a Demonstration

We offer two approaches to re-orient payment for nursing home services to promote high quality care:

One way of linking payment and quality involves applying lessons learned in successful state Medicaid programs. Payment systems need to balance a set of competing objectives: quality, reasonable cost containment, and administrative feasibility. A number of states—including Iowa, Indiana, Ohio, and Pennsylvania—have "modified pricing" systems that create this balance and provide accountability for public payments by splitting payments into at least two components. Prospective payments for direct care (e.g., nurse staffing) are directly tied to spending on direct care (up to appropriate limits); profit potential on this direct care component is minimized. This linkage ensures that dollars added to the system achieve the desired objective—sufficient staffing to deliver high quality services and meet residents' needs. Incentives to reduce spendingare focused on other aspects of nursing home costs such as administration. By contrast, the Medicare system and some state Medicaid systems create strong incentives for homes to reduce spending on both direct and indirect care by providing profit opportunities on the total payment amount. AAHSA suggests that Medicare consider adapting some successful strategies such as modified pricing systems used in state Medicaid payment systems to better link payment and quality.

Second, AAHSA recommends that the federal government implement a demonstration program, with a strong evaluation component, to explore ways to successfully link the quality of care and services provided with payments for nursing home care, beyond ensuring that sufficient resources are allocated to direct care services. The demonstration should develop and test a method for paying bonuses to facilities that achieve excellent ratings in performance of a set of appropriate quality markers—similar to the current Medicare demonstration on hospital payments.

A critical first step in implementing such a demonstration for nursing facilities would be the development of a set of quality markers that capture desired *processes* of care that should be fostered, e.g., implementation of standardized pressure ulcer risk assessment protocols to identify high risk residents, use of pressure-reducing devices and strategies for residents at high risk of developing pressure ulcers, consistent screening and monitoring of all residents for pain, etc.

Current measures used in long-term care focus on resident-level outcomes, e.g., prevalence of pressure ulcers, prevalence of pain, decline in ability to perform Activities of Daily Living, etc. The outcomes measured are often the result of a vast set of complex interactions between intrinsic resident-specific factors (e.g., major medical conditions, co-morbidities, resident preferences and choices, etc.) and the care provided by the nursing home and other providers. The difficulties inherent in teasing apart the relative influence on outcomes of intrinsic versus extrinsic factors have led to a greater focus on process measures in other health care settings such as hospitals and managed care plans.

Definition of valid process markers, based on research to identify clinically appropriate, evidence-based care for specific types of residents, will allow public and private payers to create incentives that encourage the adoption and consistent use of evidence-based care processes. This can be expected, in turn, to lead to improved outcomes. Focusing on measurement of appropriate processes, however, rather than outcomes, eliminates the need for complex, controversial risk-adjustment formulas to attempt to account for the various intrinsic factors that play a significant part in influencing resident outcomes. Process measurement also allows for capturing the implementation of appropriate preventive health services that should be offered to nursing home residents, such as immunizations to prevent influenza and pneumonia.

In addition to incorporating markers of quality care processes, it is equally important for such a demonstration to expand the definition of nursing home quality beyond the clinical domain addressed in currently available measure sets. It is critical that a system designed to link payment with quality also includes valid, reliable markers of resident quality of life, as well as resident and staff satisfaction. Nursing homes are far more than settings where clinical care is provided—for long-term residents, these facilities are in fact, their homes. To accurately capture key elements of quality that are important to nursing home residents, our systems for measuring quality must evolve to be more holistic.

Finally, AASHA believes that this demonstration should also involve implementing and testing innovative technologies for information management that improve accuracy while reducing the paper work burden on staff. Better information systems and technology will be an important part of tracking the type of quality markers we envision without new and excessive paperwork. In addition, advances

in technology, including information technology, are critical to enhancing the quality of aging services for the future.

AAHSA strongly encourages the Administration and Congress to embark upon this path of greater accountability for public funds directed to the provision of services for America's frail elderly and looks forward to participating in the process of designing a system that will benefit nursing home residents across the nation.

Conclusion

Achieving the vision of the highest possible quality long-term care for all Americans will require all of us—Members of Congress, long-term care providers, consumers, workers, families, and other stakeholders—to work together on innovative solutions to the challenges we all face in making sure that our residents receive the care and services they need.

Statement of American College of Surgeons

The American College of Surgeons (ACS) commends House Ways and Means Health Subcommittee Chair Nancy Johnson for convening today's hearing on health quality initiatives. Improving the quality of surgical care is a founding principle of ACS and we are pleased to submit this statement for the record on behalf of our 66,000 Fellows.

History of Surgical Quality Improvement Initiatives

ACS was formed in 1913 to improve the quality of care of the surgical patient by setting high standards for surgical education and practice. Since then, the College has developed a number of innovative programs and initiatives to achieve this goal.

In 1922, the College established the multi-disciplinary Commission on Cancer (CoC) to set standards for quality cancer care delivered in hospital settings. Today, its membership is comprised of more than 100 individuals representing 39 national professional organizations. Among other initiatives, the CoC establishes standards for 1,438 Commission-accredited cancer programs; provides clinical oversight for standard-setting activities and the development and dissemination of patient care guidelines; and coordinates national site-specific studies of pattern of care and outcomes through the annual collection, analysis, and dissemination of data for all cancer sites.

In addition to our cancer initiatives, the College is working to develop a program that accurately measures quality for most major operations. Through a grant funded by the Agency for Healthcare Research and Quality (AHRQ) in 2002, the College was able to further validate the Department of Veterans Affairs (VA) National Surgical Quality Improvement Program (NSQIP) in 14 private sector hospitals. The NSQIP program allows surgeons to compare their observed versus expected outcomes experience with national averages and comparable hospitals. The College now plans to expand the NSQIP program into over 100 additional private sector hospitals.

With regard to surgical education, the College administers the Surgical Education and Self-Assessment Program (SESAP) to help surgeons stay abreast of current practice standards. Based on the opinions of expert surgeons and the published literature, SESAP reproduces the diagnostic and treatment challenges faced in the practice of surgery and provides immediate feedback for self-improvement.

Recognizing that much of surgical practice has not been evidence based—especially during the introduction of new surgical technology—the College initiated a program to develop and implement clinical trials in 1994. The first trials, designed to assess watchful waiting, open operation, and laparoscopic hernia repairs, were funded by AHRQ and the VA Cooperative Studies Program. Subsequently, the American College of Surgeons Oncology Group was established with funding from the National Cancer Institute to evaluate the surgical management of patients with malignant solid tumors. The purpose of the clinical trials program is to test the safety and efficacy of new surgical procedures before they are widely disseminated into practice, develop educational programs that help surgeons safely introduce new technology into their practices, and critically evaluate current practices.

The College also maintains several other resources that surgeons utilize in their practices. ACS pioneered the development of a systems approach for trauma; and its Advanced Trauma Life Support program is now the worldwide standard for training providers who first attend to injured patients. The College has also established a National Trauma Data Bank, which is used to inform the medical community, the public, and decision makers about a wide variety of issues that charac-

terize the current state of care for injured persons. The information contained in the data bank has implications in many areas including epidemiology, injury control, research, education, acute care, and resource allocation.

In short, for the last 91 years, through the programs and initiatives outlined above and other efforts, the College has consistently worked to improve the quality of surgical care.

MedPAC's March 2004 Report

In its March 2004 Report to Congress, MedPAC examines the issue of improving the quality of care for Medicare beneficiaries and concludes that the Medicare payment system should incorporate incentives for improving quality. We would like to commend the Commission for its focus on quality improvement. Surgery has never lost sight of its fundamental responsibility to be the patient's quality care advocate and provider. Towards this end, we strongly agree with the Commission that surgeons must consistently measure, analyze, and improve the quality of care they provide to patients. However, the College is concerned about several of the specific measures and techniques used to assess quality in the March 2004 Report.

Using administrative data, the Commission measured the effectiveness of care for eight procedures based on mortality rates both in the hospital and 30 days after admission. Three of the procedures assess surgical care: CABG; Craniotomy; and AAA repair. In addition, the report references evidence suggesting that facilities with higher volume have lower rates of mortality for similar populations.

Although convenient and fairly inexpensive to collect, administrative data alone cannot be used to assess surgical outcomes. More specifically, age, sex, and all patient refine diagnosis related groups (APR–DRGs) are not adequate risk-adjustment measures. For example, recent research has identified the following characteristics as some of the most powerful predictors of surgical outcomes: American Society of Anesthesiologists (ASA) class, preoperative functional status (fully independent, partially dependent, full dependent), whether or not the operation was done as an emergency, and DNR status.[1] Unfortunately, none of these characteristics has a corresponding ICD–9–CM code and therefore is not included in the billing record. We believe surgical outcomes data must be gathered by a highly-trained clinical nurse from medical records and a 30-day patient followup survey. While it is currently more expensive to collect such non-administrative data, emerging medical technology systems will clearly help alleviate many of the additional financial and administrative burdens.

We are also concerned by the report's reference to evidence that facilities with higher volume have lower rates of mortality for similar populations. We do not believe that surgical volume alone provides an accurate measure of surgical quality. In fact, we would like to draw your attention to a study published in the *Annals of Surgery* that analyzed the relationship of surgical volume to outcomes in eight common operations. The study found no statistically significant associations between procedure or specialty volume and 30-day mortality rate.[2] In addition, it is important to keep in mind that the volume numbers linked to many of the most technically demanding surgical procedures—for which the relationship between volume and quality are perhaps strongest—are really very small and easily skewed by just a few poor outcomes that may be unrelated to the quality of the care provided.

We are hopeful that the Commission and Congress will consider using a different model to measure the quality of surgical care: the NSQIP effort mentioned earlier. NSQIP is the first national, validated, outcome-based, risk-adjusted, and peer-controlled program for the measurement and enhancement of the quality of surgical care. Developed 12 years ago by the Veterans Administration (VA), NSQIP compares the performance of all VA hospitals providing surgical services. The results of these comparisons are provided to each hospital and are used to identify areas of poor performance and excess adverse events.

Since NSQIP was implemented, the VA has seen a 28 percent reduction in 30-day postoperative mortality and a 43 percent reduction in 30-day postoperative morbidity.

The College also has serious concerns about using administrative data to measure patient safety. Many of the selected adverse events can be caused by pre-existing conditions that are not identified in the hospital billing record. For example, seniors

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[1] Best, WR et al, "Identifying Patient Preoperative Risk Factors and Postoperative Adverse Events in Administrative Databases: Results from the Department of Veterans Affairs National Surgical Quality Improvement Program," Journal of the American College of Surgeons, Vol. 194, No. 3, 2002, Pg. 257–266.

[2] Khuri, SF et al, "Relation of Surgical Volume to Outcome in Eight Common Operations," Annals of Surgery, Vol. 230, No. 3, 1999, Pg. 414–432.

commonly experience postoperative physiologic derangement after surgery. This condition is often unrelated to poor surgical care, but rather results from the senior being confused or disoriented because they are in an unfamiliar setting. Heavy drinkers also experience postoperative physiologic conditions, yet rarely is their drinking history noted in the administrative comorbidity data.

In its landmark 1999 report, "*To Error is Human: Building a Safer Health System*," the Institutes of Medicine (IOM) identifies another example of how adverse events identified through administrative data cannot measure performance. The report states, ". . . if a patient has surgery and dies from pneumonia he or she got postoperatively, it is an adverse event. If analysis of the case reveals that the patient got pneumonia because of poor hand washing or instrument cleaning techniques by staff, the adverse event was preventable (attributable to an error of execution). But the analysis may conclude that no error occurred and the patient would be presumed to have had a difficult surgery and recovery (not a preventable adverse event)."[3] Administrative data alone cannot measure performance. A detailed analysis must also be conducted to identify the true cause of the problem.

In the conclusion of the March 2004 Report's chapter on quality, MedPAC acknowledges that "more and better data on quality to be used in pay-for-performance programs is needed." The College is committed to working with the Commission and Congress to resolve the concerns addressed above and identifying accurate and effective ways to improve the quality of surgical care for Medicare beneficiaries.

Conclusion

Surgeons have a unique responsibility to improve the quality of surgical care for their patients. Since many procedures are performed on an emergent or urgent basis, there is often no time to provide patients with comparative information that they can actually use to make their own assessments and perhaps choose alternatives. Instead, they count on their surgeons to help them make informed decisions based on their own unique circumstances. Consequently, an even greater burden is placed on our profession to not only define and measure quality, but to develop the systems and practices that can actually elevate the quality of care generally.

We applaud Subcommittee Chair Johnson, Ranking Member Stark, and the rest of the House Ways and Means Health Subcommittee for their commitment to improving the quality of our nation's health care system. We look forward to working together with you to ensure all Americans have access to high-quality surgical care.

The American College of Surgeons is a scientific and educational organization of surgeons that was founded in 1913 to raise the standards of surgical practice and to improve the care of the surgical patient. The college is dedicated to the ethical and competent practice of surgery. Its achievements have significantly influenced the course of scientific surgery in American and have established it as an important advocate for all patients. The College has more than 66,000 members and is the largest organization of surgeons in the world.

Statement of America's Health Insurance Plans

INTRODUCTION

America's Health Insurance Plans (AHIP) is the national organization which represents companies providing health benefits to over 200 million Americans. AHIP member companies contract with large and small employers, state and local governments, as well as with public programs, including Medicare, Medicaid, the Federal Employee Health Benefits Program (FEHBP), the State Children's Health Insurance Program (SCHIP) and the military's TRICARE program.

AHIP commends the U.S. House of Representatives Ways and Means Subcommittee on Health for convening this important hearing to explore measures to improve health care quality. As demonstrated by two statements recently approved by AHIP's Board of Directors—*A Commitment to Improve Health Care Quality, Access and Affordability* (March 2004) and *Improving Health Care Quality Through Transparency* (February 2003)—we strongly share the Subcommittee's goals of promoting high-quality care for all Americans and helping to ensure that consumers have the information they need to make informed health care decisions.

[3] Committee on the Quality of Health Care in America, Institute of Medicine, 1999, *To Error is Human: Building a Safer Health System*, Washington, DC, National Academy Press, Pg. 6.

DEFINING THE SCOPE OF THE QUALITY CHALLENGE

Health policy experts have written compellingly about the disturbing gap between what science suggests and what practitioners actually do as well as the need to engage and empower consumers with information about their health care. The landmark 2001 Institute of Medicine (IOM) report, *Crossing the Quality Chasm*, found that many patients consistently fail to receive high-quality health care, and wide variations in practice—even in clinical situations where there is data on what works and what does not—suggest that relevant and meaningful information fails to reach many clinicians and patients. The IOM study called for a renewed national commitment to build an information infrastructure to support health care delivery, public accountability, research and education. Further, the study recommended that the health care system be transparent, making information publicly available so that patients and families can make informed health care decisions.

Recent major studies support the IOM's conclusions that evidence-based medicine [1] is not consistently being practiced, including continuing research by Dr. John Wennberg and others at Dartmouth [2] and a 2003 RAND study finding that patients receive only 55% of treatments that have been determined to be the "best practices" for addressing their medical conditions.[3]

As this documented overuse, underuse and misuse of services continues, the health care system is also plagued with an unacceptably high number of preventable medical errors each year. The highly publicized Institute of Medicine report, *To Err is Human*, found that between 44,000–98,000 Americans die each year as a result of preventable medical errors.[4]

Clearly, the consistent adoption of what we know works (and elimination of what we know does not work) in everyday medical practice and a reduction in preventable medical errors would improve health outcomes and, ultimately, the health of Americans. What may not be as obvious is that both also would result in significant efficiencies to the entire health care system:

- Thirty percent of all direct health care outlays are the result of poor quality; this translates into $420 billion spent each year. Indirect costs of poor quality (e.g., reduced productivity due to absenteeism) include an additional $105–$210 billion.[5]
- Total health costs due to preventable adverse events (medical errors resulting in injury) are estimated to be more than $8.5–$14.5 billion.[6]

All of these findings emphasize the need for health plans and insurers, employers, physicians, hospitals and policymakers to work together to build momentum for system-wide change. To most effectively improve quality, the IOM calls for the transformation of our system across the entire health care industry, and not individual segments. Thus, all stakeholders play a role in ensuring that physicians, hospitals and other health professionals have useful information about the latest scientific evidence and about their performance, and that consumers have meaningful quality information to make informed decisions.

ONGOING HEALTH PLAN AND INSURER INITIATIVES TO PROMOTE A SAFER AND MORE EFFECTIVE HEALTH CARE SYSTEM

By promoting evidence-based medicine, increasing transparency, and reducing preventable medical errors, health plans and insurers actively engage providers and consumers to improve health outcomes and overall health status. Specific strategies that our member companies use include:

- Report cards on health plan and insurer performance;
- Investing in information technology, particularly in the area of pharmacy management; and
- Incentives to reward quality.

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[1] Evidence-based medicine is the daily practice of medicine based on the highest level of available evidence determined through scientific study.

[2] E. Fisher, D. Wennberg, T. Stukel, D. Gottlieb, F.L. Lucas, E. Pinder, "The Implications of Regional Variations in Medicare Spending. Part 2: Health Outcomes and Satisfaction with Care," Annals of Internal Medicine, February 18, 2003. J.E. Wennberg and M.M. Cooper, *The Dartmouth Atlas of Health Care in the United States*, 1999.

[3] E. McGlynn, S. Asch, J. Adams, J. Keesey, J. Hicks, A. DeCristofaro and E. Kerr, "The Quality of Health Care Delivered to Adults in the United States," NEJM, June 26, 2003.

[4] *To Err is Human*, Institute of Medicine, 1999.

[5] *Reducing the Costs of Poor-Quality Health Care*, Midwest Business Group on Health in collaboration with the Juran Institute, Inc. and The Severyn Group, Inc., 2003.

[6] *To Err is Human*, Institute of Medicine, 1999.

Report Cards on Health Plan and Insurer Performance

Collecting and disclosing information is an important first step to quality improvement. Performance benchmarks are also needed for stakeholders to determine the extent to which providers are delivering treatments that have proven to be effective. This information allows consumers and employers to select the highest quality physicians, hospitals, medical groups and other health professionals.

For nearly ten years, health plans and insurers have been collecting and reporting on more than 50 measures of quality and performance using the Health Plan Employer Data and Information Set (HEDIS)®. In 2003, 513 commercial, Medicaid, and Medicare health plans and insurers nationwide covering 72 million people collected HEDIS data that was independently audited to assure validity. Performance on these benchmarks is broadly and publicly disclosed by the National Committee for Quality Assurance (NCQA) in its annual report, data base and website, as well as by Federal, state and local government agencies and other regional collaboratives.

Performance is also made transparent through health plan-specific report cards that are readily available on their respective websites. These report cards assist employers and consumers to make choices among various health care products, among various types of health plans and insurers, and among doctors, hospitals and other health professionals who deliver medical care. Examples include:

- *AvMed Health Plan* publishes results from NCQA's HEDIS measures on its website so that members can compare their commercial health plan's value to other health plans. Reports from HEDIS 2000 through 2003 are available on the website. The AvMed HEDIS 2003 report is divided into six sections, featuring multiple measures: (1) effectiveness of care (e.g., immunization rates); (2) health plan stability (e.g., physician turnover); (3) access/availability (e.g., children's access to primary care physicians); (4) satisfaction with the experience of care (e.g., overall satisfaction with plan); (5) use of services (e.g., number of well child visits in the first 15 months of life); and (6) plan description (e.g., member enrollment numbers).
- *CIGNA HealthCare* recognizes participating physicians and hospitals who have met certain quality criteria in its online *Provider Excellence Recognition Directory*. Physicians are recognized for being certified by the National Committee for Quality Assurance for providing high quality diabetes or heart/stroke care. Hospitals are highlighted for meeting the Leapfrog Group's three patient safety standards (e.g., Computer Physician Order Entry systems, Intensive Care Unit Physician Staffing, and Evidence-based Hospital Referrals).
- Since 1998, *PacifiCare Health Systems* has produced publicly disclosed medical group-specific report cards on approximately fifty-five measures that focus on clinical quality (e.g., cervical cancer screening), service quality (e.g., claims complaints), affordability (e.g., member cost for hospital and pharmacy services), and administrative accuracy (e.g., quality of the claims and encounter data submitted by the medical groups). Additional report cards focus on hospitals and women's health.

Investing in Information Technology, Particularly in the Area of Pharmacy Management

A growing body of evidence indicates that investing in information technology improves both patient safety and quality of patient care.[7] According to a California Health Care Foundation survey of small physician practices on the benefits of an electronic medical record (EMR), almost all physician practices reported increased quality of patient care due to better data legibility, accessibility and organization, as well as prescription ordering, and prevention and disease management care decision support. One physician responded that:

"The biggest benefit [of an EMR] is to patient care. Patient care charts are legible and drug interactions can be seen. One of the biggest problems is that patients are on multiple medications and go to multiple specialists and pharmacies, so nobody knows who's taking what. Now, every time they come in, they get a print-out of all their medicines and they're told 'take this to all your different specialists. . . .' So all the specialists know exactly what the patient is taking."

[7] Investing in electronic medical records also often results in financial benefits partially due to decreased staff (e.g., transcriptionist, medical records, data entry, billing and receptionist) costs. A couple of physicians in one small practice reaped gains of more than $20,000 per year by implementing the EMR. *Electronic Medical Records: Lessons from Small Physician Practices*, California Health Care Foundation, Prepared by University of California, San Francisco, October 2003.

Recognizing its value in improving quality and patient safety, our member companies have implemented various information technology systems and e-health initiatives. These initiatives provide patients and physicians with online access to extensive information about prescription drugs, including their appropriate uses, potential side effects and adverse interactions. They also improve administrative processes and communications between patients and physicians, such as online enrollment, online physician selection, and online patient care advice. Examples include:

- *Blue Cross Blue Shield of Massachusetts and Tufts Health Plan* are working together to facilitate prescription drug ordering by physicians. Initially, the two health plans conducted separate demonstration projects providing 200 physicians with handheld e-prescribing tools. Results from the demonstrations showed impressive improvements in quality, patient safety (through the reduction of preventable medical errors), and cost efficiencies. Currently, the two health plans, located in one service area, are collectively contributing $3 million for more widespread rollout, providing over 3,400 physicians with handheld e-prescribing tools by the end of 2003.
- In 2003, *Horizon Blue Cross Blue Shield of New Jersey* launched a pilot program to allow patients to visit their physicians on-line. The goal of the program is to assist members to better manage their health through the convenience of the Internet. The pilot, involving 2,500 members and two participating physician groups, enables members to schedule appointments, request specialist referrals, obtain their medical histories, refill prescriptions and receive routine lab results.
- On its health plan member website, *Humana, Inc.* offers a comprehensive pharmacy section that offers access to information related to: (1) members' pharmacy benefit packages; (2) cost differences among drugs, alternatives to specific drugs by therapeutic class, and potential drug interactions; (3) a prescription drug library, with reference information about medications; (4) participating pharmacies; and (5) personalized prescription drug claims history (including ability to track deductibles and maximum benefits). In another section on the members' homepage, members can access a "natural" health encyclopedia, with detailed information about herbs and natural supplements and other health information about disease conditions from Healthwise Knowledgebase. During 2003, there were more than 3 million visits to Humana's ePharmacy website.
- *United Healthcare* offers an interactive website for health plan members to: (1) order prescription drugs and over-the-counter medications online; (2) ask a pharmacist questions about medications; (3) identify adverse drug interactions; (4) access clinical and other information about specified health conditions; and (5) set up a "my health" account, which tracks medical and medication history and provides tools to promote wellness, prevention, and prescription drug compliance.
- In January 2004, *WellPoint* announced a new $40 million initiative that will provide either a "Prescription Improvement Package" or a "Paperwork Reduction Package" to 19,000 physicians in California, Georgia, Missouri and Wisconsin. The "Prescription Improvement Package" features wireless handheld Personal Digital Assistants (PDAs) that allow physicians to check prescription drug coverage and formulary inclusion, screen for adverse drug interactions, write prescriptions electronically, and have them automatically faxed directly to the pharmacy. Alternatively, physicians may choose a "Paperwork Reduction Package," which includes computer systems that will help facilitate real-time on-line communication between the physician's office and WellPoint or other health insurers to verify enrollee eligibility and streamline claims processing and reimbursement.

Incentives to Reward Quality

In general, payment systems have traditionally not paid for higher quality (e.g., improved clinical outcomes and patient satisfaction), or improvements in processes and structures, such as developing integrated information systems. Instead, traditional payments to providers have historically been based on the volume and technical complexity of services.

Responding to these concerns, the Institute of Medicine urged health care stakeholders to re-align payment incentives with the delivery of safe and effective, high-quality care. Our member companies have been at the forefront of this movement and are developing innovative *paying for quality* programs for physicians, medical groups and hospitals, and incentives for consumers who select high quality providers. These programs include:

- In January 2004, *Aetna* launched a network of specialist physicians developed based on quality and efficiency indicators. The new Aexcel℠ network was created by identifying medical specialties associated with a large portion of health care spending and features specialists who demonstrate effectiveness against certain clinical measures (such as hospital readmission rates over a 30-day period, and reduced rates of unexpected complications by hospitalized patients), volume of Aetna members' cases, and efficient use of health care resources. Physicians in six medical specialties—cardiology, cardiothoracic surgery, gastroenterology, general surgery, obstetrics/gynecology, and orthopedics—who have met the established measures have been designated to participate initially in the network option. Aexcel benefits consumers through lower copayments for seeking services from more efficient providers and providers benefit through increasing the volume of patients to their practice. The Aexcel network is currently available in the three markets of Dallas/Fort Worth, North Florida and Seattle/Western Washington and will be expanded to additional service areas and specialties throughout the next two years.
- *Anthem Blue Cross and Blue Shield* is one of the first health benefits companies to collaborate with hospitals on an extensive hospital quality program that includes increased reimbursement based in part on quality measures. The program has been successful in improving the quality of care and outcomes at participating hospitals for all patients, not just Anthem members.

Anthem's Hospital Quality Program began in Ohio in 1992 with the quality reimbursement component added in 2002. The Hospital Quality Program evaluates quality of care provided in its network hospitals based on quality indicators, such as care provided for coronary services, obstetrics, breast cancer, asthma, joint replacement surgery, emergency departments, patient safety and accreditation status. Since its inception, this program has made statistically significant improvements in the care delivered to Anthem members in areas such as neonatal mortality rates, the use of beta blockers after heart attacks, and patient safety. Hospitals convene and share best practices. This Midwest program has been extended across all Anthem regions. These programs incorporate a payment system to recognize and reward physicians and hospitals for improved health care quality, patient safety and clinical results, such as reduced infections or medical errors. The programs measure a broad set of metrics that are based on best practices and developed in collaboration with participating hospitals and specialty medical societies.

- *Empire Blue Cross Blue Shield* is working with several of its large employer customers—IBM, PepsiCo, Xerox, and Verizon—to provide bonuses to hospitals that implement two of the Leapfrog Group standards: Computer Physician Order Entry (CPOE) and Intensive Care Unit (ICU) staffing. As of December 31, 2002, 53 hospitals in the plan's service area had completed the voluntary Leapfrog Group hospital survey and self-certified the status of CPOE and ICU staffing at their facilities. Bonuses were paid under the program to 29 hospitals during 2002.
- *Harvard Pilgrim Health Care* has a Provider Network Quality Incentive Program which includes support for medical directors and clinical practices, a Quality Grant Program and an Honor Roll program that publicly recognizes outstanding physicians. Another component of the Provider Network Incentive Program is a Rewards for Excellence program that recognizes and rewards the exemplary performance that local quality efforts achieve. Harvard Pilgrim has identified a subset of key HEDIS performance measures where effective clinical interventions have been identified and/or where current levels of performance—nationally, regionally, and within Harvard Pilgrim—are less than clinically optimal. Harvard Pilgrim offers its providers financial rewards for achieving excellent levels of performance in the defined target areas. In 2003, Harvard Pilgrim rewarded 55 out of 66 eligible practices.
- In California, the *Integrated Healthcare Association*, including health plans and insurers, physician groups, and health care systems, is implementing a statewide *Pay for Performance* initiative. Participating health plans/insurers include *Aetna, Blue Cross of California, Blue Shield of California, CIGNA HealthCare of California, Inc., Health Net, and PacifiCare Health Systems*. A common set of performance measures will evaluate physician groups in six clinical areas, patient satisfaction, and information technology investment (e.g., electronic medical records or computerized physician order entry of medications) and financial incentives will subsequently be awarded based on the physician groups' performance. A public scorecard will be available in September 2004 and initial payouts are expected in June 2005.

CONCLUSION

We agree with the Committee that there are opportunities to achieve the goal of a safer and more effective health care system. We believe that all stakeholders, including payers, providers, consumers, and employers, should play a role in making health care information publicly available so that consumers can make more informed health care decisions and choices.

Health plans and insurers have led the way in:

- Measuring the performance of health care providers and health care organizations in providing safe and effective care;
- Promoting transparency and public disclosure of health system performance in meeting quality goals;
- Working with health care practitioners and other stakeholders in the health care system to improve health care quality and reduce preventable medical errors through the use of information technology and system changes; and
- Promoting the incorporation of evidence-based medicine into everyday medical practice by aligning payment incentives with quality.

We urge Congress to advance the national effort to improve health care quality by considering proven private sector initiatives, including the alignment of incentives with quality, as models for the broader health care system.

Statement of David G. Schulke, American Health Quality Association

The American Health Quality Association (AHQA) represents independent private organizations—known as Quality Improvement Organizations (QIOs)—that hold contracts with the Centers for Medicare & Medicaid Services (CMS) to improve the quality of health care for Medicare beneficiaries in all 50 states and the U.S. territories.

AHQA is pleased that the Ways and Means Subcommittee on Health is conducting a hearing to examine Federal and private sector initiatives to improve health care quality. While recent reports published by the Agency for Healthcare Research and Quality (AHRQ) and the Medicare Payment Advisory Commission (MedPAC) show that the quality of care provided to Medicare beneficiaries is improving for a number of important quality measures, it also shows a clear gap between the care beneficiaries need and what they actually receive. To close this gap, it is imperative to develop, test and implement initiatives that will accelerate the pace of quality improvement.

WHY THE QIO APPROACH WORKS

The Medicare QIO program represents the largest coordinated Federal effort dedicated to improving the quality of health care for Americans. QIOs are local organizations, employing local professionals, with a national mandate to improve systems of care. As such, QIOs are catalysts for change trusted by both beneficiaries and providers. QIOs educate beneficiaries about preventive care and encourage hospitals and doctors to adopt and build "best practices" into daily routines for treating seniors with common and serious medical conditions.

Medical professionals work voluntarily and often enthusiastically with QIOs because QIO projects reduce duplication of effort for doctors participating in multiple hospitals and health plans. These projects also reduce the burden on hospitals that participate in multiple health plans, by bringing the parties together to work on the same urgent clinical priorities, using the same measures, the same abstraction tools, the same key messages. Even the best consultants working for individual hospitals cannot have this effect—and many providers cannot afford costly consultants. In short, QIOs accelerate diffusion of evidence-based medicine to all providers—small, large, urban and rural—in all health care settings.

The QIOs are helping to close the gap in quality of care by continuing to work on the health care quality improvement aims set forth by the Institute of Medicine in its landmark 2001 report "*Crossing the Quality Chasm*,"—that care is safe, timely, effective, efficient, equitable, and patient-centered. Today, QIOs are working to:

- Improve patient safety and reduce common and dangerous errors of omission.
- Ensure that appropriate care is delivered in a timely manner.
- Ensure care is provided in accordance with professional standards of care.
- Ensure preventive care is delivered to avoid unnecessary costs to the health care system.
- Eliminate health care disparities among minority populations.

- Help consumers use available quality information to make health care decisions and resolve beneficiary complaints about the clinical quality of care they receive.

NURSING HOMES

As part of the CMS National Nursing Home Quality Initiative (NHQI), QIOs have been assisting long-term care facilities on a national basis since 2002. The effort has involved helping consumers understand and use publicly reported quality data for making better health care choices, providing informational material and workshops for facilities, as well as offering intensive technical assistance to a smaller group of nursing homes in each state—with a specific focus on nursing home quality measures (addressing pain, pressure sores, delirium, and others) approved by the National Quality Forum.

Historically, most nursing homes have focused on compliance with regulations and quality assurance. But the impetus of public reporting of quality data and the availability of QIOs for technical assistance has resulted in more and more nursing homes developing a quality improvement approach to improving resident outcomes and quality of life. Across the country, nursing homes are voluntarily connecting with QIOs that are training nursing home managers to implement quality improvement systems in a culture where front line staff not only participate in quality improvement projects, but also are empowered to continually identify and solve problems.

While the initiative has been in place for just a year and a half, nursing homes and their QIO partners already boast unprecedented nationwide improvement on selected quality measures (see nursing home success stories at www.ahqa.org). In January, CMS reported that since the NHQI began in 2002:

- Approximately 2,500 nursing homes are actively pursuing quality improvement efforts with the help of their state QIO, and nearly all (99.5%) of the nation's 17,000 nursing homes have been contacted by their local QIO to participate in quality improvement efforts.
- Residents with chronic pain dropped by more than 30% (from 10.7% to 7.3%) and improvement has been achieved in every state.
- Residents who were physically restrained declined by 15% (from 9.7% to 8.2%) nationally and improvement has been achieved in 92% of states.
- Short stay residents who experienced pain decreased nationally by 11% in one year (from 25.4% to 22.6%).

In fact, every QIO is surpassing its required targets for quality improvement in the nursing home setting as measured by the publicly reported quality indicators. But performance on some measures has not improved as rapidly as others. So QIOs are working with nursing homes—and continuing to engage other stakeholders such as state survey agencies, long-term care ombudsmen, and hospital discharge planners—on new and innovative ways to drive performance and build on early successes.

HOME HEALTH

QIOs also are playing a pivotal role in a Federal initiative to help home health agencies improve the quality of their care and assist beneficiaries in understanding how publicly reported quality data can be used to select a home health agency provider. QIOs are training agency caregivers to evaluate their own performance using standardized Medicare quality measures; select treatment processes for improvement; create and implement step-by-step plans to improve care; and integrate continuous quality improvement into ongoing staff training.

QIOs are training home health agencies in an evidence-based process—called Outcomes-Based Quality Improvement (OBQI). OBQI involves collection, analysis, and feedback of data on quality of care and patient progress that is of practical value to clinicians. The data documents how well agencies are helping patients improve grooming, bathing, dressing, meal preparation, and other activities. OBQI provides home health agencies with methods for interpreting patient data, targeting care processes for improvement, restructuring care, and monitoring how change in care impacts patient recovery and quality of life.

The Delmarva Foundation, the QIO for Maryland and the District of Columbia, trained all QIOs in the OBQI method prior to the launch of the initiative, and those QIOs in turn trained the home health agencies in their states that volunteered to participate. As of this week, 5,275 agencies, or three-quarters (76%) of all Medicare-certified Home Health Agencies, have been trained by QIOs. Nearly two-thirds (63%) of all Medicare-certified HHAs have submitted quality improvement plans of action based on their OBQI training and self-assessment, and more than half (55%)

of all HHAs have signed up to share quality improvement information with other agencies via the website OBQI.org, where they can also receive refresher trainings from QIOs. These Home Health Agencies continue to demonstrate a persistent dedication to working with QIOs on improving their residents' clinical outcomes and quality of life (see home health success stories at http://www.ahqa.org/pub/media/159_766_4627.CFM).

HOSPITALS AND PHYSICIAN OFFICES

QIOs work with hospitals and physician offices to improve clinical care for heart attack, congestive heart failure, pneumonia and post-surgical infections in the inpatient setting, as well as diabetes, breast cancer and influenza and pneumonia in the outpatient setting. QIOs work in these settings to assess the use of accepted best practices, analyze systems for providing care and assist with implementation of quality improvement interventions. As outlined in a January 15, 2003 JAMA article by Jencks, et al, the QIOs, working with the medical community, reduced the overall gap in quality by about 13% between 1998–2001. For example, for the median state, prescription of the correct antibiotic for pneumonia patients went from 79% (a quality gap of 21%) in 1998–1999 to 85% (a quality gap of 15%) in 2000–2001. This 6-point absolute improvement represents a 32% closing of the quality gap, expressed in the study as "relative improvement." Areas showing strong gains nationally in relative improvement also included administration of aspirin for heart attack with 24 hours (15% relative improvement), beta-blockers at discharge for heart attack patients (28% relative improvement), avoidance of nifedipine for acute stroke patients (77% relative improvement), annual hemoglobin test for diabetes (29% relative improvement), and bi-annual lipid test for diabetes (38% relative improvement). QIOs are refining their methods in areas where improvement was less significant. (Please see hospital success stories at http://www.ahqa.org/pub/media/159_766_4627.CFM.)

REDUCING DISPARITIES/IMPROVING RURAL CARE

As part of their contracts with CMS, each QIO conducts a quality improvement project in their state to improve care for rural beneficiaries or address racial and ethnic disparities in care between minority populations and the general Medicare populations.

QIOs have partnered with local coalitions addressing disparities, particularly faith-based organizations, to reach out to African Americans, Hispanics, and other minority beneficiaries to assist them in getting evidence-based health care. In addition, QIOs work with health care providers and practitioners on ways to recognize and eliminate racial and ethnic disparities that may exist in their treatment of patients. The establishment of systematic, reliable methods of routinely delivering evidence-based care to every patient can eliminate much of the under treatment that otherwise afflicts vulnerable populations.

About 20 QIOs are currently working with critical access hospitals, health centers, and clinics to improve care delivered to rural beneficiaries. However, the demand for QIO assistance in rural areas far exceeds available funding. AHQA supports statements by MedPAC and others recommending that the HHS Secretary increase and dedicate funding for QIO work in rural areas, so the rural population can receive more attention without undermining work that focuses on high-volume providers in order to achieve the greatest benefit for Medicare beneficiaries.

CASE-BASED QUALITY IMPROVEMENT

Case-based quality improvement helps QIOs improve patient safety, protect beneficiaries and identify opportunities to improve systemic quality of care. Investigating beneficiary complaints, ensuring proper coding, adjudicating certain beneficiary appeals and reviewing EMTALA cases are all examples of how QIOs protect both beneficiaries and taxpayers by ensuring that quality care is delivered appropriately, and that the Medicare trust fund does not pay for unnecessary care.

PUBLIC REPORTING

Public reporting of health care quality data can help many consumers make more informed health care choices. Equally important is the effect of public reporting on providers—making apparent clinical areas where the quality of their care can be improved, and motivating them to seek out assistance to do so. While participation in QIO quality improvement activities is voluntary, the volume of providers seeking assistance has been tremendous, and appears to have been increased by public reporting.

Beginning in 2002, CMS launched new national quality initiatives in nursing homes, home health agencies and hospitals. Consumers can turn to their local QIOs in those initiatives for help in understanding the publicly reported quality measures

and how they can be used to make better health care decisions. QIOs are also assisting hospitals, nursing homes and home health agencies to ensure the accuracy of the information they collect.

Public reporting of hospital quality data depends on capturing large amounts of comparable data, requiring a set of uniform quality measures and a data collection tool that permits easy reporting of a standard set of quality data. The QIO program funded the creation of a sophisticated set of evidence-based clinical quality process measures, now widely used in both public and private sectors, which provides an ongoing assessment of the quality of fee for service health care under Medicare. In addition, all QIOs have been offering technical assistance to hospitals to facilitate their use of a free, CMS-developed data collection tool, and to help providers submit quality data to a centralized data warehouse.

PAY FOR PERFORMANCE

The concept of payment-for-performance holds real potential for spurring improvement and should be examined carefully. CMS should continue to test ways to provide differential payments to providers and practitioners that provide high quality care. QIOs are available to assist hospitals in the Premier Hospital Quality Incentive Demonstration with data submission and quality improvement. CMS is also using QIOs through the Doctors Office Quality—Information Technology project (DOQ–IT) to implement the care management performance demonstration required by the Medicare Modernization Act. In this capacity, QIOs will work with physicians to implement technology to improve care for chronically ill beneficiaries, provide technical assistance with quality improvement interventions and care process redesign, and measure provider performance on quality measures that could lead to increased payment.

Some QIOs are also working with private sector innovators to examine options for differential payment. One key challenge of such programs is that no payer, public or private, should offer additional payments for performance that has not been verified by an independent organization such as a QIO. The Virginia Health Quality Center (VHQC), which serves as the Medicare QIO for the Commonwealth of Virginia, is participating in a private pay-for-performance initiative sponsored by Anthem Blue Cross and Blue Shield of Virginia (Anthem). VHQC is facilitating the initiative as a Patient Safety Organization, designated under Virginia state law. The QIO receives quality and safety measures submitted by hospitals, and validates them against confidential medical records, so that Anthem can be assured of paying only for verified quality improvement. The Anthem–VHQC partnership is a model for national payment incentives program that we urge Congress to emulate in the context of the Medicare program.

PATIENT SAFETY

The IOM's 1999 report *To Err is Human* publicized previous research finding as many 98,000 deaths annually are attributable to health care errors in the inpatient setting alone. Clinical quality improvement efforts by QIOs are reducing errors of commission and errors of omission in a wide variety of settings. MedPAC notes in their March 2004 report to Congress that Medicare QIO program measures show improvement in the areas of timeliness and effectiveness of care, two key dimensions of quality identified by the IOM in its work on patient safety and quality.

The current work of the QIOs to reduce the frequency of surgical site infections will soon be expanded in the Surgical Complication Improvement Project (SCIP), a vital initiative to improve patient safety while reducing costs. States are also increasingly turning to QIOs in their patient safety efforts, and some QIOs are serving as Patient Safety Organizations, in addition to their work for Medicare to improve health care quality.

HEALTH CARE INFORMATION TECHNOLOGY

More than a decade ago the IOM presciently recommended that electronic health records become the standard for patient care. The widespread adoption of electronic health records and other technologies holds great potential for transforming the health care system by accelerating the pace of quality improvement, reducing and preventing errors, increasing efficiency, and promoting development of systems of patient-centered care.

While the potential for health information technology to improve quality is great, a number of challenges remain. Barriers to the automation of clinical information include the lack of national standards for interoperability, privacy, security, and confidentiality of information, and little to no means to finance investments in new technology, particularly for rural providers. However, many experts agree that the most challenging barrier to the widespread adoption of electronic health records and other IT tools is managerial in nature, demanding redesigned clinical processes and

workflow in office practices and hospitals. QIOs are building the expertise required to effectively educate and assist practitioners and providers in adopting information technology in clinical practice.

NEW OPPORTUNITIES FOR QUALITY IMPROVEMENT

The MMA has created major new opportunities for quality improvement, expanding the work of the QIOs to Medicare Advantage plans under Part C and outpatient prescription drugs under Part D. QIOs will offer quality improvement assistance to providers, practitioners, MA plans and prescription drug plans with regard to medication therapy. The QIOs are in a unique position to integrate inpatient and outpatient claims and medical record data with prescription drug data to provide a more complete view of patient care. This will be a powerful tool for efforts to support the safe and effective use of prescription drugs in the health care of Medicare beneficiaries.

CONCLUSION

AHQA supports full consideration by Congress and the administration of innovations to accelerate the pace of quality improvement. We believe it will take a coordinated effort on the part of government and the private sector to close the significant quality gaps that exist in American health care. There are clear indications that the QIO program is helping private plans and providers employ standardized quality measures, report them publicly, and work together to eliminate those gaps. Without QIO assistance, the pace of progress would slow down, as every plan and provider would be obliged to rediscover proven techniques already implemented by others.

In the year 2002, Medicare spent just $6.33 per beneficiary to fund the quality improvement activities of the QIOs. While these funds are being put to effective use, the resources are extremely low in relation to the scope and size of the problem. The QIO program is an investment in a coordinated national effort to improve health care. AHQA urges Congress and the administration to ensure that the investment is adequate to meet the goals the program is striving to achieve.

Statement of American Hospital Association

Hospitals: Committed to Quality Improvement and Patient Safety

On behalf of our nearly 5,000 member hospitals, health systems, networks and other providers of care, the American Hospital Association (AHA) is pleased to share its views on the future of health care quality improvement. Hospital care is the single largest component of health care in the United States. In the year 2001 alone, hospitals cared for 612 million outpatients, treated 109 million in emergencies, performed 27 million surgeries and delivered more than 4 million babies. Caring for millions of ill and injured patients is an extraordinary responsibility, and it is a responsibility that hospitals take very seriously. Hospitals believe that every patient who enters their doors deserves the guarantee of safe, high-quality care. As such, quality and patient safety are the cornerstones of every hospital's mission, and caregivers continually strive to improve safety and outcomes.

Despite hospitals' efforts to ensure safe, high quality care, mistakes do occur, and there is both overuse and under use of some diagnostic and treatment procedures, as described in the Institute of Medicine's (IOM) landmark 1999 report, "To Err is Human: Building a Safer Health System," and its second report, "Crossing the Quality Chasm." Though the exact consequences of missteps in care are sometimes unknown, any preventable harm to patients is unacceptable and underscores the need for a comprehensive, unified approach to quality improvement.

The Quality Initiative: A Unified Approach to Quality Reporting

Since the IOM released its 1999 report on errors in America's health care system, public demand for more and better information about hospitals' safety and performance has been overwhelming. In recent years, there has been a proliferation of quality measurement activities: Organizations such as the Joint Commission on Accreditation of Healthcare Organizations (JCAHO), states, hospitals, researchers, insurers and other payers, the business community, consumer organizations, commercial enterprises that compile and sell "report cards," and the media all offer the public different concepts of quality and relevant data.

According to a 2000 Rand Health report, "Dying to Know: Public Release of Information about Quality of Health Care," the California Office of Statewide Health Planning and Development in 1994 identified more than 40 report cards using a total of 118 different measures of quality, and the number of organizations trying to collect and use quality data has grown exponentially since then. Not only does

the information differ from rating system to rating system, it is collected using different methodologies, and the validity and reliability of the data are highly variable. Providers are confused by the disparate ratings and rankings, and the potential for confusing the public with conflicting and sometimes misleading information is even greater.

On December 12, 2002, leaders of the AHA, Association of American Medical Colleges (AAMC) and Federation of American Hospitals (FAH) announced hospitals' effort to create a more unified approach to collecting and sharing hospital performance data with the public. The initiative was developed with the full support of Federal agencies, consumer and employer organizations and accrediting bodies alike, including the Department of Health and Human Services (HHS) and its Centers for Medicare & Medicaid Services (CMS) and Agency for Healthcare Research and Quality (AHRQ), the Joint Commission on Accreditation of Healthcare Organizations (JCAHO), the National Quality Forum (NQF), the AARP and the AFL–CIO.

The national, hospital-led initiative aims to:

- Provide the public with meaningful, relevant and easily understood information about hospital quality;
- Bolster hospital and physician efforts to improve care; and
- Standardize data collection priorities and streamline duplicative and burdensome hospital reporting requirements.

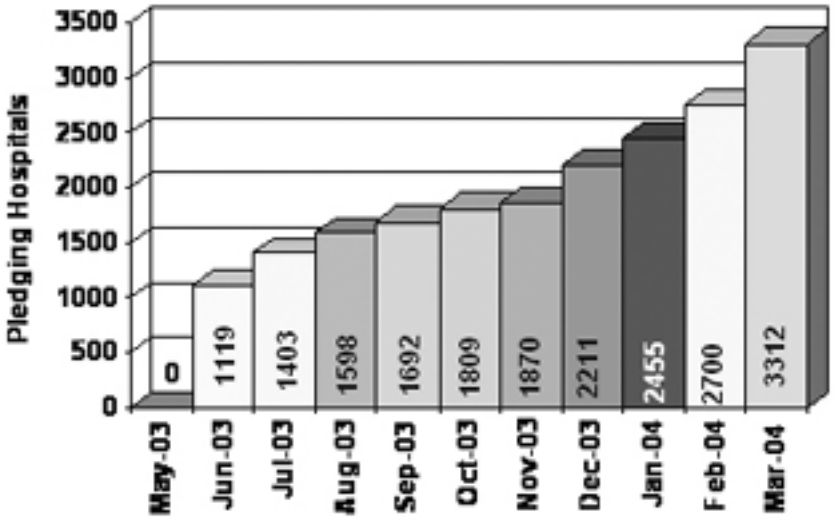
This landmark public-private partnership marks an important first step in developing predictable, useful and understandable quality information about hospital patient care and outcomes. The initiative begins by asking hospitals to voluntarily report performance data on 10 measures of care for three conditions:

Heart Attack	• Aspirin at arrival
	• Aspirin at discharge
	• Beta blocker at arrival
	• Beta blocker at discharge
	• ACE inhibitor for left ventricular systolic dysfunction (LVSD)
Heart Failure	• Left ventricular function assessment
	• ACE inhibitor for LVSD
Pneumonia	• Initial antibiotic timing (within four hours)
	• Pneumococcal vaccination
	• Oxygenation assessment

These measures were carefully selected based on their scientific validity and near universal acceptance. JCAHO and CMS use these measures, and the National Quality Forum endorsed them as part of their core set for hospitals.

Hospitals swiftly embraced The Quality Initiative, seizing the opportunity to demonstrate their commitment to openness and accountability. More than 500 hospitals agreed to take part in the initiative within the first month, and that number had more than tripled to 1,700 within less than six months. Today, more than 3,300 of the nation's approximately 4,200 acute care hospitals have pledged to take part in the effort. Though the Medicare Modernization Act—which requires hospitals paid under the inpatient prospective payment system to report these measures in order to receive a full Medicare inpatient market basket update—provides an added incentive for hospitals to take part in the initiative, hospital participation was increasing steadily before its enactment.

Hospital Participation in The Quality Initiative



Since October of 2003, hospitals' performance on the initiative's 10 measures has been displayed on a public CMS Web site, www.cms.hhs.gov/quality/hospital. Though intended primarily as a "test site," valuable primarily for researchers and clinicians, the launch of the site marked the first step toward creating a comprehensive, user-friendly consumer site. By February, more than 1,400 hospitals had allowed their data to be shared, and that number is expected to jump to 2,000 hospitals when the site is updated in May. Our partners in the Quality Initiative have been impressed by hospitals' willingness to step forward and share this data.

From the beginning, we've noted that the 10 measures of care with which we began were just a starting point. Creating a truly meaningful resource on hospital quality, one that will arm consumers with information they need to make the most appropriate decisions about their care, and clinicians with a tool for continued quality improvement, requires data on a broad range of hospital services. As promised, partners in the initiative recently agreed on 12 new measures of care, including new measures of the steps taken to prevent surgical infections, which hospitals will be asked to share starting early next year. The Hospital CAHPS survey developed by CMS and AHRQ, which will allow a comparison across hospitals of patients' perceptions of the care they received, also will become a key component of the Quality Initiative next year following further testing of the survey tool and its administration instructions. In addition, we are eager to begin to develop measures for hospitals for which the current measures do not apply, including small, rural hospitals, children's hospitals and psychiatric hospitals.

Moving Forward: Challenges in Sharing Quality Information with the Public

1. Making Information Useful

Despite the wealth of information available to the public on hospital quality, research suggests that few are using the information to make decisions about their care. A survey of nearly 500 patients who had undergone coronary artery bypass graft (CABG) surgery at one of the four hospitals rated in Pennsylvania's *Consumer Guide*, found that only 12 percent were aware of a report card on cardiac surgery mortality before undergoing surgery, and fewer than 1 percent knew the correct rating of their surgeon or provider and reported that it had a moderate to major impact on their selection. A 2000 Kaiser Family Foundation/AHRQ survey of 2,000 adults similarly found that only 4 percent had used information comparing the quality of hospitals to make a decision about their care. While 63 percent of respondents said their family and friends would have "a lot" of influence on their choice of a hospital,

few said the same of same of newspapers and magazines (12%) or government agencies (15%). In fact, 62 percent said they would choose a hospital that their family and friends had used for many years without problems over a hospital that is rated higher.

Though it is still important to share hospital performance information with the public, these findings suggest that clinical measures will be of more value to clinicians than to consumers. ***Therefore, clinical measures chosen for public reporting must be actionable, credible, science-based measures that will help clinicians assess and improve the quality of care they are providing.***

2. Measuring the Right Elements

Measures must be selected carefully to ensure they paint an accurate picture of hospital quality. For instance, some organizations, like the Leapfrog Group, have sought to use volume as a proxy for quality; yet, a study published in a recent issue of *Journal of the American Medical Association* concludes that volume is an unreliable indicator of a provider's quality of care. The authors of the study analyzed outcomes for very low birth-weight infants at more than 300 hospitals with neonatal intensive care units and found that the annual number of very low birthweight babies admitted to a hospital is not an accurate predictor of the hospital's outcomes. Data collected by the Veterans Administration as part of the National Surgical Quality Improvement Project have also shown that volume is not a reliable proxy for quality for surgical patients. Moreover, hospital volume is not an "actionable" item that caregivers can change to improve care.

We also must ensure that the measures used are true indicators of the care provided—and not of other factors. For instance, mortality rates, if not properly adjusted for the health status of the patients, say more about the severity of patients' conditions than they do about the quality of care provided, and can have harmful unintended consequences. The 1996 study by Eric Schneider, M.D. and Arnold Epstein, M.D., "Influence of Cardiac-Surgery Performance Reports on Referral Practices and Access to Care—A Survey of Cardiovascular Specialists," suggests that using mortality rates as a performance indicator deters physicians from operating on risky or especially ill patients. The physicians surveyed in the study overwhelmingly indicated that risk adjustment was inadequate.

3. Adapting to Advances in Care

Though providers and consumers share the goal of standardizing care so that patients receive the recommended care regardless of the setting, mandating or regulating the use of clinical standards may impede caregivers' ability to respond to advances in science. ***Standards of care change over time, and caregivers need the flexibility to adapt to those changes.***

For instance, hormone replacement therapy (HRT) was, for decades, the standard treatment for alleviating menopausal symptoms. In recent years, HRT even was thought to reduce the risk of cardiovascular disease and to help prevent memory loss and Alzheimer's disease. In July of 2002, however, researchers from the National Institute of Health's Women's Health Initiative announced that they were pulling the plug on a study of HRT, three years before its scheduled completion, after having discovered a link between the therapy and an increased risk for heart disease, breast cancer and stroke. The researchers concluded that the long-term risks of the therapy could outweigh its benefits. If providers were being measured on how often they put women on hormone replacement therapy, the measure would no longer be a good indicator of whether clinicians were treating patients in accordance with medical science.

Even when a standard of care is proven safe and effective, there may be equally acceptable alternatives, as evidenced by a recent study led by researchers at Brigham and Women's Hospital, Duke University and the University of Glasgow. Though ACE inhibitors have been a standard of care since 1992, when they were shown to reduce one-year mortality rates in heart attack patients by 19 percent, the researchers found that a new medication, the angiotensin-receptor blocker valsartan, is just as clinically effective as an ACE inhibitor in improving outcomes for heart attack patients. While it is important to promote the use of clinical standards so that patients receive the best possible care regardless of the provider, this discovery demonstrates that clinicians often have several options to consider when caring for patients.

The Road Ahead: The Role of the Federal Government in Fostering Quality Improvement

We applaud Congress for recognizing the important role it can play in fostering continued health care quality improvement. The federal government is the largest single purchaser of health care in the United States, and as such, can be a powerful agent in spurring progress. As we move forward with a national, unified quality improvement agenda, continued collaboration between the public and private sectors will be critical. However, it is sometimes difficult for Federal agencies to fully partner as part of a collaborative effort. Therefore, Congress might want to consider analyzing whether or not CMS should have expanded authority to work collaboratively with other organizations. Also critical is continued support for the quality improvement activities of AHRQ. Their research is essential to creating the evidence-based clinical measures and the information technology standards that will ensure patients receive the safest, most appropriate care—no matter where they live or which hospital they choose. Finally, because hospitals experience many competing resource demands, it is difficult for many hospitals to find the capital to invest in some of the new information technologies that will help to improve quality and patient safety. Congress also may want to consider grants and other funding mechanisms to promote the faster adoption of IT.

Again, hospitals thank you for taking an active interest in promoting their patients' quality of care. Our shared commitment to quality improvement will ensure that Americans enjoy the promise of safer, more effective care in the years to come.

Statement of Alliance for Quality Nursing Home Care, and American Health Care Association

The American Health Care Association (AHCA) and the Alliance for Quality Nursing Home Care appreciate the opportunity to provide the House Ways and Means Subcommittee on Health with perspective on the progress we are making in regard to improving the quality of long term care we provide to more than 1.5 million elderly and disabled Americans annually.

We thank Chairman Johnson for calling this important hearing, and for providing stakeholders a valuable opportunity to discuss our ongoing commitment to quality long term care services. It is especially essential that we foster an environment in which the federal government and the profession can continue to work successfully together.

The process of health care delivery is dynamic and achieving progressively higher levels of care quality and customer satisfaction is an ongoing effort—as is the progressive effort to measure, assess, evaluate and report quality care itself.

The long term care profession is demonstrating its dedication to quality and performance excellence by joining together to create Quality First, the first-ever, nationwide, publicly articulated pledge to voluntarily establish and meet quality improvement targets. Through this initiative and other programs, we as a profession have partnered with the federal government and consumer advocates, among other stakeholders, to work in tandem to ensure the delivery of quality care in our nation's nursing homes, assisted living residences and homes for persons with mental retardation and developmental disabilities. The broad collaboration has fostered successful practices of the delivery and measurement of quality in long term care, which is focused on those we serve each day—the patients, residents and their families in long term care facilities nationwide.

Quality improvement is an internal process that is complex. Survey compliance rates are one of several measures that are used to assess the provision of quality in long term. Additional measures that benchmark the delivery of quality include Centers for Medicare and Medicaid Services' (CMS) quality measures, resident, family and staff satisfaction, employee retention, and financial stability. Quality First provides the tools to more accurately measure quality based on the full spectrum of care and outcomes, rather than isolated incidents.

Today's emphasis on evaluating and reporting results benefits patients, policymakers, caregivers and consumers alike. Just as competition spurs choice, productivity and product innovation in the economic marketplace, the increasing competition that stems from public disclosure of quality information is producing similar benefits in the health care marketplace.

The many innovations and improvements in healthcare quality measurement we've seen in just the past two decades have been extraordinary, and we fully expect and hope that more reliable systems to measure quality will emerge. We are excited about the pace of change in long term, and we look forward to working col-

laboratively with all stakeholders to determine, on an ongoing basis, which measures best predict quality, and how we can use those measures to keep improving patient care.

In evaluating the initiatives and progress the entire health care provider community is making on the quality front, Mr. Chairman, it is notable and significant that America's long term care profession came to the forefront first. As home health care and hospitals are just now becoming involved in government quality improvement initiatives, we maintain the positive involvement and results experienced by long term care providers and patients have served as a useful, positive and instructive guide for the entire health care system.

In prefacing our comments and evaluation of government and profession-wide quality initiatives, we cannot stress enough the important linkage between the financial stability of the long term care sector and the extent to which care quality improvements have moved forward and will continue moving forward.

Our responsibility to maintain and sustain quality improvements is straightforward and obvious; it is also obvious and necessary that the federal government must to do its part to help bring about a more stable and viable financing environment for Medicare and Medicaid.

In this context, it is noteworthy that the Medicare Payment Advisory Committee's (MedPAC) March 2004 report to Congress specifically noted that:

"Many efforts are currently underway to improve quality in Skilled Nursing facilities (SNF's) and nursing homes, but these efforts are grafted onto a payment system that is largely neutral or even negative with respect to quality."

As the first panel of today's hearing will discuss government quality initiatives, we will outline our participation in the Nursing Home Quality Initiative (NHQI). For the second panel, we will discuss the progress of the long term care profession's successful and innovative Quality First initiative.

The NHQI: More Accountability, Increased Disclosure, More Competition

The NHQI, like our profession's Quality First initiative, has helped place us on the course necessary to ensure care quality improves and evolves in a manner that best serves patient needs.

Its focus on resident centered care, care outcomes, increased public disclosure, better collaboration and increased accountability and dissemination of best practices models of care delivery is making a positive, measurable difference in the lives of our patients.

Implemented nationally in 2002, the long term care profession endorsed CMS' NHQI from its inception, and the profession has been intimately involved with the initiative's implementation. NHQI, in conjunction with the long term care profession, is working successfully to:

- Improve regulation and enforcement efforts to assure nursing homes' compliance with rules regarding patient health, safety and quality of care;
- Improve consumers' access to nursing home quality information via internet and other public media;
- Encourage nursing homes to seek help from the Medicare quality improvement organizations (QIOs) to improve performance; and
- Encourage more communication among Federal and state agencies, QIOs, independent health quality organizations, consumer advocates and nursing home providers regarding ways to improve nursing home quality.

According to the CMS, the NHQI efforts have resulted in approximately 2,500 nursing homes nationwide pursuing quality improvements with assistance from their QIOs, nearly all nursing homes contacting their QIOs about the NHQI, and more than 60 percent of nursing homes attending QIO-sponsored workshops.

CMS has found notable improvements since the inception of NHQI, including, among others, "decreasing reports of pain among long and short stay patients and decreasing use of physical restraints."

CMS has also taken recent steps to improve its quality measures and is now using an updated set of measures endorsed by the National Quality Forum (NQF)—the non-profit consensus-building organization.

CMS, stakeholders, members of congress, researchers and consumers recognize the value of quality assessment and improvement methods and their effectiveness in measuring, promoting and rewarding quality outcomes in nursing facilities.

The increasing complexity of the long term care environment in recent years and the growing demands and expectations on the regulatory process offer both an opportunity and a need to creatively incorporate methods into the equation of providing and regulating long term care.

Patient, family and staff satisfaction should, officially, we believe, be a key measurement of quality. We recommend that Congress allow CMS to use measures in addition to the survey process to assess patient outcomes and their satisfaction. CMS will then have the requisite legal latitude and authority to develop better measures of quality of care in skilled nursing facilities so the process can begin to design appropriate payment incentives.

Quality First: A Proactive, Profession-Wide Partnership to Advance Quality Care

The long term care profession is also taking the lead in the area of improving care quality, public trust and customer satisfaction, and we are doing this on a voluntary basis. In July of 2002, AHCA, the Alliance for Quality Nursing Home Care and American Association of Homes and Services for the Aging (AAHSA) joined together to establish Quality First—a proactive, profession-wide partnership to advance the quality of care and services for seniors and persons with disabilities.

We are proud of the fact long term care providers are leading the way in taking steps to improve quality through increasing accountability and disclosure—a voluntary initiative no other health care provider group has taken.

Our Quality First Covenant, as it is known, is based upon seven principles that cultivate and nourish an environment of continuous quality improvement, openness and leadership.

These principles include: Continuous quality assurance and quality improvement, public disclosure and accountability, patient/resident and family rights, workforce excellence, public input and community involvement, ethical practices, and financial stewardship.

Quality First supports and builds upon CMS's Nursing Home Quality Initiative—and is based on the concept that reliably measuring nursing home quality and making the results available to the public is in the best interest of consumer and caregiver alike.

Within Quality First there are six expected outcomes for assessing quality, and, by 2006, we are working to achieve the following benchmarks:

- Continued improvement in compliance with Federal regulations;
- Demonstrable progress in promoting financial integrity and preventing occurrences of fraud;
- Demonstrable progress in the quality of clinical outcomes and prevention of confirmed abuse and neglect;
- Measurable improvements in all CMS Quality Improvement measures;
- High rates on consumer satisfaction surveys that will indicate improved consumer satisfaction with services; and,
- Demonstrable improvement in employee retention and turnover rates.

Since Quality First was announced, a growing number of providers nationwide have joined this effort as we move forward toward the goal of establishing an independent National Commission—overseen by the National Quality Forum—to objectively advise and monitor performance and the need for improvement.

The National Commission will be a private sector, non-partisan panel composed of nationally respected health care and quality improvement experts, consumer representatives, former government officials, and business leaders.

As part of its work, the Commission will independently evaluate the current state of long term care performance, identify key factors influencing the ability of providers to achieve meaningful quality improvement, and make recommendations on national initiatives that will lead to sustainable quality improvement.

Mr. Chairman, we look forward to sharing and elaborating upon the findings and opinions of the Commission as they are announced. It is our assumption and expectation there will be contentious issues raised by the Commission from time to time, but, consistent with the intent of Quality First, we believe all long term care stakeholders are best served by maintaining an open, collaborative dialogue in a manner that best lends itself to problem-solving and, ultimately, improved patient care across the board.

We would like to thank the Committee again for providing us the opportunity to share our views about how we can continue to work together to improve the quality of long term care for our nation's frail, elderly and disabled—and do so in a manner that helps us best measure both progress as well as shortcomings.

AHCA and the Alliance are enormously pleased there has never been a broader recognition of the importance of quality, nor a broader commitment to ensure quality improvements are sustained.

We are committed to continuing to achieve demonstrable, measurable quality improvements on every front so our nation is prepared to provide quality care for sen-

iors today, and for the 77 million baby boomers who will inevitably require quality long term care services in the decades ahead.

Statement of Sandra C. Canally, Compliance Team, Inc., Ambler, Pennsylvania

Chairman Johnson and distinguished Committee Members:

Thank you for your thoughtful consideration in creating this opportunity for those of us who could not attend your March 18th hearing. I believe that your recommendations regarding the future course of healthcare quality initiatives is a most serious matter that will have a far reaching impact on our national interests. Thus, I am compelled to respond to your call for contributions to the discussion by informing the Committee of my company's efforts to change the status quo in the critically important realm of healthcare accreditation.

During my formative years in healthcare some forty years ago, I came to believe that all patients deserve exemplary care no matter what their social status happened to be at the time care is delivered. Years later when I began my professional career as a Nurse Oncologist and National Cancer Institute Instructor, my heroes were those providers who put the interests of their patients first above all else.

Ten years ago I formed The Compliance Team, Incorporated for the purpose of exploring new approaches to healthcare quality evaluation. As a matter of professional survival, I became expert in government mandates dealing with healthcare delivery regulations as well as the myriad requirements of private healthcare accreditation plans put forward by such entities as the NCQA, JCAHO, URAC and others.

During The Compliance Team's first years in business, we conducted National Committee on Quality Assurance-driven credentialing inspections of more than 4,000 physician practices, and nearly 40,000 medical record reviews for various managed care interests based in the middle Atlantic states. In addition, I personally took on a managed care assignment to develop their Medicaid patient quality protocols.

Since I was intimately familiar with the JCAHO accreditation process as the result of my experiences with a national orthopedic rehabilitation equipment company some years before, a substantial part of the Compliance Team's business in the early years was devoted to healthcare accreditation consulting for home health durable medical equipment companies going through JCAHO accreditation.

Long before the Medicare Modernization Act mandated that home health and durable medical equipment providers go through an accreditation process in order to participate in Medicare programs, I decided that the arcane world of accreditation had become far too complex and much too costly (when consulting fees et al were factored in) for the average small business that represents your typical home medical equipment operation.

A close reading of the Institute of Medicine's much heralded Report to Congress "To Err is Human" lends credence to the assertion that overly complex accreditation requirements may be a root cause of many medical staff errors. In 1999, the CMS Report to Congress on the quest by the JCAHO for deemed status to review Skilled Nursing Facilities was even more direct. The CMS Report concluded that because JCAHO's process of accreditation was needlessly complex and confusing, "patients would be placed at serious risk" if it were granted deemed status. Indeed, my earlier findings had been validated. What had started out in 1953 as a sensible effort to standardize surgical theater procedures had morphed into a confusing milieu of minutia filled directives that tended to distract healthcare providers rather than lead them towards better patient care.

Beginning in 1996, a full two-years before the aforementioned Reports to Congress came to the public's attention, I set out to develop a new type of accreditation process through which healthcare organizations could validate their quality claims while putting the best interests of their patients above those of the accrediting body.

In fall 1998, the Compliance Team's Exemplary Provider™ Award programs were launched. Each Award (so far there are 12 in all) is a service and/or product-line specific measured continuous quality improvement program that is driven by a dramatically simplified set of Quality Standards and Evidence of Compliance.

March 1999 marked a milestone for private accreditation competition. The Compliance Team received its first formal recognition as a Home Health DME accrediting body by North Carolina Blue Cross/Blue Shield. Shortly thereafter, Medicare's National Supplier Clearinghouse recommended our programs to providers seeking

to avoid fraud and abuse sanctions. (To this day, we remain the only accrediting body to incorporate Corporate Compliance measures into our programs.)

March 16th, 2004 marked another hallmark in the Compliance Team's quest for national recognition. I was invited to join JCAHO, ACHC (Accreditation Commission for Healthcare) and CHAP (Community Health Accreditation Plan) at the Accreditation Summit which convened in Las Vegas, Nevada at the Medtrade Spring medical equipment exposition. It was the first time that the durable medical equipment industry sponsored such an event. Approximately 150 providers had an opportunity to hear the four DME accrediting bodies give comparative details about our programs.

The key point I would like to make about the Summit is most germane to the deliberations of your Subcommittee. With the coming of mandatory accreditation, ad hoc private healthcare quality initiatives such as the Compliance Team's Exemplary Provider Award programs represent a clear departure from the status quo. The failures of accreditation plans in the past have contributed to a growing cynicism among healthcare providers. Many believe that our government today doesn't really care that patients have become America's most "at risk" consumers.

In the few short years that the Compliance Team's programs have become known to our old school competitors (our quality standards can be obtained FREE of charge), they each in turn have adopted many of the features that we first introduced in 1998; a clear sign that we are winning converts in the marketplace of ideas.

Although we take some comfort in knowing that our peers at JCAHO, ACHC and CHAP grasp the merits of our ideas, their market dominance constantly reminds us of the perils we face. (Since we are in essence social entrepreneurs, we chose to give away our intellectual property as an altruistic gesture in the hope that we will win even greater public and industry support in the future).

Although we are a small fledgling enterprise that lacks the deep pockets of our competitors, we have deep beliefs; a belief that every patient deserves exemplary care; the belief that healthcare delivery excellence does not have to be costly or difficult; and the belief that all providers should excel in the three areas that matter most to patients—Safety, Honesty and Caring™.

Madam Chairman and distinguished Committee Members, the following pages contain an outline of our paradigm shifting programs. More details and instructions on how to obtain a PDF copy of our quality standards can be found on our web site—www.exemplaryprovider.com.

In closing, I make reference to the Committee's March 11th Advisory regarding one of the principle focuses of the March 18th hearing. The Compliance Team's programs represent a challenge to the status quo that brings real competition and comparative information to the accreditation marketplace which leads me to ask for the Committee's support in recommending that the Exemplary Provider Award programs be included among the accreditation plans approved by the Department of Health and Human Services and CMS when mandatory accreditation is fully implemented. Thank you again for this opportunity to address the Committee.

Statement of Eric D. Peterson, Duke University, Division of Cardiology, and CRUSADE, Durham, North Carolina

Chairman Johnson and Members of the Subcommittee, I appreciate the opportunity to submit written testimony for the March 18, 2004 hearing "New Frontiers in Quality Initiatives." I applaud your efforts and those of your colleagues to improve the quality of health care in America. The Hospital Quality Initiative provisions you included in the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) are critical first steps toward achieving measurable improvements in patient outcomes. I am pleased that as a focus of this hearing you are considering quality initiatives that are ongoing in the private sector that have a direct relationship to what you would like to accomplish in the Medicare program.

As a practicing cardiologist, as a researcher, and as an active participant and contributor in the health quality community, I am involved in a number of activities to improve outcomes in heart care. These private-sector efforts involve hundreds of hospitals and hundreds of thousands of patients. These programs are achieving considerable success in improving hospital practices across the country. The indicators Medicare is encouraging hospitals to report (which will become the basis rewarding performance) are focused on the acute myocardial infarction (AMI), coronary artery bypass graft (CABG), and heart failure populations—those who are having the most serious conditions—a full-blown heart attack or surgical intervention. The private

sector quality initiatives cover a broader spectrum of heart patients and a wider range of treatments.

Today, I would like to tell you about one of these programs that is improving outcomes for a group of patients that is different from the population that is the focus of Medicare's Hospital Quality Initiative. My purpose in doing so is to make two points: First, it is important that the CMS Hospital Quality Initiative build on and coordinate with existing private-sector efforts on which hospitals are already expending considerable resources. Working together, we can all be much more effective. Second, we would like to work with CMS in broadening its indicator program over time. There is a danger in focusing hospital attention on the things we can most easily measure and causing them to shortchange Medicare populations that may be at greater risk and could benefit more from optimal treatment.

The program I want to discuss is called CRUSADE—"**C**an **R**apid risk stratification of **U**nstable angina patients **S**uppress **AD**verse outcomes with **E**arly Implementation of the American College of Cardiology/American Heart Association (ACC/AHA) treatment guidelines."

Acute coronary syndromes (ACS) include acute ST-segment elevation myocardial infarction (MI), non-ST-segment elevation MI (NSTEMI), and unstable angina and are a major cause of morbidity and mortality worldwide. CRUSADE is a national quality improvement initiative designed to improve the care of high-risk patients with unstable angina and non-ST-segment elevation acute coronary syndromes (NSTE ACS)—the patients are what you might call the "early heart attack" patients. There are approximately 1.4 million patients presenting at the hospitals every year with these serious heart conditions—so it is a larger population than the 600,000 a year AMI population, with a higher mortality than the AMI population. Nevertheless, it is a population that is currently not tracked and monitored by federal government quality indicator and quality measurement programs.

CRUSADE aims to improve patient outcomes for the NSTEMI ACS population by collecting data regarding practice patterns in the U.S. and using those data to target educational interventions designed to improve adherence to the ACC/AHA practice guidelines.

CRUSADE is a unique collaboration between many academic institutions from around the country and private industry. The program is run and owned by the Duke Clinical Research Institute, with an executive committee that is comprised of leading cardiologists and emergency physicians from around the country. It has private sector funding, including grants from several pharmaceutical and biotechnology companies.

Since the CRUSADE program began in 2001, more than 90,000 retrospectively collected data collection forms have been submitted from over 430 hospitals across the country. The data that CRUSADE has compiled has been astonishing. For example, recent CRUSADE analyses show that:

- Adherence to ACC/AHA Guidelines varies markedly among U.S. hospitals. Hospitals with the highest adherence rates (top quartile of centers using evidence-based treatments) have 40% lower mortality rates than those hospitals with the lowest adherence rates (bottom quartile). Thus, better care truly translates to better patient outcomes. (Peterson ED, Roe MT, Lytle BL, Newby LK, Fraulo ES, Gibler WB, Ohman EM. The association between care and outcomes in patients with acute coronary syndrome: national results from CRUSADE. *J Am Coll Cardiol* 2004;43(5):406A)
- We also found that hospitals whose care improves over time as part of participating in the CRUSADE initiative see significant reductions in in-hospital mortality at their centers. In contrast, those who did not improve care patterns did not experience any change in patient outcomes. This provides further evidence that quality improvement efforts translate into meaningful benefits for patients. (Peterson—personal communication)
- One hospital that participates in the CRUSADE program found that after modifying treatment protocols to more closely adhere to the ACC/AHA guidelines, FY 2000 to FY 2002, in-hospital mortality of ACS patients dropped from 4.8% to 1.9%, and length of stay dropped from 5.9 days to 4.6 days. The average cost per case dropped form $11,777 to $10,623, an average savings of $1,154 per ACS patient. (Jackson S, Sistrunk H, Staman. Improved patient care and reduced costs: results of Baptist Health Systems' acute coronary syndromes project. *J Cardio Management* 2003;14:17–20)
- Despite having higher-risk characteristics at presentation and greater in-hospital risk, women with NSTE ACS are consistently treated less aggressively than men. (Blomkalns AL, Newby LK, Chen A, Peterson ED, Trynosky K, Diercks D, Boden WE, Roe MT, Ohman EM, Gibler WB, Hochman JS. Sex dis-

parities in the treatment of non-ST-segment elevation acute coronary syndromes. *J Am Coll Cardiol* 2004;43(5):304A)

- African American patients with NSTE ACS are significantly less likely than whites to receive medical and invasive therapy. (Sonel AF, Good CB, Mulgand J, Roe MT, Gibler WB, Smith SC Jr, Cohen MG, Zalenski R, Pollack CV Jr, Ohman EM, Peterson ED. Racial variations in treatment and outcomes of African-American and white patients with non-ST-elevation acute coronary syndromes: insights from CRUSADE. *J Am Coll Cardiol* 2004;43(5):414A)
- Medicaid patients younger than 65 admitted with NSTE ACS are less likely to receive evidence-based therapies and interventions and have significantly higher in-hospital mortality rates than those with other forms of insurance. (Calvin JE, Roe MT, Chen A, Brogan GX Jr, DeLong ER, Gibler WB, Ohman EM, Fintel D, Smith SC Jr, Peterson ED. Higher mortality and less evidence-based therapies among Medicaid-insured patients with high-risk acute coronary syndromes (ACS): results from CRUSADE. *J Am Coll Cardiol* 2004;43(5):413A)

CRUSADE has shown us that there is a large population of ACS patients being under-treated today, compared to the care recommended by evidence-based clinical practice guidelines published by the American College of Cardiology and the American Heart Association, and this is largely a Medicare population. CRUSADE has also shown us that there are prominent gender, race, and socioeconomic disparities in the quality of care provided to patients with ACS and that adherence to evidence-based clinical process indicators are strongly associated with reduced mortality in this population, as in the ACS population.

At this point, Medicare is not measuring the quality of care provided to the ACS population and the Medicare Quality Improvement Organizations (QIOs) are not deployed to help hospitals improve the quality of care they provide to this patient population. I believe that the Centers for Medicare and Medicaid Services, the Agency for Healthcare Research and Quality, and other government agencies and programs could help address this population. I would offer three recommendations to address this problem:

- CMS should evaluate the ACS indicators being used in the CRUSADE study for inclusion in its heart disease (AMI) quality indicator set, even if only for use in the Quality Improvement Organization program (not necessarily for public reporting).
- CMS should fund a QIO to conduct either a national or a significant pilot breakthrough collaborative with some or all of the 400+ CRUSADE hospitals.
- QIOs should have the ability to distribute information that does not directly pertain to the Medicare's hospital quality indicators.

In summary, government programs currently do not track the ACS population, and the CRUSADE program is generating valuable data and making a difference at hospitals around the country. I urge you and your committee to further explore private-sector quality initiatives such as CRUSADE and look to find ways for such programs to collaborate with government quality programs. I believe we have an ethical professional duty to address this problem if we can.

I would be happy to answer any questions or work with you and your colleagues on this very important issue. Thank you again for the opportunity to provide this testimony.

Medical Technology and Practice Patterns Institute, Inc.
Bethesda, Maryland 20814
March 30, 2004

Congresswoman Nancy L. Johnson
Chairman
Subcommittee on Health of the Committee on Ways and Means
U.S. House of Representatives
Washington, D.C.

Dear Congresswoman Johnson:

I am writing to suggest that implementation of MMA include a provision that relevant physiological information be included in future Medicare claims for prescription drugs. Such a requirement will enhancing the informational content of the health care system and its treatment outcomes of Medicare beneficiaries.

As an example of the usefulness of such information, we are studying—hematocrit values contained in Medicare administrative databases for purposes of epoetin billing—to enhance understanding of therapy, outcomes, and cost-effectiveness associated with an expensive drug. Unlike controlled clinical trials, our observational analysis of administrative data must grapple with the confounding effects of unobserved events. If done well, analysis of such information can provide important insight into the 'real-world' risks and benefits of new interventions.

Our work was recently presented at The American Society of Nephrology's (ASN), 36th Annual Meeting & Scientific Exposition conference November 2003, San Diego. The poster (attached) contained a review of our current research on epoetin alfa dosing levels and patient survival. This information has also been submitted to the Centers for Medicare & Medicaid Services in response to their request (attached) for 'scientific evidence related to EPO (Epoetin) dosing and hematocrit/hemoglobin levels that will assist us in the development of a clinically and scientifically robust policy that will ensure appropriate administration of EPO in ESRD patients.'

Sincerely,

Dennis J. Cotter
President

Centers for Medicare and Medicaid Services
Office of Clinical Standards and Quality
Baltimore, Maryland 21244
September 22, 2003

To Those Interested in Medicare Coverage of Erythropoietin:

Medicare coverage for erythropoietin (EPO) is consistent with the Kidney Dialysis Outcome Quality Initiative (K–DOQI) guidelines and the Food and Drug Administration (FDA) approved indications. K–DOQI recommends management of anemia within a target hematocrit range of 33 to 36 percent. FDA has approved EPO to treat patients with anemia when it is used to raise the blood hematocrit to a target range of 30 to 36 percent (or the blood hemoglobin to a range of 10 to 12 grams per deciliter). Neither entity recommends the use of EPO for raising hematocrit levels above 36 percent.

Medicare pays over a billion dollars annually for EPO administered to end stage renal disease (ESRD) patients, with aggregate payments for the drug doubling between 1998 (550 million) and 2001 (1.1 billion). The law provides a payment formula of $10 per 1000 units of EPO administered to ESRD patients. There is concern that this payment formula may result in some patients receiving more EPO than is required to maintain their hematocrit level within the target range. If so, Medicare spending on EPO may be higher than necessary without resulting in optimal patient benefit.

In an effort to reduce potential EPO over-utilization, CMS issued a policy in 1997 instructing Medicare contractors to monitor the hematocrit levels of ESRD patients. This policy provided for pre-payment review of EPO claims and denial of claims when the 90-day average hematocrit level exceeded 36.5 percent. Through discussions with clinicians and industry representatives, we learned that normal fluctuations in hematocrit levels make it extremely difficult to maintain patients at the upper end of the target range without exceeding the upper boundary of the range.

Over the past three years, CMS has issued temporary instructions to implement a revised policy that allows more flexibility at the upper boundary of the hematocrit range. The current instructions prohibit Medicare contractors from performing pre-payment review of EPO claims. Contractors are instead instructed to perform post-payment review using a 90-day average hematocrit level of 37.5 percent to trigger further medical review. It has come to our attention that this policy may be difficult to implement because of the administrative burden of continually averaging hematocrit levels. CMS has also been asked to provide more precise definitions for several critical terms in the existing Program Memorandum AB–02–100. In addition, we have been asked to revise the point at which facilities may initiate EPO therapy.

For these reasons, CMS will undertake a thorough review of our current policy on EPO utilization in ESRD. We have established a schedule for this re-evaluation (see table below). In the meantime, we have reissued the temporary policy in Program Memorandum AB–03–138. We invite interested parties to send us scientific evidence related to EPO dosing and hematocrit/hemoglobin levels that will assist us

in the development of a clinically and scientifically robust policy that will ensure appropriate administration of EPO in ESRD patients.

Time Period	Activity
Letter Issuance Date—November 30, 2003	The public is invited to submit scientific evidence related to EPO dosing and hematocrit/hemoglobin levels. Parties submitting data are invited to also schedule meetings to present data and provide verbal explanations of their analysis if they so desire.
December 1, 2003–February 1, 2004	CMS staff will analyze data submitted. We may supplement the submittals with data from the USRDS or CMS data sources such as national claims history files, performance measurements, REBUS, etc.
March 1, 2004	CMS will circulate a draft policy for comment.
May 1, 2004	CMS will issue a final revised policy or a memorandum announcing the decision regarding national monitoring of EPO for ESRD patients.

We encourage all interested experts and stakeholders to participate in this public process by submitting scientific evidence related to EPO dosing, hematocrit levels and ESRD patient outcomes. Interested parties can submit information to Steve Phurrough, MD, MPA, Director, Coverage and Analysis Group, Centers for Medicare and Medicaid Services, Mail Stop C1–09–06, 7500 Security Boulevard, Baltimore, Maryland 21244–1850. If you have questions or wish to schedule an appointment to discuss your submittal, please contact Jackie Sheridan-Moore at 410–786–4635 or by email at jsheridan@cms.hhs.gov.

Sincerely,

Sean R. Tunis
Chief Medical Officer

Statement of Eve Becker-Doyle, National Athletic Trainers' Association, Dallas, Texas

As executive director of the 30,000-member National Athletic Trainers' Association (NATA),[1] I am sharing the NATA's thoughts on improving quality of care in America's health care systems, with a specific emphasis on therapy services. The NATA maintains that a *wide range* of health care professionals are well qualified to provide outpatient therapy services. The Social Security Act currently recognizes only physical therapists and PT assistants, occupational therapists and OT assistants, and speech and language pathologists as qualified to provide outpatient therapy services—but athletic trainers are equally as qualified, educated and capable of providing quality outpatient therapy services.[2] We believe all allied health care professionals qualified to provide outpatient therapy services should be permitted to provide and receive reimbursement for therapy services.

Because of its rapid growth, both in terms of aggregate dollars and as a share of the U.S. budget, the Medicare program has been a major focus of deficit reduction legislation considered by Congress in recent years.[3] At the same time, concerns about quality of care are also at the top of the agenda. Balancing cost reductions with improving quality of care is a daunting task. Although the perfect balance is difficult, if not impossible, to obtain, measures can be taken to improve this balance. One such measure to achieve improved quality of care is to offer financial incentives to health care providers. While this may be effective in achieving higher quality of care, it does not address, and even has a negative impact on, the rising cost of

[1] See *Exhibit A* for required supplemental statement supplying NATA's contact information.
[2] Social Security Act, Title XVIII, Section 1861(p); 42 USC s. 1359x(p).
[3] U.S. House of Representatives, Ways and Means Committee, *2004 Green Book*, D–2 (Feb. 11, 2004).

health care with which the government, private insurers, and all Americans struggle.

Competition promotes both cost-containment and achieves high quality of care for Americans. Restricting reimbursement for health care services to a small, incomplete list of qualified providers is unreasonable, arbitrary and anti-competitive. It improperly provides those groups exclusive rights to Medicare reimbursement. Moreover, it unreasonably restrains trade and prevents patients from receiving the highest quality of care available in a truly competitive market. While regulating health care providers is an essential aspect of ensuring quality of care, excluding those health care providers who are amply qualified tends to have the reverse effect on the quality of care provided.

The provision of therapy services is an excellent example of the impact competition could have on a segment of the health care market. As mentioned above, Medicare currently only reimburses physical therapists and PT assistants, occupational therapists and OT assistants, and speech and language pathologists for the provision of outpatient therapy services. Having no competition for employment or referrals provides little incentive for professionals to strive to provide above-average quality health care services that still adhere to Medicare rehabilitation rules. If, however, athletic trainers were integrated into the Medicare reimbursement system for outpatient therapy services, all health care professionals would have to strive to provide a superior quality of care in order to remain competitive in the health care market.

Certified athletic trainers (ATCs) are fully qualified to provide outpatient therapy services.[4] ATCs have national academic and certification standards. ATCs are highly skilled allied medical professionals who specialize in the prevention, assessment, treatment and rehabilitation of injuries and illnesses that occur to both the physically active and athletes. All ATCs have a bachelor's degree, and more than 70 percent have a master's degree. Medically-related continuing education is required to maintain certification.

ATCs work in a wide array of settings, including physicians' offices, clinics, hospitals, corporate health programs, secondary schools, colleges and universities, and professional athletics. Practicing ATCs satisfy stringent educational and experiential requirements, and are required to pass a day-long, three-part competency examination administered by the NATA Board of Certification (NATABOC). The NATABOC is reviewed and re-accredited every five years by the National Commission for Certifying Agencies.

Furthermore, most ATCs practice under the direction of licensed physicians. The Commission on Accreditation of Allied Health Education Programs (CAAHEP), which certifies programs representing 21 allied health education professions, accredits programs for athletic training based on input and approval of the American Academy of Family Physicians, the American Academy of Pediatrics, the American Orthopedic Society for Sports Medicine, and the NATA. CAAHEP provides that "the athletic trainer, with the consultation and supervision of attending and/or consulting physicians, is an integral part of the health care system associated with physical activity and sports."

To facilitate competition in the health care market, and therefore enhance the overall quality of care provided, *all* health care professionals must be permitted to provide and receive reimbursement for the provision of health care services for which they are qualified. The NATA requests that you will consider the following in your analysis of the health care industry's quality of care initiatives:

- The U.S. is experiencing an increasing shortage of credentialed allied and other health care professionals, particularly in rural and outlying areas. If patients are not permitted to utilize a variety of qualified health care professionals, it is likely the patient will suffer delays in health care, greater cost and a lack of local and immediate treatment.
- Patients who would be referred outside of the physician's office would incur delays of access. In the case of rural Medicare patients, this could not only involve delays but, as mentioned above, cost the patient in time and travel expense. Most importantly, delays would hinder the patient's recovery and/or increase recovery time, which would ultimately *add to the medical expenditures* of Medicare. In the worst cases, lack of immediate therapy could result in nursing home admittance and long-term care.
- Curtailing to whom the physician can delegate outpatient therapy services will result in physicians performing more of these routine treatments themselves.

[4] See *Exhibit B*.

Increasing the workload of physicians diminishes the physician's ability to provide the best possible patient care in the least amount of time.

Thank you for the opportunity to submit our comments. We look forward to hearing the Subcommittee on Health's conclusions regarding quality of care initiatives, a tremendously vital issue to all Americans.

EXHIBIT B

The FACTS About Certified Athletic Trainers and The National Athletic Trainers' Association

This document corrects misinformation frequently cited about Certified Athletic Trainers (ATCs). It is provided to state and Federal legislators and regulators, compliance specialists, third-party payers, physician office and group practice managers, hospital and clinic administrators, school boards and district administrators, post-secondary health care educators and others interested in the facts about the athletic training profession in the 21st century. Readers should note that the treatment of an adolescent or adult person does not change simply because the injury or treatment location changes. Whether the person is on a soccer field or manufacturing floor, the treatment protocols and methods for injuries and illnesses remain the same.

1. FACT: All athletic trainers have a bachelor's degree from an accredited college or university. Athletic trainers are equivalent mid-level professionals to other therapists, including physical, occupational, speech, language and similar specialties.

ALL certified or licensed athletic trainers **must have a bachelor's degree** from an accredited college or university. Degrees are in accredited athletic training programs and include established academic curricula. Prior to obtaining a bachelor's degree in athletic training, athletic trainers gained bachelor's degrees in pre-medical sciences, kinesiology, exercise physiology, biology, exercise science and physical education. Academic programs are approved and certified by the Commission on Accreditation of Allied Health Education Programs (CAAHP) and the Joint Review Commission of Athletic Training.

2. FACT: This is the Athletic Training Program content for a bachelor's degree, which has been in place since the 1980s.

- Risk Management and Injury Prevention
- Pathology of Injury and Illness
- Assessment and Evaluation
- Acute Care of Injury and Illness
- Pharmacology
- Therapeutic Modalities
- Therapeutic Exercise
- General Medical Conditions and Disabilities
- Nutritional Aspects of Injury and Illness
- Psychosocial Intervention and Referral
- Health Care Administration
- Professional Development and Responsibilities (*added in mid-1990s*)
- *Note that these academic subjects are not setting- or practitioner-specialized. Nor is course content specific to athletes.*

3. FACT: 70% of athletic trainers have a master's or doctorate degree.

ATCs are highly educated. Seventy (70) percent of certified athletic trainers (ATCs) hold a master's degree or higher. This is equal in education to physical therapists, occupational therapists, registered nurses, speech therapists and many other mid-level health care practitioners. The ATC's educational and clinical skills greatly exceed those of paraprofessionals like physical therapy assistants or medical aids/assistants.

4. FACT: Athletic trainers know and practice the medical arts at the highest professional standards.

Athletic trainers meet the qualifications and standards of any group—including Medicare and Medicaid—necessary to render skilled services and gain reimbursement for services rendered. A four-year undergraduate and/or two-year graduate academic major in the field are qualifications needed to render skilled services. Ath-

letic trainers specialize in injury and illness prevention, assessment, treatment and rehabilitation for all physically active people, including the general public.

5. FACT: An independent board nationally certifies athletic trainers.

The independent Board of Certification Inc. (BOC) nationally certifies athletic trainers. Athletic trainers must pass a three-part written and practical examination and hold a bachelor's degree to become an Athletic Trainer, Certified (ATC). To retain certification, ATCs must obtain 80 hours of medically related continuing education credits every three years and adhere to a code of ethics. The BOC is accredited by the National Commission for Certifying Agencies.

6. FACT: ATCs are recognized by the American Medical Association as allied health care professionals.

ATCs are highly skilled, multi-skilled allied health care professionals, and have been part of the *American Medical Association's Health Professions Career and Education Directory for more than a decade. Additionally*, American Academy of Family Physicians, the American Academy of Pediatrics and the American Orthopaedic Society for Sports Medicine are all strong clinical and academic supporters of certified athletic trainers.

7. FACT: 40 percent of NATA's certified athletic trainer members work outside of school athletic settings, and provide services to physically active people of all ages, including athletes.

ATCs work in physician offices as physician extenders. They also work in rural and urban hospitals, hospital emergency rooms, urgent and ambulatory care centers, military hospitals, physical therapy clinics, high schools, colleges/universities, commercial employers, professional sports teams and performance arts companies. ATCs are multi-skilled health care workers who, like others in the medical community with science-based degrees, are in great demand because of the continued and increasing shortage of registered nurses and other health care workers. The skills of ATCs have been sought and valued by sports medicine specialists and other physicians for more than 50 years. As the U.S. begins its fight against the obesity epidemic, it is important that people have access to health care professionals who can support lifelong physical activity for all ages.

8. FACT: Athletic trainers have designated CPT/UB codes.

The American Medical Association (AMA) granted Current Procedural Terminology (CPT) codes for athletic training evaluation and re-evaluation (97005, 97006) in 2000. The codes were effective in 2002. In addition, the American Hospital Association established Uniform Billing (UB) codes for athletic training in 1999, effective 2000.

9. FACT: CPT and UB codes are not provider specific.

The AMA states that the term "provider," as found in the Physical Medicine section of the CPT code, is a general term used to define the individual performing the service described by the code. According to the AMA, the term therapist is not intended to denote any specific practice or specialty field. Physical therapists and/or any other type of therapist are not the exclusive provider of physical therapy examinations, evaluations and interventions.

10. FACT: ATCs improve patient outcomes.

Results from a nationwide Medical Outcomes Survey conducted 1996–1998 demonstrate that care provided by ATCs effects a significant change in all outcomes variables measured, with the greatest change in functional outcomes and physical outcomes. The investigation indicates that care provided by ATCs generates a change in health-related quality of life patient outcomes. (ref: Albohm MJ, Wilkerson GB. An outcomes assessment of care provided by certified athletic trainers. J Rehabil Outcomes Meas. 1999; 3(3):51–56.)

11. FACT: ATCs provide the same or better outcomes in clinical settings as other providers, including physical therapists.

Results of a comparative analysis of care provided by certified athletic trainers and physical therapists in a clinical setting indicated that ATCs provide the same levels of outcomes, value and patient satisfaction as physical therapists in a clinical setting. (ref: *Reimbursement of Athletic Training* by Albohm, MJ; Campbel, Konin, pp. 25)

12. FACT: ATCs demonstrate high patient satisfaction ratings.

Patient satisfaction ratings are more than 96 percent when treatment is provided by ATCs.

13. FACT: ATCs frequently work in rural, frontier and medically underserved areas and with physically active people of all ages.

ATCs are accustomed to working in urgent care environments that have challenging, sometimes-adverse work and environmental conditions. The athletic training tradition and hands-on clinical and academic education combine to create a health care professional that is flexible and inventive—ideal managers of patient care and health care delivery.

14. FACT: ATCs specialize in patient education to prevent injuries and reduce rehabilitative and other health care costs.

Recent studies, reports, outcomes measures surveys, total joint replacement studies and many other case studies demonstrate how the services of ATCs save money for the employers and improve quality of life for the patient. For each $1 invested in preventive care, employers gained up to a $7 return on investment, according to one NATA survey. The use of certified athletic trainers supports a market-driven health care economy that increases competition in order to reduce patient and disease costs. The patient's standard of care is not sacrificed by using ATCs. Instead, care is enhanced because of the ATCs' broad medical knowledge and capabilities.

15. FACT: Regulated and licensed health care workers.

While practice act oversight varies by state, the athletic training professional practices under state statute recognizing them as a health care professional similar to physicians, physician assistants, nurse practitioners, registered nurses, physical therapists, occupational therapists and similar mid-level professionals practice. Athletic training licensure/regulation exists in 43 states, with aggressive efforts underway to pursue licensure in the remaining states. Athletic trainers work under the direction of physicians.

16. FACT: The National Athletic Trainers' Association represents 30,000 members.

The National Athletic Trainers' Association (NATA), founded in 1950, represents more than 30,000 members of the international profession. Of the total membership, 24,000 are ATCs, which represents more than 90 percent of ATCs practicing in the United States.

Statement of Pharmaceutical Care Management Association

I. INTRODUCTION

PCMA is the national association representing America's pharmaceutical benefit managers (PBMs). PCMA represents both independent, stand-alone PBMs and health plans' PBM subsidiaries. Together, PCMA member companies administer prescription drug plans that provide access to safe, effective, and affordable prescription drugs for more than 200 million Americans in private and public health care programs. PCMA appreciates the opportunity to submit testimony to the House Ways and Means Health Subcommittee regarding "New Frontiers on Quality Initiatives." We applaud Chairwoman Johnson for her leadership on this important issue.

PCMA believes that PBMs' quality initiatives have demonstrated real value for consumers resulting in better health and lower costs through therapeutic compliance and disease management programs. We now anticipate the same benefits for the Medicare population with the recent enactment of the Medicare Modernization Act. By availing itself of the very best that the private sector has to offer beneficiaries, the MMA has expanded choices and benefits for seniors in a way that maximizes private sector competition.

II. OVERVIEW OF PBMs

PBMs are the cornerstone for any system seeking to manage a prescription drug benefit. Prescription drugs must be an integrated component to health delivery because of the value which they offer consumers. This is particularly true for those living with chronic conditions who, through prescription drugs, can now manage life-threatening illnesses.

Today, PBMs' clients are major purchasers of health care. They include employers, unions, Federal and state governments, and health plans which rely on us to manage their drug benefits. Our ability to drive down prescription drug costs while

increasing patient safety through disease and therapeutic management services is well documented—18–47% according to the General Accounting Office.[1]

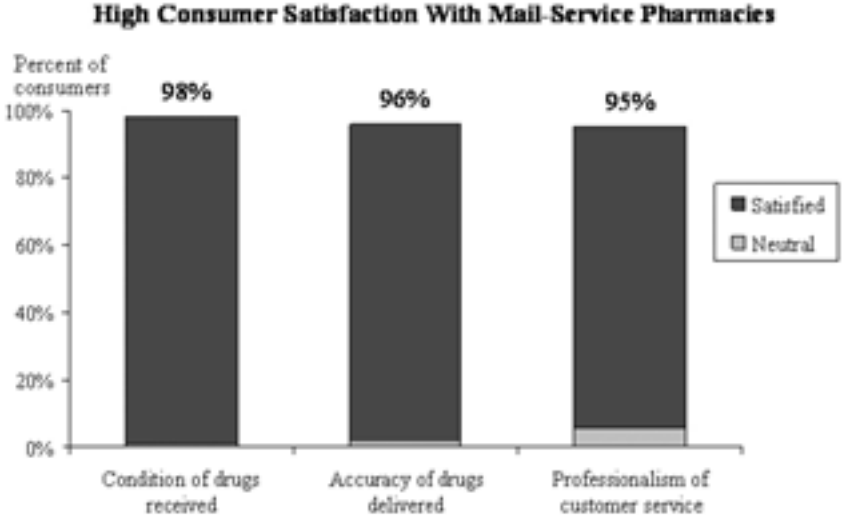
PBMs have evolved over the years to not only administer drug benefits, but to offer home delivery pharmacy services, provide real-time electronic claims adjudication, negotiate deep discounts from prescription drug manufacturers and pharmacies, and now even offer clinically-based services. These include drug utilization review; disease management techniques; consumer, pharmacy and physician education services; and compliance programs that not only reduce costs but add tremendous quality to drug management.

The PBM marketplace today is highly competitive, with PBMs existing in a number of forms which offer public and private purchasers a wide variety of choices to meet the needs of their plan members. A PBM may offer multiple variations of models from the more basic plan to the most comprehensive plan relying on multi-tiered co-payments, formularies developed with physicians and pharmacists, pharmacy networks, home-delivery pharmacy, and other similar tools that make drugs more affordable and accessible.

Home Delivery Service. Home delivery or mail-service pharmacy allows for even more convenient access to even deeper discounts through an automated system (as much as 53% for generic medications according to GAO).[2] PBM-owned home delivery pharmacies predominantly fill prescriptions for maintenance medications for individuals managing complex or chronic illnesses. Consumers save money through reduced co-payments and the highly efficient method for managing prescriptions and refills through the automated system.

Although automated, mail-service pharmacies provide services to on-staff pharmacists available to counsel consumers and consult with physicians on appropriate drug therapies. Counseling is done primarily through a toll-free telephone and most mail-service pharmacies have counseling by pharmacists available 24 hours a day/seven days a week. The process offers convenience to consumers, particularly seniors and the disabled, who may have transportation or other constraints that make going to a retail pharmacy difficult. The mail-service pharmacy option is also particularly helpful in serving residents of rural areas who would otherwise have to travel long distances to the nearest retail pharmacy. In addition, some consumers may prefer telephone consultation in order to afford them more privacy than consultations available in public at retail pharmacies would.

According to a survey of nearly 14,000 mail-service pharmacy users, customer satisfaction was as high as 98%.



[1] "Federal Employees Health Benefits: Effects of Using Pharmacy Benefit Managers on Health Plans, Enrollees, & Pharmacies," GAO, January 2003.

[2] Ibid.

Rebates and Discounts. Individual PBMs use a variety of strategies to provide their clients with value. For instance, some PBMs focus on securing retailer discounts, some focus on pharmaceutical manufacturer discounts for volume purchases, and others on obtaining discounts for key generic drugs. As a result of the confidential nature of their contracts and the diversity of their discounting strategies, PBMs are not certain of the competition's position which motivates PBMs to continually improve its products, services, and contracts out of fear that a competitor may have improved its services and deepened its discounts.

PBMs currently require drug manufacturers to bid confidentially for preferred drug status through a blind bidding process which has tremendous pro-competitive implications. Risk adverse manufacturers raise rebates in order to prevent being underbid and losing market share. These motivating factors generate higher rebates which translate into lower consumer prices. In addition, blind bidding prevents collusive pricing among manufacturers—or price fixing. Implementation of the MMA must recognize this or risk higher drug prices and less competition.

While public disclosure of drug prices for consumer shopping is important, it is imperative that this not include confidential contracting information on rebates and discounts which would eviscerate competition. This includes the protection from public disclosure of financial arrangements between PBMs and prescription drug manufacturers or labelers, as well as other information that may be broad enough to require PBMs to publicly disclosure their negotiated prices with manufacturers and their negotiated reimbursement rates with individual retail pharmacies. We recognize that the federal government is a sophisticated market player and that it has the authority to appropriately monitor our contracts and prices to prevent any type of "bait and switch." Clients must keep this information confidential, as well, to prevent broader disclosure of highly significant, competitive information that will inevitably lead to loss of control over the data. Without assurances of confidentiality, competitors could obtain detailed pricing information and, ultimately, set prices.

III. QUALITY ACTIVITIES

Claims Data Technology. PBMs offer sophisticated data management and information systems, processing 98% of claims electronically. We adjudicate claims on a real-time basis and determine eligibility, and the amount of co-payment to collect. Real-time claims administration activities work in tandem with our ability to increase patient safety.

Patient Safety. While maintaining privacy and confidentiality, PBMs work with physicians and pharmacists to monitor what drugs enrollees are getting from the pharmacy, and provide real-time information at the point of sale to the pharmacist on potential drug-drug interactions, dosage issues, or other safety concerns before a patient receives a drug. The pharmacist may also act to resolve the issue by contacting the prescribing physician at that time.

Prescription Drug History. PBMs are often the only repository of a patient's total prescription drug history because we hold information in one centralized electronic file. This is especially important when enrollees are prescribed medications by more than one physician or when enrollees use more than one retail pharmacy to purchase their prescriptions.

Inappropriate Use and Fraud Detection. Centralizing patient drug history information also serves to help identify fraud or inappropriate prescribing practices. If a patient is using multiple physicians to get multiple prescriptions of an inappropriately used medication, PBMs are well-suited to identify that pattern.

Disease and Therapeutic Drug Management. It is well documented that chronic patients must stay in compliance with drug regimes to stay healthy. The Institute of Medicine states that 18,000 Americans die each year from heart attacks because they did not receive preventive medications.[3] Disease management programs typically target common chronic diseases such as asthma, diabetes, depression, hypertension, heart failure, and certain other cardiovascular conditions in hopes of preventing hospitalization and death.

PBM disease management programs employ a team of clinicians to identify appropriate individuals for intervention, educate the participants about their disease, and provide them with self-management tools. This is particularly important since those with chronic conditions often do not refill their medications. PBMs will collaborate with the treating physician providing them with treatment guidelines developed from medical literature, patient profiles, and patient management tools. It its worth noting that all treatment and prescribing decisions rest with the treating physician and PBMs offer assistance where needed. For some participants, the PBM will arrange for nurse outreach and case management intervention programs.

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[3] Chassin, 1997; Institute of Medicine, 2003.

Therapeutic Compliance. Through the above-referenced disease management programs, PBMs can increase patient compliance by coordinating and monitoring patient care with specific drug therapies. Clinical outcomes are then tracked and additional information may be given to participants to help them continue to manage their condition. These strategies have been proven effective—in fact, according to a recent study in the Archives of Internal Medicine, therapeutic drug management served to increase the rate of achieving therapeutic goals for patients from 74 to 89 percent.[4]

Electronic Prescribing. Adverse drug events have been cited as a contributing factor to the rising incidence of medical errors in the health care system. However, electronic prescribing by physicians holds the promise of decreasing drug related medical errors through the application of enhanced technology. PBMs are health care leaders in electronic prescribing. We use technology to improve the prescribing process for both physicians and their patients. Advantages of e-prescribing include reduced dispensing errors due to illegible handwriting, real-time physician access to benefits, eligibility and formulary information, notification to pharmacists of possible adverse drug interactions, and the availability of medication history information for use by physicians and pharmacists in their care decisions. Sending prescriptions electronically saves significant time for the patient in filling their medication and enhances efficiency in the prescribing process by reducing administrative burdens.

E-prescribing, once implemented for use in Medicare, will be a significant tool in reducing costs to the program through increased use of the most clinically effective and least costly medications, including greater use of generics. Congress included an important first step toward e-prescribing in the new MMA. With the appropriate efforts dedicated to standards development, this can truly prove a pivotal policy to reduce medical errors, increase administrative efficiency and save costs for the program.

IV. CONCLUSION

PBMs bring tremendous value, in addition to cost containment, to the delivery of prescription drugs through our leadership in the use of advanced technology and information systems. The MMA is a historic opportunity to expand that value to the Medicare population through PBMs. PCMA believes that our participation in Medicare will only serve to improve and strengthen the program in the years ahead.

Statement of Richard A. Norling, Premier, Inc.

I would like to thank the Chairwoman and distinguished Members of the House Ways and Means Subcommittee on Health for taking the time to hold a hearing (March 18, 2004) on an issue so critical to the health of our communities as quality of care improvement. As an alliance of leading not-for-profit hospitals and health systems across the country, Premier *exists* to facilitate hospitals' delivery of the highest quality healthcare services.

In July 2003, Premier and the Centers for Medicare and Medicaid Services (CMS) launched the *Hospital Quality Incentive Demonstration Project*, a three-year program designed to demonstrate that economic incentives are, indeed, effective at improving the quality of inpatient care. In the course of this joint demonstration, CMS will measure and pay incentives, in the form of enhanced Medicare payments, for high-quality inpatient care delivery among hospitals participating in Premier's *Perspective*™ quality measurement system. To be sure, the incentives achievable by these hospitals are based *entirely* on clinical performance.

Significantly, Premier is providing data collection and analysis services in support of a new and innovative Medicare demonstration project that is testing the impact of incentive payments on quality of care improvement. A total of 278 participating hospitals began submitting data in October 2003. For each of the next three years, the top-performing hospitals in each of five clinical areas (acute myocardial infarction (AMI); coronary artery bypass graft (CABG); heart failure; community-acquired pneumonia; and hip and knee replacement) will receive additional payments from the Medicare program. (In order to participate in the project, however, hospitals must be able to submit quality data corresponding to *all* five clinical areas.)

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[4] Brian J. Isetts, PhD, BCPS; Lawrence M. Brown, PharmD; Stephen W. Schondelmeyer, PharmD, PhD; Lois A. Lenarz, MD. "Quality Assessment of a Collaborative Approach for Decreasing Drug-Related Morbidity and Achieving Therapeutic Goals." *Arch. Of Intern Med.* 2003;163;1813–1820.

As Dr. Carolyn Clancy, director of HHS' Agency for Healthcare Research and Quality (AHRQ), noted in her testimony before the Subcommittee, demo-participating hospitals that perform in the top 10 percent (decile) for a given diagnosis or clinical area—CABG, for instance—will see a two-percent increase (i.e., bonus payment) in their Medicare base rate for the measured condition. Hospitals performing in the second decile will be paid a one-percent bonus. Scores will be calculated at least semi-annually, and bonus payments will be made annually in a lump sum. In the third year, participating hospitals that fail to improve their performance in a specific clinical area beyond a *minimum threshold* established in the first year of the project will be subject to a payment reduction of one- or two percent. Thus, hospitals will be duly motivated to not only improve, but maintain the gains throughout the course of the project.

The 34 indicators utilized in the *Hospital Quality Incentive Demonstration Project* are widely accepted throughout the industry as important to quality of care. They stem from quality care research conducted by the National Quality Forum (NQF), the Joint Commission on the Accreditation of Healthcare Organizations (JCAHO), the Centers for Medicare and Medicaid Services' (CMS) 7th Scope of Work initiative, the Leapfrog Group, the Agency for Health Research and Quality (AHRQ) and others. These are both *process* indicators—measuring such things as timely administration of medication—and *outcome* indicators—measuring mortality rate and the like. Significantly, case volume is not one of the indicators.

As Premier, providers on the frontlines, and countless authorities in the quality care arena have long hypothesized, we are already seeing, through our initial data collection and analyses, indications that high quality and volume are certainly *not* mutually exclusive. A forthcoming study using the Premier *Perspective*™ database demonstrates that the incidence of adverse events, as defined by patient safety indicators developed by the Agency for Healthcare Research and Quality (AHRQ), did not, in fact, decrease as hospital volume increased. Further, no meaningful difference between low-volume and high-volume facility quality of care could be identified in the clinical area of coronary artery bypass graft (CABG) surgery. (Kathryn Leonhardt, MD, MPH; Stephen Grossbart, Ph.D.: "Metrics and Measurements in Patient Safety," scheduled for presentation at the sixth annual NPSF Patient Safety Congress, May 4, 2004.)

Medicare Payment Advisory Committee (MedPAC) Chairman Glenn Hackbarth testified in a similar vein before the Subcommittee during the March 18 hearing:

> *Simply providing more care does not necessarily lead to improving quality. The amount of care Medicare beneficiaries receive varies widely across the nation. Yet, as noted in our June 2003 report to the Congress, higher use of care does not appear to lead to higher quality care; in fact, it appears that states with the highest use tend to have lower quality than states with the lowest use. . . . Other researchers have found similar phenomena in smaller geographic areas—that is, areas with the highest service use tend to have lower, not higher quality.*

In closing, I'd like to reference an open letter published in the November/December edition of the *Health Affairs* policy journal in which several leading and veteran authorities on the quality care landscape argued that government, private payers, and other stakeholders must "support and continue efforts to provide economic incentives for high quality care." The authors concur that "payment for performance should become a top national priority, and [that] Medicare payments should lead in this effort, with an immediate priority for hospital care." In that vein, they recognize and applaud CMS for having "launched a breakthrough demonstration project . . . to pay quality-improvement incentive bonuses for Medicare patients at participating institutions." The CMS-Premier demonstration, the authors conclude, shows that we have "adequate tools to accelerate the pace of change."

As President and CEO of Premier, in which the majority of demonstration hospitals are allied, I can assure you that this project will make a significant contribution to that effort. Thank you, most sincerely, for your time and consideration.

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