

HEALTH CARE QUALITY: THE PATH FORWARD

HEARING
BEFORE THE
COMMITTEE ON FINANCE
UNITED STATES SENATE
ONE HUNDRED THIRTEENTH CONGRESS
FIRST SESSION

—————
JUNE 26, 2013
—————



Printed for the use of the Committee on Finance

—————
U.S. GOVERNMENT PRINTING OFFICE

WASHINGTON : 2013

87-577—PDF

For sale by the Superintendent of Documents, U.S. Government Printing Office
Internet: bookstore.gpo.gov Phone: toll free (866) 512-1800; DC area (202) 512-1800
Fax: (202) 512-2104 Mail: Stop IDCC, Washington, DC 20402-0001

COMMITTEE ON FINANCE

MAX BAUCUS, Montana, *Chairman*

JOHN D. ROCKEFELLER IV, West Virginia	ORRIN G. HATCH, Utah
RON WYDEN, Oregon	CHUCK GRASSLEY, Iowa
CHARLES E. SCHUMER, New York	MIKE CRAPO, Idaho
DEBBIE STABENOW, Michigan	PAT ROBERTS, Kansas
MARIA CANTWELL, Washington	MICHAEL B. ENZI, Wyoming
BILL NELSON, Florida	JOHN CORNYN, Texas
ROBERT MENENDEZ, New Jersey	JOHN THUNE, South Dakota
THOMAS R. CARPER, Delaware	RICHARD BURR, North Carolina
BENJAMIN L. CARDIN, Maryland	JOHNNY ISAKSON, Georgia
SHERROD BROWN, Ohio	ROB PORTMAN, Ohio
MICHAEL F. BENNET, Colorado	PATRICK J. TOOMEY, Pennsylvania
ROBERT P. CASEY, Jr., Pennsylvania	

AMBER COTTLE, *Staff Director*

CHRIS CAMPBELL, *Republican Staff Director*

CONTENTS

OPENING STATEMENTS

	Page
Baucus, Hon. Max, a U.S. Senator from Montana, chairman, Committee on Finance	1
Hatch, Hon. Orrin G., a U.S. Senator from Utah	2

WITNESSES

McClellan, Hon. Mark B., senior fellow, The Brookings Institution, Washington, DC	4
Cassel, Dr. Christine K., president and CEO, National Quality Forum, Washington, DC	6
Lansky, Dr. David, president and CEO, Pacific Business Group on Health, San Francisco, CA	8
McGlynn, Dr. Elizabeth A., director, Kaiser Permanente Center for Effectiveness and Safety Research, Pasadena, CA	10

ALPHABETICAL LISTING AND APPENDIX MATERIAL

Baucus, Hon. Max:	
Opening statement	1
Prepared statement	35
Cassel, Dr. Christine K.:	
Testimony	6
Prepared statement	37
Hatch, Hon. Orrin G.:	
Opening statement	2
Prepared statement	53
Lansky, Dr. David:	
Testimony	8
Prepared statement	55
McClellan, Hon. Mark B.:	
Testimony	4
Prepared statement	68
McGlynn, Dr. Elizabeth A.:	
Testimony	10
Prepared statement	85

COMMUNICATION

Wisconsin Health Information Organization (WHIO) et al.	93
--	----

HEALTH CARE QUALITY: THE PATH FORWARD

WEDNESDAY, JUNE 26, 2013

U.S. SENATE,
COMMITTEE ON FINANCE,
Washington, DC.

The hearing was convened, pursuant to notice, at 10:06 a.m., in room SD-215, Dirksen Senate Office Building, Hon. Max Baucus (chairman of the committee) presiding.

Present: Senators Wyden, Stabenow, Carper, Cardin, Casey, Hatch, Crapo, Thune, Burr, Isakson, and Toomey.

Also present: Democratic Staff: Mac Campbell, General Counsel; David Schwartz, Chief Health Counsel; Tony Clapsis, Professional Staff Member; and Karen Fisher, Professional Staff Member. Republican Staff: Kristin Welsh, Health Policy Advisor.

OPENING STATEMENT OF HON. MAX BAUCUS, A U.S. SENATOR FROM MONTANA, CHAIRMAN, COMMITTEE ON FINANCE

The CHAIRMAN. The hearing will come to order.

The American statistician who also helped pioneer quality, especially in the automobile business worldwide, W. Edwards Deming, once said, "Quality is everyone's responsibility."

In 1999, the Nation received a wake-up call about our health care system. The Institute of Medicine published a landmark report entitled, "To Err is Human." It concluded that nearly 100,000 people die each year in hospitals due to preventable errors. That is more than die from motor vehicle accidents, breast cancer, or AIDS.

High-quality care clearly needed to be more of a priority at every level: Medicare, Medicaid, insurance companies, doctors, hospitals, and for policymakers as well. Each group started focusing on quality. The largest hospital accreditation group, the Joint Commission, required hospitals to report performance data. Congress required Medicare providers to submit quality reports. Medicare created tools for beneficiaries to compare provider quality. Hospital boards incentivized their leadership to improve quality.

We saw some early wins. Between 2001 and 2009, for example, central line IV infections dropped by more than half. This quality improvement saved \$2 billion and, more importantly, 27,000 lives.

When we first started to focus on quality, we realized that we had a long way to go. We began by requiring providers to simply report their data. The Affordable Care Act moved Medicare to the next level, from 1.0 to 2.0. Instead of paying just for reporting, Medicare now pays for results.

Under new programs, Medicare will pay hospitals and physicians for providing high-quality care more than those providing low-quality care. These health reform programs will move Medicare closer to a system built around the value and not the volume of care.

Let me provide a current example. From 2007 through 2011, nearly 1 in 5 Medicare patients admitted to a hospital returned within a month. For many of them, that readmission could have been avoided. In the Affordable Care Act, we gave hospitals incentives to reduce avoidable readmissions, and hospitals responded. They made sure that patients had follow-up visits, doctors spent more time talking with patients about their discharge plans and answering questions, and we are seeing results.

I am proud to say that, from 2007 to 2012, Montana's readmission rate fell by 11 percent, the largest reduction in the country. Last year, Medicare saw 70,000 fewer beneficiaries readmitted to hospitals nationwide.

The Affordable Care Act also worked to increase quality in Medicare Advantage plans. The law gives bonuses to plans with high quality ratings. Seniors use these ratings to pick the best plan. Tying payments to performance has made plans focus more on quality.

Since the "To Err is Human" report, everyone has worked to improve quality. It is time for us now to do a gut check. What has been most effective? What can we do better? What are the right measures of quality? It is astounding that we do not have agreement on how to calculate, for example, the risk of dying in a hospital. Three different commonly used measures of mortality produced different hospital rankings, so, depending on the measure, a hospital could be at the top or the bottom of the list.

Separately, Medicare uses 1,100 different measures in its quality reporting and payment programs—one thousand, one hundred. While we need to recognize the differences among providers, do we really need more than 1,000 measures? That is just Medicare. Medicaid programs and dozens of commercial insurance companies all pay differently and run their own quality programs. Providers are pulled in different directions by different payers, and they have a tough time finding the right way forward to higher quality.

So let us identify the key measures, develop them faster, align these efforts across payers, and reduce the administrative burden on providers. We all have a stake in this; after all, quality is everyone's responsibility.

[The prepared statement of Chairman Baucus appears in the appendix.]

The CHAIRMAN. Senator Hatch?

**OPENING STATEMENT OF HON. ORRIN G. HATCH,
A U.S. SENATOR FROM UTAH**

Senator HATCH. Well, thank you, Mr. Chairman. I am pleased that we are having this series of hearings addressing different parts of our health care system. Last week's hearing showed us that transparency goes beyond price to include quality as well. Indeed, the price-quality equation should help us determine the value of our health care.

Currently, there is so much marketing around provider quality, particularly with regard to hospitals. Everyone seems to be claiming to be the best at something. Many of these claims are based on proprietary data, making it hard for consumers to have an accurate picture of our health care system. Perhaps quality is in the eye of the beholder.

I hope that today's hearing will help us to better understand another very important part of our health care system. For years, providers, payers, and Federal programs have been consumed with measuring quality with an eye towards altering the payment system to reward better quality care. I understand how complicated it can be. My concern is that the system as it currently stands seems quite unorganized, focusing on far too many things. We need to be very mindful that the primary purpose of quality measurement is to promote quality improvement.

To be clear, I think a focus on measurement is the appropriate first step in building a solid foundation for quality. However, I wonder whether we have the right tools in place to help clinicians learn how to improve rather than simply showing them how they compare to their peers.

Assessing a starting point is important, but ultimately the goal should be to improve care for every patient. That means giving clinicians the necessary resources in terms of best practices and care management. It also means providing clinicians with clear and consistent definitions of clinical concepts.

If our collective goal is to ensure that every patient receives the right care in the right place and at the right time, providers need to know how those are defined and determined. Because data will be determined by measurement, it is imperative that we get measurement right in the first place.

Providers should have confidence in the data being used to assess their care and payment for that care. In addition, we need to remember that the job of a clinician is to provide care to patients, not spend an unreasonable part of their day inputting data for measurement purposes.

It seems to me that in order for quality programs to be successful, the collection of data needs to be as streamlined as possible and simply be an outgrowth of routine clinician work flow. I have the good fortune to represent a State with some of the highest-quality health care providers in the Nation. They are constantly striving to do better, and I commend them for that.

However, I am aware that some providers in this country are struggling to make improvements, and I think we need to understand and appreciate that resources vary greatly across this country and this has an impact on quality data.

Sometimes quality scores might not truly reflect the care being given at an institution, but I want to be clear about this: efficient and high-quality care must be an expectation that we have, not merely a goal. We cannot accept providers not making quality a top priority.

Our witnesses this morning will share with us all of the activities going on in the quality space today, both in the Medicare and Medicaid programs, as well as the private sector. With so much at stake and so many taxpayer dollars going into various reporting

initiatives, I would encourage all of us to work together to ensure that the process is well thought out, streamlined, and moves us towards improving outcomes and care, which of course is the ultimate goal.

And so, Mr. Chairman, I want to thank you once again for this hearing, and I look forward to hearing from our witnesses. It is great to see some of you back here again. Mark, we are very happy to see you again, and all of you as well. So, thanks for being willing to testify.

Thanks, Mr. Chairman.

The CHAIRMAN. Thank you, Senator. Thank you very, very much.

[The prepared statement of Senator Hatch appears in the appendix.]

The CHAIRMAN. Today we will hear from four witnesses: Dr. Mark McClellan, director of the Engelberg Center for Healthcare Reform at the Brookings Institution; Dr. Christine Cassel, president and CEO of the National Quality Forum; Dr. David Lansky, president and CEO of the Pacific Business Group on Health; and Dr. Elizabeth McGlynn, director of the Kaiser Permanente Center for Effectiveness and Safety Research.

We will begin with you, Dr. McClellan. As I am sure you all know, your statements will automatically be included in the record. Do not worry about that. Second, we urge you to summarize your statements. I strongly urge you to tell it like it is; do not pull any punches. Let 'er rip. [Laughter.]

All right. Dr. McClellan, you are first.

**STATEMENT OF HON. MARK B. McCLELLAN, SENIOR FELLOW,
THE BROOKINGS INSTITUTION, WASHINGTON, DC**

Dr. McCLELLAN. All right. Thank you, Mr. Chairman. With that challenge, Chairman Baucus, Ranking Member Hatch, and members of the committee, I very much appreciate your leadership in focusing the Nation's attention on improving quality. As you all pointed out in your opening statements, we have been making progress with measurement and with improvement of quality, but the measures keep showing us that big gaps remain, leading to worse health outcomes and avoidable health care costs.

I have four recommendations for the committee that are discussed in more detail in my written testimony. First, and most importantly, we need to take further steps to transition payment systems in public programs to case- and person-level payments. The quality problem is not just or mainly a problem of quality measurement, it is a problem of providers and patients getting support for better care at the person level through our financing and our regulations.

Fee-for-service payments for specific services and quality measures for processes of care undertaken by particular providers are important, but they have not been sufficient to fundamentally improve care. And they are growing more out of step with health care that should be increasingly personalized to the needs of each patient based on their genomics, their preferences, and other characteristics when they increasingly involve wireless technologies, wellness initiatives, home-based services, and other approaches that are just not covered by traditional fee-for-service insurance.

Recently, along with a bipartisan group of health care leaders and experts, I authored a report on “Person-Centered Health Care Reform: A Framework for Improving Care and Slowing Health Care Cost Growth.” We proposed directing more of our health care resources to getting better care at the person level through moving to more person-level payments and outcome-oriented measures of quality.

Other recent reports all agree that the most important thing that policymakers can do now to improve health care quality is to make feasible changes in health care payments and benefits so that they can better support patient-centered care.

Building on recent reforms like bundled payments and accountable care payments in the private sector and public insurance programs, Medicare should take further steps to move away from fee-for-service and transition to greater use of these person- and episode-based payments. This could be enacted this year as part of legislation to address the physician SGR problem, as well as in post-acute care and other systems that are paid primarily on volume and intensity.

This would build on ideas like the primary care medical home where primary care physicians get some of their payments based on providing better care for a patient, not based on specific services. Some oncologists are implementing an oncology home for their cancer patients where they can devote more effort to tracking their patients’ care and helping them avoid pain and other costly complications.

Cardiologists and cardiac surgeons have proposed collaborative heart teams to care for complex heart patients. These could all be supported by case-based payments. I want to emphasize that these are shifts in payments away from fee-for-service, not additional payments, because better coordination and better quality should mean fewer unnecessary services and lower health care costs.

The second step is to take further steps to implement case- and person-level quality measures in public programs. A growing set of case- and patient-level measures are becoming available or could transition into more widespread use. The payment reforms I have described would accelerate the development and use of such measures, but more must be done.

Further funding for quality measurement activity should require a clear path for the development and use of patient experience measures and patient outcomes through Medicare’s payment systems. For example, instead of using quality measures like whether or not a patient was screened for body mass index, an outcome-oriented measure like a patient’s overall risk for cardiovascular disease could be tied to the collection of data for quality improvement, reporting, and eventually become a component of payment.

This emphasis on key outcomes and experience measures could help drive both alignment of performance measures, as you all have emphasized is a key goal, and also better outcomes. They would also reinforce efforts that many, many clinical organizations and quality improvement organizations are taking today to develop better data and underlying measures to help drive improvements and outcomes.

Third, there needs to be more support for the NQF, along with a streamlined process for developing, endorsing, and incorporating more meaningful quality measures in the public programs. You will hear more about the National Quality Forum from Dr. Cassel on my right.

Once again, this core set of common measures should focus on patient experience and engagement, outcomes related to care coordination like readmissions, and measures of important safety complications. And measures of population and preventive health should also include outcome measures relevant to particular conditions. These measures should be prioritized, and they should be the basis for, first, alignment, because they can be used across multiple programs to reduce administrative burdens and achieve greater impact.

Finally, I have some proposals in my written testimony for supporting collaborations to implement quality measures using existing and emerging electronic data systems along the lines that, Senator Hatch, you suggested, to make these a routine part of care provided in a way that supports clinicians in taking steps to improve care.

Thank you all very much for the opportunity to join you today.

The CHAIRMAN. Thank you very much, Dr. McClellan. That is very interesting.

[The prepared statement of Dr. McClellan appears in the appendix.]

The CHAIRMAN. Dr. Cassel? Since he introduced you, you may proceed.

STATEMENT OF DR. CHRISTINE K. CASSEL, PRESIDENT AND CEO, NATIONAL QUALITY FORUM, WASHINGTON, DC

Dr. CASSEL. Thank you. Mr. Chairman and Minority Leader Hatch, first I want to commend your leadership and actually that of the entire committee, because, after all, it was your action that established so many of these initiatives—public reporting, value-based purchasing, delivery reform—intended to improve our Nation's health care. These efforts all rely on quality measures.

I joined the National Quality Forum—this is actually my first official week on the job—because I understand the power of good quality measures. We need the good quality measures to create information that patients need and, as you pointed out, to enable hospitals, doctors, and nurses to know how to improve.

For those who are not aware, NQF is a nonprofit, nonpartisan organization with 440 organizational members, including physicians, nurses, hospitals, business leaders, patients, insurance plans, and accrediting and certifying bodies, all of which collectively embody NQF's public service mission.

Over the last few months, I have been reaching out to dozens of people to listen to their ideas about what is needed to accelerate quality. The goal of this listening tour has been to identify ideas to make NQF more responsive to a shared urgent imperative that you are going to hear from all of us today: to more swiftly and effectively drive performance improvement.

What I have heard from all these people is that we need measures that matter to clinicians, measures that are meaningful to pa-

tients and families, and a process that is transparent, efficient, flexible, and responsive. We also need measures so that policymakers like yourself can tell whether innovative public programs like medical homes and Accountable Care Organizations enhance patient care and reduce costs.

If everyone agrees on the same basic measures, then we are all rowing in the same direction. That is where NQF comes in. NQF has two distinct and complementary roles: (1) endorsing measures based on rigorous scientific criteria; and (2) convening diverse stakeholders to gain agreement about measures and about priorities, as Mark just mentioned, that we all need to agree on for improvement.

Since NQF started endorsing performance measures a decade ago, much has been accomplished. Hundreds of endorsed measures are now publicly available. We are constantly evaluating them to stay up with the science and to reduce burden and bring higher impact measures into play. Last year, for example, we retired more measures than we added.

Most of the measures now are focused on clinical care and patient safety, but, as you heard, we are at work on patient- and family-centered care measures, affordability, and population health, with all of them focusing more on outcomes.

We are also looking at how to improve our own work. Last year we reduced our measure endorsement time by half, and this year we want to launch a better open pipeline approach for reviews. Here are a few examples of how NQF-endorsed quality measures have improved care and reduced costs. Chairman Baucus mentioned the almost 60-percent decrease in some hospital bloodstream infections, saving thousands of lives and billions of dollars. In obstetrics, the reduction of inappropriate early elective deliveries before 39 weeks is resulting in healthier babies, fewer ICU days, and lower costs. Improvements using our measures in Medicare's End-Stage Renal Disease kidney failure program have produced reduced hospitalizations and deaths in this very sick and very vulnerable population. There are many, many such examples in many, many very good systems around the country, but there are not nearly enough of them.

What will it take to accelerate improvement? One, we need more strategic and coordinated measure development that is tightly focused on filling serious gaps in order to reduce duplication and facilitate the use of new medical knowledge in easy-to-use and -understand measures.

Two, NQF must work on making measurement information more understandable for consumers and policymakers.

Three, we must all foster public and private alignment, public and private payers using the same measures. This would provide great clarity to both consumers and providers.

Four, electronic systems need to live up to their promise to make it easier to derive measures from clinical practice, not add more clerical work for busy doctors.

Five, NQF's current review process must expand to meet changing needs and progress in data sources, for example, by setting standards for measurement systems like physician registries so that they can be available for accountability programs. To make

this happen, we need support from both the public and private sectors for all of this work.

The bottom line is that mistakes, poor care, and complications hurt people and increase costs to workers, families, businesses, and taxpayers. We can, and must, do better, and with your help I am confident we will. I thank you for your past support and for the opportunity to speak to you today. Our challenges are solvable, but only if we all work together. Thank you.

The CHAIRMAN. Thank you, Dr. Cassel.

[The prepared statement of Dr. Cassel appears in the appendix.]

The CHAIRMAN. Dr. Lansky, you are next.

**STATEMENT OF DR. DAVID LANSKY, PRESIDENT AND CEO,
PACIFIC BUSINESS GROUP ON HEALTH, SAN FRANCISCO, CA**

Dr. LANSKY. Thank you. Good morning.

The CHAIRMAN. Good morning.

Dr. LANSKY. My name is David Lansky, and I am the president and CEO of the Pacific Business Group on Health—we call it PBGH. Thank you, Chairman Baucus and Ranking Member Hatch, for letting me present the purchaser's view of health care quality today.

PBGH represents large health care purchasers who are working together to improve the quality and affordability of health care in the United States. Our 60 member organizations provide health care coverage to over 10 million people, and they spend over \$50 billion each year. They include a wide range of familiar companies like Wells Fargo, Target, Intel, Boeing, and public purchasers like the California Public Employees' Retirement System (CalPERS).

These companies believe that care will improve when providers compete on value, on quality, and cost, as each of them must do in their own industries. They are looking for meaningful transparency on price and quality, and neither is available today. Our large employer members believe that providers should be required to measure and report the outcomes that American families and employers care most about: improvements in quality of life, functioning, and longevity.

After a patient has a knee replacement, is her pain reduced? Can she walk normally? Can she return to work? When a child has asthma, can he play school sports? Can he sleep through the night? Unfortunately, the measurements we use today leave us unable to make many of these vital judgments about the quality of doctors, hospitals, or health care organizations.

When I asked our members last week how they would describe the value of our national quality measurement efforts to their own companies, they responded with one word: abysmal. Still today, the only information large employers have to differentiate hospitals, clinics, or doctors in most communities is their reputation, not their true price nor their likelihood of obtaining good results.

There are three areas where we believe that Federal action can help put us on the right path: developing useful measures, building out a national data infrastructure, and making use of performance information for payment and public reporting.

First, PBGH companies see that the quality measures available today will not create a successful health care market. We know the

kind of quality data that is needed, and we look to the public agencies to ensure that the needed information becomes available.

Congress should direct CMS to identify and adopt useful standardized measures that address consumer and purchaser concerns far more quickly. CMS could either continue to rely on a multi-stakeholder consensus process under a new and more stringent mandate, or take on this responsibility directly in order to expedite action.

Continued funding of the measurement enterprise should be tied to stronger decision-making roles for those who experience and pay for health care; rapid adoption of outcome measures already in widespread use, such as those for total knee replacement and depression in Minnesota; and collaboration with publishers so that the results of measurement can be rapidly distributed to the public through generally accessed channels.

If we make quickly available measures that can differentiate high-performing providers from others, then the employers involved with PBGH and many others will be able to change their payment policies, reconfigure their health care networks, and create consumer incentives to encourage the people that they cover to get care from the high-performing organizations. This is the critical market signal needed to drive improved quality and affordability.

Second, PBGH member organizations see that we still do not have a national data infrastructure to support a continuously improving health care enterprise or the ability for people to make informed decisions about their care. While purchasers applaud the important progress made in the adoption of electronic health records since 2009, it is time now to jump-start a new era of technology standards and interfaces that take advantage of the global explosion in cloud computing, mobile technology, and the Internet.

CMS and the Office of the National Coordinator for Health IT should develop and quickly implement a framework that will allow for evaluation of a patient's care over time, including the appropriateness of care decisions, their outcomes, and the total resources consumed.

This data infrastructure should also permit Congress and the public to assess whether new models of care, such as episode payment, ACOs, and even the new insurance marketplaces, are contributing to improved health.

Such a data infrastructure will also allow employers to evaluate the performance of physicians and health care organizations across settings and across time, and support continued innovation in the care models that they offer to their employees.

Third, and most importantly, PBGH members are concerned that Medicare, as the largest purchaser of all, continues to send financial signals to providers that reward volume over value and leave millions of beneficiaries and the general public with no useful information on the quality of care they receive. Congress should require the Secretary to imbed the most useful outcome and efficiency measures into platforms like Physician Compare and into all Federal recognition and payment programs within 24 months.

In particular, the current interest in replacing the Sustainable Growth Rate mechanism with a value-based payment update could tie positive incentives to the collection and reporting of measures

of appropriateness, patient outcomes, care coordination, and efficiency.

PBGH companies believe that a health care marketplace where providers compete based on their ability to improve health and manage resources efficiently will prove to be sustainable and will improve the health of all Americans. But time is short. Such a system must be based on meaningful performance information available in the public domain.

Just as we created the SEC and fuel efficiency ratings and nutrition labels to drive successful markets, we must create a flow of information that consumers and purchasers can use to make critical health decisions. You have the opportunity to direct Federal resources to address this vital national interest, and you will have the support of major employers in accelerating this agenda.

Thank you for considering the purchasers' perspectives in your deliberations.

The CHAIRMAN. Thank you, Dr. Lansky. That was very interesting, very thoughtful.

[The prepared statement of Dr. Lansky appears in the appendix.]

The CHAIRMAN. Dr. McGlynn?

STATEMENT OF DR. ELIZABETH A. McGLYNN, DIRECTOR, KAISER PERMANENTE CENTER FOR EFFECTIVENESS AND SAFETY RESEARCH, PASADENA, CA

Dr. McGLYNN. Thank you, Chairman Baucus, Ranking Member Hatch, and members of the committee, for inviting me here today. I am Dr. Elizabeth McGlynn, director of the Kaiser Permanente Center for Effectiveness and Safety Research. I am testifying today as a health care quality measurement expert and also on behalf of the National Kaiser Permanente Medical Care Program, which is the largest integrated health care delivery system in the United States.

My experience at Kaiser Permanente over the last 2½ years has deepened my understanding of the challenges of measuring and providing high-quality care on the delivery system front lines.

My written testimony makes five points. First, we are making progress on quality, but we cannot declare victory yet. When I started studying health care quality in 1986, most people thought it was not a problem in the United States. But in 2003, my colleagues and I found that American adults were receiving just 55 percent of recommended care for the leading causes of death and disability.

Along with the IOM reports that you referred to, Senator Baucus, measurement demonstrated that we had a problem and provided the motivation to fix it. The question that you are asking now is, how can we do this better? That in itself indicates progress. The conversation has changed.

We know it is possible to deliver on the promise of high quality. Within Kaiser Permanente, for example, we used our electronic health records to evaluate our performance on a range of preventive care interventions, such as mammography screening. We set goals for improvement and used all of the tools in our integrated system to ensure that our patients got the right care at the right time, every time. Now our rates are among the best in the Nation,

and our patients benefit, but this is not true everywhere. Making progress is hard work. It requires team problem-solving, robust and timely information, effective leadership, and rewards for doing better, not just doing more.

Second, we must be clear about what we are trying to achieve and what measures will allow us to track progress. A decade ago, Dr. Cassel and I were members of the Strategic Framework Board, which recommended to the National Quality Forum a goal-oriented, broad-based vision for a national quality measurement system. That vision remains relevant today and has yet to be fully implemented.

Goals for U.S. health care should be audacious and engage the public, on par with landing a man on the moon. What if we set out to make obesity a rare event or cut the number of people with diabetes in half? Without clear, quantifiable goals and a commitment to reach them, measurement becomes a separate enterprise rather than a purpose-driven tool for change.

Third, we must make sure that we have the right set and number of quality measures. This requires robust development processes closely linked to established goals. Too many measures used today represent outdated technology created when the goal was simply to raise awareness about quality deficits.

Delivery system and payment reforms were not yet a major focus, and claims data were all we routinely had. Times and health care realities have changed. We need to invest in developing measures that help us achieve our health outcomes goals. Measures should also encourage development of innovative delivery systems, support payment reforms, and take advantage of the increasing availability of clinical and patient-reported data.

Fourth, new quality measures should anticipate the future. With the advance of electronic health records, information technology is becoming a real tool in health care, providing new opportunities to drive measures from richer clinical data.

Consumer mobile devices can enable real-time data feedback into quality improvement programs. The explosion of apps for health care represents valuable technology that we are just beginning to learn how to harness.

The need for delivery system improvement should foster integrated models as the norm, not the exception. Payments should reward quality, and we should engage the public and providers broadly in achieving major advances in the country's health.

This vision differs from the Nation's current enterprise by moving away from sole reliance on old data sources. It would be sufficiently flexible to work as systems and payment designs change. It would accelerate the rate at which improved health is realized. If we cling to the past in our measurement strategy, we will stifle important innovation in all these domains.

Finally, the Federal Government can, and should, lead by bringing the right stakeholders together to have honest dialogue about goals. The government should facilitate, as well as participate in, actions to achieve those goals. The government should promote and reward innovation.

By tying payment to quality standards, programs like the 5-star quality rating system for Medicare Advantage plans are already al-

tering the value equation, and we have recent evidence that consumers are acting on this information by choosing higher-value plans.

The Federal Government can also lead by educating the public about health care value through clear, easily accessible, reliable information about quality. Consumers are both beneficiaries and drivers of quality improvement when they can make educated choices about the care they receive.

Thank you for the opportunity to talk with you today.

The CHAIRMAN. Thank you, Dr. McGlynn.

[The prepared statement of Dr. McGlynn appears in the appendix.]

The CHAIRMAN. Let me ask you, Dr. Lansky, you named—if I understood you correctly—a few different recommendations to develop useful measures and some kind of national data entry structure, and then somehow—well, then another, third recommendation.

I am wondering, tied in with Dr. McClellan's ideas of more patient-centered efforts to determine quality and outcomes, are those the kind of measures that you are talking about in your first recommendation or not?

As I heard you: better reporting, everybody reporting both price and quality in the ideal world, then payers such as yourself can decide, companies can decide, patients can decide, where to go. But those measures that you would like to see reported, do they include items mentioned by Dr. McClellan, that is, patients' experiences and outcomes? What should be available to people?

Dr. LANSKY. My answer is "yes." I will let Dr. McClellan answer and see if he agrees. I think we have advocated for a long time that patients are able to report on the outcomes, many of the outcomes, of care that they receive.

Tracking the experience of a patient's care over time, seeing a number of doctors in a number of settings, we might think of that as an episode of care or managing a condition for a year, diabetes or another problem. It needs to be assessed comprehensively.

We can ask patients after a knee replacement—and there are very systematic ways of doing this—whether they can walk better, whether they can climb stairs, whether they can go back to work, whether their pain has been relieved. Those kinds of measures are what the employers want to know and what the patient, of course, wants to know.

If the patient is about to choose a surgeon or a hospital, they want to know which of those surgeons or hospitals is most likely to get them back to successful functioning and get them back to work. There have been a number of health systems around the country and around the world that have done this, and they do see significant variations in the ability of teams, hospitals, and surgeons to get people—in this example—back to high levels of functioning.

So we want to help people get into the hands of the best doctors and hospitals that will help them be most successful and recover most quickly from these treatments. So yes, I think, to me, the two dimensions of patient-centeredness are capturing the patient's experience over time, not in specific slices of process, and second, ask-

ing the patient, are you doing better at the end of the treatment you have been undergoing?

The CHAIRMAN. What measures are your companies taking? Companies want to do the best for their employees. So how are they determining price, but more importantly for the sake of this hearing, quality? How are they determining that?

Dr. LANSKY. They are frustrated. They are relying on the measures that are publicly available for the most part, or those that are provided by their health plans, the carriers that provide their network of services. The measures that are available to them today are not adequate to answer the kinds of questions you were raising a minute ago.

So they are using what is available, but they frankly feel that they are being brought into a process of choosing networks based on cost, because that is all there is. They cannot really determine whether those networks are high-quality, and they cannot with confidence say to the employee, if you go to this hospital or this doctor, we have evidence that they are going to get you a better result. That is what they want to be able to do. One of the reasons they are reluctant to steer employees into certain networks is they cannot with confidence say that those networks are actually better.

The CHAIRMAN. Let me just ask all of you a basic question: what do you recommend that we do? What should Congress do? One of you tried to answer that question, but I would like to briefly ask each of the four of you just, bottom line, what should we do? Dr. McClellan?

Dr. MCCLELLAN. Mr. Chairman, you cannot do everything. But, as I think you have heard from all of us, there is a lot of support for being clear about incorporating measures that have outcomes, that have patient experience, that have these key features that patients really care about, incorporated in the payment system. For the Finance Committee, I know this hearing is first and foremost about quality, but how you pay, as you have heard from all the people on the panel, matters.

The CHAIRMAN. So this could be part of reforming SGR?

Dr. MCCLELLAN. It could be, yes.

The CHAIRMAN. All right.

Dr. Cassel, what do we do?

Dr. CASSEL. Thank you. I have two suggestions. One is, support for measurement development. Actually, there was funding authorized in the ACA for measurement development, but it has not been appropriated. That money could help develop—the kind of measurement development that Dr. Lansky is referring to does not just happen by snapping your fingers.

There are smart scientists like Dr. McGlynn who know this. It takes testing, it takes getting the right people together, the right kinds of data, et cetera. So, specialists in this area are at work trying to do this and have been doing it with sort of a hodgepodge of support. If we really had a major man-to-the-moon kind of effort that you heard about to get these right measures, that would be very helpful.

The CHAIRMAN. My time is expiring.

Dr. CASSEL. Can I mention one other thing?

The CHAIRMAN. All right. Sure.

Dr. CASSEL. One other thing is to have the public/private sector entities and the multi-stakeholder groups like NQF help us push for alignment between the public and private sector payers. One of the reasons that the employers cannot get the information they need is that the private insurance companies often use different measures or proprietary measures.

The CHAIRMAN. My time is expiring, but how do we push for alignment? How do we do that?

Dr. CASSEL. Well, one thing would be to push us, that is to say the stakeholder groups—

The CHAIRMAN. We are pushing right now. [Laughter.]

Dr. CASSEL [continuing]. To do more in this area.

The CHAIRMAN. You have just been pushed. [Laughter.]

Dr. CASSEL. Thank you. Thank you.

The CHAIRMAN. All right. My time has expired.

Senator Hatch? We will get to you later, Dr. Lansky—next round. Senator Hatch?

Senator HATCH. Well, thank you. I hope you do not feel badly about being pushed like that. [Laughter.]

Now, Dr. Lansky, you and other experts acknowledge that there has been a proliferation of measures, and yet much more work needs to be done to improve outcomes. If that is the case, can you help us identify gaps where improvements could be made to deliver better outcomes, and should we allocate resources differently? Is some of this our fault?

Dr. LANSKY. My own view is that—and I think my members are reluctant to describe how providers should alter their care to achieve better results—if the market rewards them for better results because we measure and expose outcomes, they will be brilliant in finding the best ways to achieve those results.

Many of the breakthroughs in care recently have not been with new technology, but with deploying the right kinds of people to the bedside, to the home, through the Internet. We want to encourage people to be innovative in how they achieve good results, but we want to see that they are producing those results. So my answer, Senator, would be to have the measurement requirements be stringent, demanding, understandable to the public, and then let the providers do what they need to do to be successful.

Senator HATCH. Well, let me ask this of all of you. Have any of you seen reports that have estimated how much providers are spending to collect and report quality measures? Let me start with you, Dr. McClellan.

Dr. MCCLELLAN. There have been a number of reports, and also a number of surveys of clinicians who feel quite burdened by the quality reporting effort. I think one indication of that is the participation rates in Medicare's physician quality reporting systems are much lower than I think what many of us would like. They are high in some specialties, low in others.

I think this goes to, Senator Hatch, your point earlier about trying to make quality reporting a consequence of delivering care, not a separate set of activities that needs to be done on top of everything else that clinicians are already doing.

Dr. Lansky emphasized that outcome measures and patient experience are things that providers really care about, and having some

measures that could be developed from their clinical record systems, from their patient registries, would be very helpful and would help them improve their care. The problem is that the way that they are paid today does not really give providers much support to do those kinds of things.

There are examples, I think, in every single specialty. I mentioned a few in my testimony, for example, in oncology where, if oncologists are only paid based on the volume and the intensity of chemotherapy drugs that they administer, and not paid for things like setting up a registry for their patients so they can track how each patient is doing and whether they are getting the latest evidence-based care and spending extra time, maybe hiring a nurse to help their patients who are having pain or other complications so that they do not end up in the emergency room or the hospital, you cannot do those things under current fee-for-service payments and still stay in business. So it is very frustrating and burdensome for doctors, but it is a problem that I think could be addressed with feasible legislation.

Senator HATCH. Well, thank you.

Dr. Cassel?

Dr. CASSEL. Thank you, Senator. I wanted to add to Dr. McClellan's point that there are, around the country—and you pointed out, in your own State—examples of excellent systems that actually invent their own measures and use their own measures to drive their own improvement. They do not see themselves as measure developers who are submitting measures to NQF for endorsement to be used more broadly.

What I am going to be doing at NQF is a kind of prospecting, going out there and looking for, what are the good systems doing and how could we then take advantage of some of those and make them available so that they would make sense to clinicians and lower the burden on clinicians?

The other point related to this, of course, is really accelerating some of the new electronic technologies so that the physicians themselves do not have to report these measures.

I just want to say, though, that currently some of those are compliance provisions that are put in place because of concerns about fraud and other things to make sure that the doctor is the one who is doing it, so we have to somehow get to a technological place where we can relieve the clinician of that burden. I completely agree.

Senator HATCH. All right.

Dr. Lansky, then Dr. McGlynn. We only have a few more seconds.

Dr. LANSKY. Just two other points. I think we have demonstrated in California, with a joint replacement registry that we have developed, that we can collect almost all the data from electronic systems in the hospital and the doctor's office with very little additional data burden, so it can be done with new technology.

Second, I would draw the distinction that, I think a lot of the process measures that are very burdensome, we do not need to require as a national strategy. The national interests should be in the outcomes. Let the providers innovate with the processes they

want to monitor, measure, and approve. That is not really necessarily a matter of public scrutiny.

Senator HATCH. Dr. McGlynn?

Dr. MCGLYNN. I will add two things to what has been said. The first is, I think we have over-promised on some of what is possible out of the current technologies in electronic health records. I think there ought to be—and Dr. Lansky and I were talking about this before the hearing—a real push to upgrade those technologies. They are not really optimized for the kind of quality measurement systems we are talking about today. So, that is one thing we should look at.

The second is, I think you ought to think about some innovation zones. There are systems in this country that have demonstrated, across a large number of areas, consistent high performance. One possibility is to relieve them from the burden of current reporting so that they can be part of moving some of this measurement forward.

But I think in many cases to do better, we have to stop doing something so that there is sort of time and energy. I think integrating measurement into clinical care delivery is the place that we need to go, and we certainly talk to our clinicians a lot about how to make that happen.

You really have to understand how measurement fits into the clinical work flow so that, both the data that are produced are the ones that you are interested in, and so that you are actually having providers focus on the things that are important to them and to their patients.

I just think there are real opportunities here, but we need investments to make that possible, and we need kind of everybody—it needs to be an all-in process with all of the kinds of people whom we represent here today engaged in that. Now is the time to do it.

Senator HATCH. Thank you. Thank you all.

The CHAIRMAN. Thank you, Senator.

Senator Cardin, you are next.

Senator CARDIN. Thank you, Mr. Chairman. Thank you for holding this hearing.

Quality is an extremely important subject. We were trying to get to a cost-effective quality health care system and how we maintain it, and we have been talking about this for some time. I want to follow up on the questioning, but to deal with it from the point of view of the consumer for one moment. We have talked about how the user of health care can be more informed on making a choice on quality.

If they make a choice on quality, that can drive the system to a much more cost-effective system. I find that, if you have a choice in health care, you want to go to the provider that will offer you the best care. Cost is also a factor, but you are seeking health care in order to achieve a result.

I have heard you talk about all the different information we are trying to make available on quality, but, if you had an opportunity to move forward on a tool that would be available to the end-user in order to make judgments on quality, what is the tool and what do we need to do in order to accomplish that? How do we make the consumer a better consumer on judging quality?

One last preface to that. In Maryland, we have quality indexes that are available for different providers. It has worked well in long-term care. Consumers do look at these guides. It does make a difference. But there are hundreds of thousands of providers out there in the Medicare system alone. What can we do to empower consumers to make better choices on quality?

Dr. MCCLELLAN. The examples that you gave, I think, highlight how to do it. In areas like long-term care, there are some States, including yours, that have meaningful measures of outcomes that people care about—is the care there safe?—and measures of experience of care that patients have and caregivers have as well. That is clearly what patients care about.

There are lots of examples of tools around the country: some that have been developed by the private sector, some that Dr. Lansky's employers are using, some that States are developing. The challenge is often, as you have heard from the panel, getting the right information into those tools that the patients can understand and that they really do care about. And that I think brings us back to the theme that you have heard throughout this hearing, which is making sure that there are relevant outcome measures available for each of these many different areas of care, just like we are starting to have for long-term care. For example, for ophthalmologic surgery, the surgeons have developed measures of visual acuity after procedures, something that patients—

Senator CARDIN. Dr. McClellan, MedPAC tells us there are close to 600,000 physicians in the Medicare system alone receiving payment. How do you develop that in a cost-effective way for CMS?

Dr. MCCLELLAN. There are some efforts under way for identifying a core set of these meaningful measures for patients. They include things like patient experience for every single one, almost, of these provider types. They interact with patients, and there are effective ways of measuring patients' experience with care.

It is true that different clinical areas have different outcomes that matter to patients, but in each clinical area there are some clear places to start, like operative outcomes for knee replacement and patients' functional status down the road. Each of these clinical areas is working on meaningful ways of measuring these outcomes.

So, it is a daunting task, but I want to emphasize that we are not talking about hundreds or thousands of measures, we are talking about a few key places to start on outcomes and experience in each of these major clinical areas.

Senator CARDIN. Now, as you know, I represent Maryland. CMS is located in Maryland. So, if we are talking about doubling the size of CMS, it might be good for my State. But they already have an incredible burden over there, as you know. Are we creating really a workable system? Can it be done?

Dr. MCCLELLAN. I think it can be done. I would like to let some of the rest of the panel comment on this too.

Senator CARDIN. All right.

Dr. CASSEL. Senator Cardin, thank you for that question. It is a really important question. I just want to add a couple of things. First of all, to the issue of over-promising, we cannot have perfect, complete measures for everything that you value about health care.

As an internist, a big part of what people want is to make sure they get the right diagnosis. We have no measures that tell you that.

All the measures we now have, you assume the patient comes in the door with the diagnosis on their forehead, but that is much more complex and much more difficult to get. If we get to overall outcomes and well-being and performance of systems, then we will have a better shot at including within that doctors making the right diagnosis and having the right information.

But that also gets to the point that CMS is hampered by the fact that it pays doctors individually, and it pays them by fee-for-service. Often the outcomes that you want are outcomes by teams and by groups of physicians, groups of providers, whole systems of care. So we also need to move to more system-level outcomes. I know that many of the professionals within CMS agree with this, so some of these payment reforms, I think, will help with that.

Senator CARDIN. Thank you.

Thank you, Mr. Chairman.

The CHAIRMAN. Thank you, Senator.

Senator Casey, you are next.

Senator CASEY. Mr. Chairman, thank you, and thanks for this hearing. We appreciate the panel, your testimony, and your willingness to be here to answer these questions. I know it is a difficult set of issues for us. I wanted to concentrate on two areas, and first and foremost, children and how some of these issues relate particularly to our kids.

A lot of the advocates around the country who fight every day on behalf of kids often remind us that, in the health care context, children are not small adults. You cannot just—and you know this better than I—somehow impose a course of treatment or a health care strategy that might make sense for an adult on a child; there are a whole other set of challenges there.

The Senate, for almost a generation now, has come together, led by both the chairman and the ranking member, on children's health insurance, a great advancement for the country. Pennsylvania really led the way on that. There is, despite the debates we have here, I think a fairly strong consensus about a part of the Medicaid program that works very well, the so-called EPSDT, Early Periodic Screening, Diagnosis, and Treatment. That whole program or that whole effort over time has been, I think on the whole, very successful. It could be improved. So we have had a number of efforts that focused specifically on children.

I wanted to ask you, in light of this discussion of trying to link quality to payment reform, trying to link quality to a whole other set of measures, how do we do this in the context of making sure that programs that are providing children's health insurance now are in fact doing an even better job because we are focused on these issues, particularly in the context of kids? We can go left to right or right to left. Dr. McGlynn?

Dr. MCGLYNN. Thanks for that question. I am involved right now with an effort that was funded through CHIPRA to develop new measures for the CHIPRA program, but also that would be applicable to kids in any—

The CHAIRMAN. I am sorry. What is the CHIPRA program?

Dr. MCGLYNN. Oh, I am sorry. The Children's Health Insurance Program Reauthorization Act.

The CHAIRMAN. Not SCHIP?

Dr. MCGLYNN. Well, SCHIP is—CHIPRA is the legislative acronym for the reauthorization of SCHIP. Sorry.

The CHAIRMAN. All right.

Dr. MCGLYNN. Here I am in Washington. I thought we all spoke acronyms. I am sorry. [Laughter.]

But in that legislation, the Congress put money into measure development with a recognition that quality measurement for kids was really undeveloped relative to adults, and so I am part of one of the teams that is working on measures in that area, and I will just sort of highlight two things about that.

One is, it has taken very much this approach we have all talked about, which is a multi-stakeholder approach. So our team, for instance, has at the table parents of kids who have particularly complex needs as we are developing measures, and so we are talking to them about, what is meaningful to you?

Part of what we have learned—and this has been a very helpful process—we have looked at the scientific literature about what we know clinically and we have talked to parents, and ultimately what we decided in the areas of continuity of care, coordination of care, is, we really need to hear from the parents.

We need to hear whether their needs are being met, because, frankly, they vary from individual to individual. So we have developed a set of measures that we are in the field testing right now that rely heavily on asking the people who are most important whether they are getting the kind of care they need.

So, two points: the multi-stakeholder process gives us different measures than we would have gotten otherwise; and two—and this is consistent with things we have said—we need to really ask the end-users whether they are getting the kinds of information they need and whether they feel like they can make the choices that are right for their child, whether they are supported in doing that. That information can be rolled up then to produce a sense at the State level and at systems levels about where the best care is going on.

Senator CASEY. Dr. Lansky, you have a difficult task: there are 23 seconds left. We have the lightning round.

Dr. LANSKY. Well, two points. There are a number of measures out there that have been developed that segment the child population: some with special needs, adolescents, and so on. And second, this is actually a great opportunity for alignment that was raised earlier, because our members are certainly very concerned about their kids' care, as it takes people away from the workplace and all the rest, and Medicaid programs in particular have a huge child population to take care of, so I think there is a chance for dialogue between the commercial purchasers and the public programs to sort this problem out.

Senator CASEY. I am 6 seconds over now. Our last two witnesses, if you could provide 30-second answers, I think the chairman might allow that.

The CHAIRMAN. Take as long as you want.

Dr. CASSEL. It raises the issue of people with multiple conditions, interacting conditions, and any other area of complexity where we really need major investment, whether it is for children or my area, geriatric care. Same issue.

Senator CASEY. Thank you.

Dr. MCCLELLAN. For the minority of kids who have very serious health problems, these kinds of initiatives are very important. For most kids, the most important thing is establishing good habits, education, staying in good health, staying up with preventive care and services. There are ways to measure that.

Kind of analogous to what many employers are doing about the bottom line of health is, how well is it translating into your life? Maybe some measures like some school systems are doing about health measures that track how well kids are staying in school—this is especially true for young kids in preschool programs. Think outside just the health care box for what really matters to kids.

Senator CASEY. Thank you.

The CHAIRMAN. Thank you, Senator.

Senator TOOMEY?

Senator TOOMEY. Thank you, Mr. Chairman. Thanks to the witnesses as well.

I am just trying to understand a little bit better, and I am a little bit confused. I thought I was hearing a consensus about a lot of progress that has been made in recent years about measuring quality and measuring outcomes, but then I heard something that caused me to really pause.

I think it was Dr. Cassel who might have said this. Did I understand you to say that we do not have good information about the quality of diagnoses, that that is an area in particular where we are lacking good information?

Dr. CASSEL. That is an area where there are not good outcome measures, quality measures, the same way we have if we know what the patient's diagnosis is.

Senator TOOMEY. Quality in the sense of measuring the quality of the diagnosis itself?

Dr. CASSEL. Of the process, of the clinician, the physician, or the team that is involved in making the diagnosis.

Senator TOOMEY. All right.

Dr. CASSEL. And misdiagnosis is probably 15 to 20 percent of what we would consider errors. The experts in the area of patient safety use that number from the studies that they have done.

Senator TOOMEY. And does everybody else agree that this is an area where there is a particular level of difficulty and a particular problem?

Dr. MCGLYNN. Yes. It is a challenging area to measure. Our current approaches, measurements that work well in other areas, are not particularly adequate for assessing this aspect of quality.

Senator TOOMEY. Because it strikes me that we could have a real problem measuring the final outcome of a patient's care if we do not know how well we got the diagnosis straight in the first place. It seems like that is the necessary precondition. I am not a doctor, I have no expertise here, but I am not sure how I would analyze outcomes if I was not sure whether we got the diagnosis right in the first place.

Dr. CASSEL. Senator, this gives me an opportunity to say a few words about some of the other approaches to quality that are going on in the private sector. The organization I just recently came from, the American Board of Internal Medicine, represents certifying boards for all the major medical specialties.

They have kind of a simulation for “Can You Get the Right Diagnosis,” which is an examination, a very highly developed, secure examination that physicians take every 10 years in which you have to figure out the right diagnosis to a patient case. So it is not real patients in front of you, but it does sort of tell you, has that person got what they need to be able to make the right diagnosis?

Should they have the information electronically, decision support, and other kinds of things that they need? But in terms of actual quality measures, I think it is necessary to have a high-level group getting together—and I hope we can do this at NQF—to ask this question: is this appropriately handled in the traditional way we think about quality measures now, or are there different ways that we can assure the public in this area?

Dr. MCCLELLAN. I would like to add a point, that there are common diagnostic problems out there and there is no question that there are misdiagnoses that lead to worse outcomes, and that does need to be addressed through the kinds of approaches that Dr. Casel has described. But there are common problems, like people with chest pains who do not have any known heart disease, or people with back pain, or people who have a very bad headache, that end up getting treated very differently.

Senator TOOMEY. Right.

Dr. MCCLELLAN. And I think you can take the same approach that Dr. Lansky and really all of us have emphasized on kind of a patient- or person-centered approach to care and then a focus on how different providers are working together to solve those problems.

Senator TOOMEY. All right.

Dr. MCCLELLAN. On the chest pain problems, the cardiologist, the surgeons, and the primary care doctors have an approach that would do this.

Senator TOOMEY. All right. Yes, I appreciate that. That is an interesting challenge that we have.

I just briefly wanted to get back to a point that Dr. Lansky made, which is, it seems to me there is also a gap between the information that we do have, the measurements we are making about quality and outcome, and that which is available to consumers. There is a gap there.

What is the main reason for that gap? Is there a reluctance on the part of some providers to provide information? Like, obviously not everybody is above average. Is there a problem on the part of those who might rather not have the information readily available to consumers?

Dr. LANSKY. Yes. There are very specific cases where provider organizations refused to share their data with efforts to aggregate and publish results, so I think there are several elements of this pipeline that are all problematic. One is, getting the primary raw data, and sometimes organizations withhold it. Second, once you

have it, you have to massage it and make it understandable to people. There are pretty good ways of doing that now.

But third, we have a platform. Physician Compare is in the legislation, the Affordable Care Act, already, and it should be a platform where everyone in the country can access the kind of information that we do have. The Qualified Entity Program that was also in the bill, where CMS is putting its data into the hands of regional centers, is a platform where you can very quickly spin out measures of individual doctor quality under collaboration with CMS and other private payers. So, I think the mechanism is in place.

The CHAIRMAN. I am afraid I am going to have to enforce the 5-minute rule here. There are going to be several votes starting at 11:30, and there are four or five Senators who have yet to ask questions. I am sorry, but we are going to have to start enforcing the 5-minute rule so everybody can get their questions in.

Senator Stabenow, you are next.

Senator STABENOW. Thank you very much, Mr. Chairman, for this hearing. Welcome to everyone.

It strikes me as we are listening to this that we have had these conversations before, important conversations on health reform. We have in the legislation, in health reform, at least the beginning of tools in this area that I hope we would double down on in many cases and really fund.

I mean, we have been for years moving on electronic medical records but need to move faster. We need to make it simpler, more user-friendly, and so on, the value-based purchasing efforts, the Accountable Care Organizations.

Dr. McClellan, when you are talking about how we ought to be providing payments, it reminds me of a conversation I had way back in the beginning with someone, the CEO of a Detroit hospital, who said, "Just remember that payments drive the system."

So, if you want to pay for more collaborative work or preventative work or physicians having more time on the front end to spend with people, whatever, then the system has to be designed that way to be able to pay for that. So I hope that that is something that at least was begun, and we need to do a whole lot more of, because it seems to me we know what needs to be done in many ways. Not everything certainly, but in many ways we just need to do it.

I want to talk about maternity care for a minute, which is a very big issue and concern for me, not only for the obvious reason in terms of quality of moms and babies, but in saving dollars as well. Senator Grassley and Senator Cantwell and I and others have a bill called the Quality Care for Moms and Babies Act that would push for higher-quality care, and we basically do two things.

We ask CMS to consider including the National Quality Forum quality measures in CHIP and Medicaid quality reporting programs as they are needed, and we provide some initial start-up funds for quality collaboratives.

I wonder, Dr. Cassel, you mentioned the success in reducing elective deliveries before 39 weeks. We have certainly seen this in Michigan. The Keystone Quality Collaborative, which is really, if not the first, certainly one of the very, very first to really focus on

quality. The Michigan Hospital Association has done a great job with this. But the OB project there has certainly been very successful, saving lives, saving dollars.

I am wondering if you can discuss the role you see for quality collaboratives like Keystone, as well as any particular changes in CHIP or Medicaid quality programs that would provide better maternity care outcomes.

Dr. CASSEL. Thank you. Well, first, I congratulate you on this important proposed legislation. I think that Keystone is a marvelous example. It gets to this point I made about prospecting, that there are places out there that are really ahead of the game in terms of everyone else and that we should be going to, looking for what measures they use to really get the best outcomes for their members or their patients. Kaiser is another one. NQF, with your support, can do that.

I also think that, here is a place where, in so many cases, it is the private sector. Yes, Medicaid is a really big payer and an important one for kids, and all the issues that Dr. McClellan mentioned are very important there. But we also need to have the private sector aligned here, and particularly employers and purchasers. So much of workplace productivity has to do with the health of moms and the health of their babies when they go through that process.

So I think here is another place where perhaps a part of what your leadership could do is help push us, as Chairman Baucus said, in this public/private alignment sector. I think this is a very ripe area for that.

Senator STABENOW. Does anyone else want to comment on that particular thing, on maternity care? Yes, Dr. Lansky?

Dr. LANSKY. I would just endorse Dr. Cassel's point. Our members are working very closely with a group in California called the California Maternal Health Quality Collaborative, and Stanford University is the intellectual hub of this group. They are providing feedback to doctors in the State, and the employers see a very tight alignment with the goals of improving maternity care with Medicaid and other programs.

Senator STABENOW. Thank you. I would just say in conclusion—I know my time is up—I know there are some very important issues that we have to deal with around SGR. We need your input. I ultimately am trying to figure out the way we should be looking at the physician quality reporting system and modifying that or changing that completely. So my time is up, but I would like very much in follow-up to know what your recommendations are on that. Thank you.

The CHAIRMAN. Thank you, Senator, very much.

Senator Burr?

Senator BURR. Thank you, Mr. Chairman. Thank you to all of our witnesses.

I think I have heard all of you agree that we sort of need best-in-class measurements. We need quality measurements, we need usable measurements. I have to share with you that I am a little bit concerned how often we change measurements.

I do not say that from the perspective of the providers or the consumers, because I think, on both ends, they are smart enough to

figure out how to use that. I am very concerned about government's ability to change, to recognize the value of something.

So let me turn to you, Dr. Cassel, if I can, because you noted in your testimony that NQF is in the process of streamlining measures to ensure that only the best in class are on the market. As a result, last year you retired certain measurements. Of that, some of them had been adopted by CMS and HHS.

My question to you is, are you seeing CMS and HHS begin to adjust those programs to reflect NQF's thinking, and to your knowledge are there measures that NQF has retired that CMS and HHS currently still embrace?

Dr. CASSEL. Thank you for that question. It is a very important part of this streamlining and progress towards more outcome measures. So sometimes measures are retired because science changes and the medical world changes, and then it is very appropriate to retire a measure, and I am sure that CMS will follow suit on those issues. That requires a real ongoing maintenance.

There are also times to retire measures when everybody is performing at such a high level that it does not distinguish between them anymore. Thankfully, we have a few examples of that, particularly in cardiac care, where we have actually retired measures that NQF has endorsed or that the National Committee for Quality Assurance or other accreditors use, because everybody is above average and functions at above 90 or 95 percent.

Then there is this other issue of getting away from process measures towards more outcome measures. There are times when it might be appropriate for one user to retire a measure of process because you have a better measure for outcome, but sometimes CMS, for example, is not able to use that outcome measure because the payment or legislative requirements for Physician Compare do not allow that. So it is very important that there be alignment with all of these efforts and that CMS really be allowed to be more flexible in that way.

Senator BURR. Well, Mark, let me ask you, is there a risk of developing too many quality measures and reporting requirements for providers? How do we strike the right balance?

Dr. MCCLELLAN. There is a risk. As you heard earlier, there are a lot of measures out there that are now being used in Medicare payment systems. Unfortunately, as Dr. Lansky mentioned in his testimony, most of them are either just oriented to specific processes of care or they are not used consistently across all physicians.

I think it would help for CMS to be able to focus more on some really important person-oriented, outcome-oriented measures, like measures of patient experience with care, like some of the outcomes that we have talked about before. As you have heard, those are tough to fit into current fee-for-service payments.

They involve doctors and other providers working together, or at least spending their time on things that they do not traditionally get paid for, like answering e-mails or doing other things that really can help a patient get to a better outcome and that you do not want to really micromanage from a Federal standpoint.

So I think this movement from CMS away from just paying for specific services and focusing at the same time on some key outcome-oriented measures and patient experience-oriented meas-

ures would be the best way to help simplify this proliferation, help the providers focus on what is important.

Senator BURR. Dr. McGlynn, you said in your testimony that you cautioned that measures should not be overly proscriptive. I guess my question is, do you believe that today's measures are resulting in a one-size-fits-all approach to the delivery of care?

Dr. MCGLYNN. I think we have a number of examples of that across different kinds of measurement programs. I think that is just something to be on the lookout for. I would say, even in the outcomes measure area, this could happen. If you think particularly about patients who have multiple chronic conditions, one of the things—and I was just at a set of meetings where we had some examples of better approaches to measurement that allow us to incorporate patient preferences.

That is, if patients have multiple conditions, they could choose a set of outcome preferences that make sense for their life that might not mean that they would do as well on all kinds of measures. But as long as it is tailored for their preferences—and I think there are ways to do this kind of measurement—then I think we all win. It just takes a lot more nuance than we have been able to apply today.

Senator BURR. Thank you very much.

Thank you, Mr. Chairman.

The CHAIRMAN. Thank you, Senator.

Next we have Senator Isakson.

Senator ISAKSON. Thank you, Mr. Chairman.

Dr. McGlynn, in your testimony—I think I heard this right. You said we are making progress on quality outcomes, and you immediately referred to preventative care as one of the reasons we are doing that. Am I correct?

Dr. MCGLYNN. Yes.

Senator ISAKSON. Here is my question. We have talked about everybody reporting everything except the patient. In the private sector, in the last 15 to 20 years, corporations have put incentives in their health benefit plans for their employees to incentivize wellness and disease management: managing their blood sugar, their heart rate, blood pressure, all those types of things.

Is there any way we can engage the patients' adherence to the doctors' recommendations on wellness and health care as a part of that measurement of quality? Because, if a patient is not paying attention to the doctor's prescriptions, not taking care of their own health, you are going to have a lousy outcome with no fault of the doctor.

Dr. MCGLYNN. So, at Kaiser we are trying a sort of interesting experiment, and I do not have the results of this yet, but this is in conjunction with our labor partners. We have an incentive program that is put in place that incentivizes the group of patients to achieve improvements in outcomes across the group. So, rather than holding an individual patient accountable, because we know there are different struggles, we try to incentivize the group as a whole to have better health.

So this is like a population health concept, but focused on a group of employees. The idea is to really encourage our employees to support each other in making health improvements and in that

way be responsive to these physician recommendations, but to kind of engage the larger group support.

So we have lots of examples of how we are trying to do that in a way that does not make an individual patient bad, but that says, we know this is a tough road for many people, how can we collectively support you in doing that? But it incentivizes the group so everybody will benefit if the health of the group improves. So, sort of stay tuned for the results on this. This is just something we are trying out as, I think, a pretty innovative strategy.

Senator ISAKSON. I will be interested in hearing about it.

I will ask one more quick question then go to future chairman and ranking member, one way or another, Ron Wyden, who, after the chairman retires, I think is next in line. But let me ask you the question about coordinated care. Ron Wyden has worked a lot, and I have tried to help him some, with this idea of getting care coordination as reimbursable under CMS and Medicare, because a lot of times people have multiple conditions and multiple physicians, and, without coordination in care, you can sometimes have an unintended consequence of a medical error, an over-prescription, or conflicting prescriptions one way or another. Would that help, to focus on coordinated care for seniors, in terms of producing better outcomes and lowering costs?

Dr. MCGLYNN. I absolutely think it would. I have to say, just as a person who has moved from not being in integrated care to integrated care, it is sort of priceless, the value of having a system that has the ability to see all those things together. So I think that kind of coordinated care is absolutely critical, particularly for people who have more than one thing going on, which in this country is an increasingly large portion of the population.

I would say that the other thing is really—and I think all of us are emphasizing this need to be more person-focused—people need different kinds of help in getting coordination. Not everybody, even with the same clinical conditions, has the same coordination needs.

So I think we also have to find ways to assume that one size does not fit all in terms of what good coordination looks like, but that we are hearing from patients about whether they feel that their care is adequately coordinated. That is kind of one of the approaches that we have been taking to measurement that I think will be much more meaningful than saying, this is kind of the only way to coordinate care.

Senator ISAKSON. Thank you very much.

The CHAIRMAN. Thank you, Senator.

Next is Senator Thune.

Senator THUNE. Thank you, Mr. Chairman.

I want to thank our panelists today for sharing your thoughts on this very important subject. I wanted to ask this question. This one, I think anybody can respond to. But there are stakeholders who have proposed using the electronic health records as a mechanism for measuring and reporting quality metrics.

We have a lot of providers and a lot of hospitals across the country that are participating in the electronic health care record incentive program, and ideally it would be a way in which we might be able to get at this whole issue of measuring quality.

And so I guess I am just thinking about what the advantages and disadvantages might be of using electronic health records as a mechanism for that and perhaps get your thoughts on that. Mark?

Dr. McCLELLAN. Just a couple of thoughts. Electronic health records do hold the promise of supporting exactly the kind of quality improvements and then reporting on quality improvements that you describe. I think in practice there have been a few challenges for providers.

First of all, many of the traditional electronic record systems have not been very well designed to put together data from lots of different sources and enable you to track your particular patients in the way that you really need to in order to improve their care, and a lot of providers are doing add-ons or modifications to systems to help make that happen now.

Second, from the standpoint of the meaningful use payments, so far most of those payments have been tied to whether or not, basically, you have electronic record systems that are capable of doing things like tracking a patient over time and maybe potentially reporting in on quality measures, but not actually doing it.

One way to better align the payments that providers are receiving and further the goals of getting better quality information out, especially around outcomes and improving quality, would be to move towards meaningful use payments and other payments that really do support doctors in using their systems to put these data together and then report on it from their electronic record systems.

Now, there are some concerns that that may be too big of a leap, but if you do not, as I think Senator Stabenow said earlier, focus the payments and the goals of your financing systems in Medicare and other programs on what you really want to get, it is awfully hard to get there.

Dr. MCGLYNN. And I would agree that the promise is there. Actually, larger systems invest quite a bit of money in wresting value and information out the back end of these electronic health records. So I think that there needs to be more work to make them readily usable, so, for physicians in individual practice, I think it is a much harder climb because, frankly, they are not optimized for this use right now.

I think that is very possible, and I think there are ways that we can push to make that more the case and not only possible in large systems that can make these additional investments. Half of my center's budget goes to making our data usable for research and for clinical decision support, and that is just not something everybody can afford to do.

Senator THUNE. Let me just, if I might—Dr. McClellan, if you want to respond to this, or others as well—there are also the stakeholders out there who believe that CMS has developed too many different measures. In quality improvement programs, you have things like value-based purchasing, physician quality reporting systems, electronic health records that we just mentioned, a meaningful use program, and the list goes on and on. I am wondering if you agree with that statement and, if so, what should or could be done to create a more strategic approach to enhance quality.

Dr. McCLELLAN. So there are an awful lot of measures out there, as we have said, and as I am sure you have heard from your constituents. I think I am going to maybe over-simplify things a bit, but one way of viewing what CMS is doing with all these multiple measurement systems is trying to put the same measures into each one.

So in, for example, the Physician Meaningful Use Payments and in what CMS is planning for the value-based modifier, we are seeing some of the same measures coming together. Unfortunately, it is a very long list of measures, and it is not really the smaller set of the very important outcome-oriented patient experience types of measures that really matter for patients. I think with good support in terms of financing reforms, it would be easier for providers to figure out their own best ways.

Dr. Lansky said there is a lot of innovation going on in health care delivery, and clinicians are really interested in having more resources that they can use to support better care. So, if you not only tried to align the measures across these different programs but tried to simplify them down to the measures that are really important for patients, I think it could support a lot of efforts and reduce the burden of reporting for clinicians.

Senator THUNE. Thank you.

Mr. Chairman, my time has expired.

The CHAIRMAN. Thanks, Senator.

Senator Wyden?

Senator WYDEN. Mr. Chairman, first of all, thank you for holding this special hearing on quality. It reminded me of some of the discussions that we had during health reform. There were always scores of articles about costs, and it always seemed that quality got short shrift. You said we ought to be going after that, and I think this is another indication that, when people have these debates, we ought to not just consider the quality issue an after-thought. You started talking about that a long time ago, and I appreciate it.

All of you have given excellent presentations. I am just going to ask Dr. Cassel a question or two, not just because, in Oregon, we claim her as ours. As you probably know, she was the first female dean at Oregon Health and Science University, but she was also one of the premier gerontologists that I remember reading articles about and using for the various issues that we were tackling at home.

So, Dr. Cassel, you really, I think, hit on an extremely important issue that is just now beginning to get some attention, and that is chronic care. Back when you were looking at some of the first geriatric research in Oregon and we were picking up on it in the Gray Panthers, we remember that Medicare was a very different program. There was a lot less cancer, a lot fewer strokes, a lot less diabetes. It was not the kind of chronic care challenge that it presents today.

What Senator Isakson was alluding to is that he, I, and Senator Casey, a big group of Senators, Democrats and Republicans, are very interested in this issue. I was struck by your comment that, among the challenges with respect to chronic care is that you think the quality measures with respect to chronic care are coming up short.

I was wondering what you could tell us about why that is the case. You mentioned challenges with respect to sharing data and maybe the providers in the plans are not communicating, but what is the challenge so that we can build into these bipartisan discussions on chronic care your thoughts on getting at quality, which frankly, because of Chairman Baucus, we have a chance to do this morning. I mean, nobody else is really digging into it, so I think it is a perfect time to hear your thoughts on chronic care and quality.

Dr. CASSEL. Well, thank you, Senator Wyden. Thank you for your leadership in this. I do remember those days with the Gray Panthers, and I was a fellow in geriatrics at the VA in Oregon. I remember that I had patients who had come in on a 3-hour bus ride, trying to figure out what was going to be their chief complaint, because they were only allowed one. As soon as we opened the geriatric clinic, they loved it because they could have more than one medical problem, which was the reality for many of these very elderly veterans.

Now, of course, as you point out, there are more and more people in our country, because people are living longer, which is a good thing, who are facing this issue. The quality measurement science and movement, if you want to call it that, has understandably focused initially on high-prevalence, high-yield conditions like diabetes, hypertension, heart disease. So they have looked at this one disease at a time across the spectrum and have not put as much investment into composite measures or the aggregate of a patient's outcome overall, and often these individual quality measures, as Dr. McGlynn mentioned, kind of backfire because what you might want for diabetes in somebody who does not have any other problems could be very different with a patient who also has Alzheimer's disease and is suffering from two or three malignancies and other kinds of issues, perhaps in a nursing home.

So really we need an investment in this area of aggregating information and having it all be patient-centered, all be around the individual patient and their function and their values.

In order to do that, if that were not challenging enough scientifically, we also need to get the data together from sectors outside of hospitals and doctors' offices, the traditional area that we are looking at right now—and the long-term care and community providers whom you are so familiar with have to be part of this picture as well. So I think that is doable, but I think it just needs to be lifted up and be made a higher priority.

Senator WYDEN. I still have a few seconds. Do any of your colleagues want to add to this?

Dr. MCGLYNN. So I would just add that quality measurement follows in the wake of clinical science. Frankly, clinical science has not really figured out conceptually or practically how best to deal with patients with multiple morbidities. So I think that this is something we need to do together, to figure out how to think about that.

The clinical science is pretty siloed itself, and I do not think just adding up the individual siloes is going to get us where we need to go. So these examples of engaging patients to set goals for themselves and then to measure how well the system is delivering

against those preferences is an area I think we really need to explore for this population.

Senator WYDEN. Let us do this. Chairman Baucus has been good enough to let me do this, and we have a vote on the floor. Would any of you like to make additional contributions on the question of chronic care and quality? Dr. McClellan has also been very interested in this for years. For any of you four—this has been a terrific panel. Again, Mr. Chairman, I really appreciate your doing this.

The CHAIRMAN. You bet. Thank you, Senator, very much.

The vote has begun, but we have a couple of minutes here. There are a couple of people who are not at this table. First, there are no doctors here, or any practicing doctors. [Laughter.]

Second, CMS is not at the table. We have a lot of other groups that are not at the table. Let us just start with CMS. What would you tell Marilyn Tavenner if she were here, and what would she say back to you after you told her that? [Laughter.]

Anybody? We have about 3, 4, 5 minutes.

Dr. LANSKY. I would ask her to move as rapidly as possible to use the tools she already has. She has publishing tools, she has value payment tools that can use the kinds of measures we have talked about today. That signal is the most important signal that the country needs.

The CHAIRMAN. Anybody else?

Dr. CASSEL. I would ask, and I have actually done this already, for greater flexibility in the support that CMS gives for measure development, including to NQF and groups like us that get away from fee-for-service measure development to more of an open pipeline so that we can be more rapid and more adaptive.

The CHAIRMAN. Are they not trying to do that?

Dr. CASSEL. They are trying to do that, but that would really be my urgent—

The CHAIRMAN. All right.

Dr. MCCLELLAN. We have talked some about changes in focus to measures that are outcome-oriented and simplifying and aligning all the different Medicare payment initiatives that physicians and everybody else have to face around these key measures and goals.

Beyond that, I do think she could use some legislative help in the payment systems, especially those that are completely fee-for-service-based now, like physician payment to some extent, post-acute care payment, having a piece of those payments go to something else, more flexibility for doctors to work across specialties, to work with other providers to tie those to some of these very important outcome measures that we have described. And that would take legislation.

The CHAIRMAN. So when we update SGR—

Dr. MCCLELLAN. It could be done with part of—

The CHAIRMAN. Part of that.

Dr. MCCLELLAN. A step in this direction could be done as part of even a short-term SGR bill.

The CHAIRMAN. All right.

Senator Carper, an extremely valuable member of this committee, has just arrived, and we do not have much time left. Senator Carper, it is all yours.

Senator CARPER. Thanks. Thanks so much, Mr. Chairman.

To our witnesses, welcome. It is nice to see you all. It is especially nice to see Mark. I enjoyed working with him over the years, wearing a number of different hats. But thank you all for coming. We have a bunch of things going on outside of this room today, as you know, and are trying to make some progress on those.

I want to talk a little bit about Medicare Advantage plans, if I could. If this has been asked by others, I apologize. But as you know, Medicare Advantage plans are currently judged on a variety of quality measures. I think they use a star rating system. From what you said, these quality measures seem to be effectively driving Medicare beneficiaries to choose higher-quality insurance plans.

On the other hand, Medicare fee-for-service programs to allow beneficiaries to compare quality among hospitals and providers appear to be, at least to us, outdated and used rather infrequently by seniors and by their families.

So my question is, do you think that the Medicare Advantage quality measurement system is effective for seniors? What kind of lessons should we draw from this quality system for the Medicare fee-for-service system in the private health insurance market? Please.

Dr. CASSEL. Let me start this out, but Dr. McGlynn has much more experience with the 5-star program. But I think a big part of it, Senator, is about this issue of making the measurements understandable to consumers and patients, putting the information in a broad enough framework that they can understand.

They are not going to go, or very rarely, and check individual quality measures on individual providers, and frankly that is a lot of what CMS has right now in terms of Physician Compare. The reason 5-star is successful is because it is understandable to everybody. You have four stars and five stars, and five stars is better than four stars.

So, if we had ways of describing the other parts of our quality enterprise that were as accessible as that, but that allowed you to dig down if you wanted to to get more detail about it, I think that would be hugely helpful.

Senator CARPER. Good. Thank you.

Others? Please.

Dr. MCGLYNN. I agree. That is actually consistent with a lot of research that has been done, which is to find ways to separate the details of measurement, from, are we measuring the right things to, how do we communicate that to different audiences?

The Medicare 5-star—I think what is nice about it is it produces understandable information for consumers, and, as you said, we see evidence now that there is some use for that information and it aligns incentives. And I will say at Kaiser Permanente we pay a lot of attention to the 5-star ratings in terms of driving through our system improvements that are consistent with those measures. The advantage is, with those bonuses, they go back to member benefits, so everybody wins.

The challenge is, how do you do that in a non-system? But I think that, in terms of the information, the communication aspect, absolutely that is the way to go. There are lots of systems out there, hotels, restaurants, et cetera, that use these very simple rating systems that are a roll-up of a much more complex under-the-

hood measurement, and absolutely Medicare fee-for-service fits that model.

Senator CARPER. Thank you. Let me just ask of Mark and Dr. Lansky—I had one more question I wanted to ask. Are you in general agreement with what our first two witnesses said?

Dr. MCCLELLAN. Two really quick comments.

Senator CARPER. Sure.

Dr. MCCLELLAN. It would be nice if there were more outcome-oriented components of the Medicare Advantage measures. Unquestionably, people are paying attention to them. I think you can still build in that same kind of outcome focus in Medicare fee-for-service. Let us move those in the same direction. In fact, a lot of Medicare Advantage plans like Aetna are now supporting fee-for-service providers and coordinating care and doing better on these patient-level results.

Senator CARPER. All right. Good. Thanks.

The second question. As a recovering Governor, I often think of States as good laboratories of democracy to test and perfect new ideas. You mentioned, I think, maybe Minnesota's and California's quality reporting and measurement systems as potential examples of more effective quality rating systems.

My question is, what are the lessons and best practices that Medicare should draw from the quality measurement and reporting programs in those two States, and maybe other States? Do Medicare and Medicaid have sufficient statutory authority to create similar quality reporting programs? If you can just be very, very brief. Dr. Lansky?

Dr. LANSKY. Minnesota is really a very good example, as is Wisconsin and other States. So I do think you are right: there is an opportunity to cull the best practices, especially those that are used utilizing patient-reported measures and outcome measures, which is being done in a number of the States. So I think that is an opportunity. There is no reason Medicare could not implement the same mechanisms across the country.

Senator CARPER. All right.

Dr. MCCLELLAN. Let me just add that it is not an accident that those systems are best-developed in Minnesota and California. Those States have done a lot of activities and leadership around payment reform to focus more at the person level rather than just on fee-for-service payments.

One thing that Medicare really needs to do that really could help providers is moving their payment systems away from fee-for-service, otherwise you are telling people, construct these measures, work at the patient level, but you are not paying them in a way that helps them do that.

Senator CARPER. All right.

I have to run. A vote is under way. This is great. I have been trying to get on your dance card, Mark, for a more fruitful conversation, so hopefully we can do that and I will learn even more than we have learned today.

Thank you very much for your testimony today. Thank you.

The CHAIRMAN. Thank you, Senator. Thank all four of you. Earlier on I mentioned the Edwards Deming quote that quality is the responsibility of everyone, and then I pushed you a little bit, Dr.

Cassel, who said we have to push. Well, I think, frankly, that we all need to be pushed: you all, CMS, providers, everybody, including this panel.

So let us just all agree to, not only understand that quality is everybody's responsibility, but pushing all of this is our responsibility too, because this is very important. Thank you so much. You have added a lot to this subject. Thank you.

The hearing is adjourned.

[Whereupon, at 11:45 a.m., the hearing was concluded.]

APPENDIX

ADDITIONAL MATERIAL SUBMITTED FOR THE RECORD

Hearing Statement of Senator Max Baucus (D-Mont.) On Turning Health Care Quality Measures into Real Results *As prepared for delivery*

The American statistician W. Edwards Deming once said, "Quality is everyone's responsibility."

In 1999, the nation received a wakeup call about our health care system. The Institute of Medicine published a landmark report titled, "To Err is Human."

It concluded that nearly 100,000 people die each year in hospitals due to preventable errors. That's more than die from motor vehicle accidents, breast cancer or AIDS. Americans were shocked.

High-quality care clearly needed to be more of a priority at every level: Medicare, Medicaid, insurance companies, doctors, hospitals and policymakers as well. Each group started focusing on quality.

The largest hospital accreditation group, the Joint Commission, required hospitals to report performance data.

Congress required Medicare providers to submit quality reports. Medicare created tools for beneficiaries to compare provider quality.

Hospital boards financially incentivized their leadership to improve quality.

We saw some early wins. Between 2001 and 2009, for example, central line IV infections dropped by more than half. This quality improvement saved \$2 billion, and more importantly, 27,000 lives.

When we first started to focus on quality, we realized we had a long way to go. We began by requiring providers to simply report their data.

The Affordable Care Act moved Medicare to the next level – 2.0. Instead of paying just for reporting, Medicare now pays for results.

Under new programs, Medicare will pay hospitals and physicians providing high-quality care more than those providing low-quality care.

These health reform programs will move Medicare closer to a system built around the value and not the volume of care.

Let me provide a current example. From 2007 through 2011, nearly one in five Medicare patients admitted to the hospital returned within a month. For many of them, that readmission could have been avoided.

In the Affordable Care Act, we gave hospitals incentives to reduce avoidable readmissions. Hospitals responded. They made sure patients had follow-up visits. Doctors spent more time talking with patients about their discharge plans and answering questions. We are seeing results.

I'm proud to say that from 2007 to 2012, Montana's readmission rate fell by eleven percent – the largest reduction in the country.

And last year, Medicare saw 70,000 fewer beneficiaries readmitted to hospitals nationwide.

The Affordable Care Act also worked to increase quality in Medicare Advantage plans. The law gives bonuses to plans with high quality ratings. Seniors use these ratings to pick the best plan. And tying payments to performance has made plans focus more on quality.

Since the "To Err is Human" report, everyone has worked to improve quality. It is time for us to do a gut check. What has been most effective? What can we do better?

And what are the right measures of quality? It is astounding that we don't have agreement on how to calculate the risk of dying in a hospital.

Three different commonly-used measures of mortality produce different hospital rankings. So depending on the measure, a hospital could be at the top or bottom of the list.

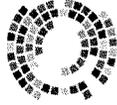
Separately, Medicare uses 1,100 different measures in its quality reporting and payment programs. 1,100 measures. While we need to recognize the differences among providers, do we really need more than a thousand measures?

And that's just Medicare. Medicaid programs and dozens of commercial insurance companies all pay differently and run their own quality programs.

Providers are pulled in different directions by different payers. And they have a tough time finding the right way forward to higher quality.

So let us identify the key measures, develop them faster, and align these efforts across payers. Let us reduce the administrative burden on providers. We all have a stake in this. After all, quality is everyone's responsibility.

###



**NATIONAL
QUALITY FORUM**

1030 15TH STREET, NW, SUITE 800
WASHINGTON, DC 20005
202 783-1300 MAIN 783-3434 FAX

“Health Care Quality: The Path Forward”

Statement of:

Christine K. Cassel, MD, MACP

Incoming President and CEO

National Quality Forum

Prepared for the Senate Committee on Finance

June 26, 2013

Written Testimony for Senate Finance Committee Hearing**Health Care Quality: The Path Forward***June 26, 2013*

Thank you Chairman Baucus and Ranking Member Hatch for inviting me to participate in today's hearing on behalf of the National Quality Forum (NQF).

My name is Dr. Christine Cassel, and I am the newly appointed President and CEO of NQF. Most recently, I was President and CEO of the American Board of Medicine and ABIM Foundation. I am board certified in geriatrics and internal medicine and have authored or co-authored 14 books and over 200 articles about quality, medical ethics, and geriatrics. I also currently serve as one of 20 scientists on the President's Council of Advisors on Science and Technology (PCAST).

Thank you for inviting me to give my first testimony as head of NQF before this distinguished panel.

Why We Are Here Today

Chairman Baucus, we commend your leadership and that of the entire committee in making it a priority to enhance the performance of the US healthcare system by establishing initiatives focused on public reporting, value based purchasing, and care delivery reforms.

As you know, these efforts are reliant on "quality measures" to assess where improvements are needed and what strategies work to improve quality. Quality performance measures can help you and other policymakers understand, for example, if linking payment to hospital readmissions rates drives down unnecessary readmissions, or if Patient-Centered Medical Homes and ACOs enhance clinical quality and help control costs.

Performance measures — if they themselves are "high quality" — help us answer these and other critically important questions about whether our public and private efforts to improve quality are paying off.

Overview of NQF

Founded in 1999, NQF is a non-profit, non-partisan organization with over 440 organizational members that span the health care spectrum — including physicians, nurses, hospitals, businesses, consumer and patient representatives, health plans, certifying bodies and other healthcare stakeholders. NQF's two main roles are: reviewing and endorsing quality measures; and convening diverse sectors that have a stake in healthcare to agree on key priorities and related measures to use in improving our nation's health.

Improving care is why I chose to serve on NQF committees before I became CEO. Last year, I was joined by over 850 other NQF volunteers — who logged about 55,000 hours or the equivalent of roughly \$4 million in donated hours — to further the quality cause. Collectively, we embody NQF's public service mission to improve the health of the nation.

Our Board of Directors is composed of 33 members—key public- and private-sector leaders who represent major stakeholders in America’s healthcare system (see Appendix A). A distinguishing characteristic of NQF is that our by-laws stipulate that a majority of the Board must be representatives of patients/consumers and purchasers. This assures a strong voice for those who receive and pay for care. By practice, patient representatives are prominent in all NQF committees and workgroups.

In terms of funding, NQF is supported by membership dues, foundation grants, and Federal funding.

How Do We Ensure that “High Quality” Measures Are Used?

It may sound simple, but it is true, that focusing on quality will only be effective if the tools we use to measure are themselves “high quality.”

For quality measurement to have an impact, the measures must be understandable to patients and payers; they need to be actionable by providers; and they need to meet high medical and scientific standards. Also, it is critical that a range of stakeholders agree on what is important to measure and that there is evidence that the measures selected can drive improvements in care.

To ensure high quality measures, we need criteria or standards. And to make sure that these measures are regularly used across the country, we need consensus or buy-in by all the sectors that have a stake in healthcare. That’s where NQF comes in.

NQF has two distinct but complementary roles focused on enhancing healthcare quality and value — endorsing measures based on rigorous criteria and, secondly, convening diverse stakeholders to gain agreement on where improvement is needed and what measures can be used to reach our goals.

More specifically:

1. NQF reviews and endorses quality performance measures against rigorous criteria.

A key role of NQF is convening clinical and other experts to review and endorse quality measures through a multi-stakeholder process. Measures recommended by these experts are then voted upon by the diverse NQF membership.

More specifically, NQF brings clinical experts from across the healthcare spectrum together to evaluate sets of quality measures. These measures are submitted to NQF from about 65 different developers from across the country, including physician specialty societies and certifying boards, the American Medical Association, The National Committee for Quality Assurance (NCQA), and others. These measures are developed largely from scientifically based clinical guidelines.

NQF does not itself develop measures. Rather, our job is to assure that measures submitted to NQF meet the following rigorous standards:

- **Importance to measure and report** – These criteria evaluate whether the measure has potential to drive improvements, including care improvements, and includes a careful evaluation of the clinical evidence.

- **Scientific acceptability of measure properties**—These criteria evaluate whether the measure will generate valid conclusions about quality; if measures are not reliable (consistent) and valid (correct), they may be improperly interpreted and providers may be mis-classified.
 - **Usability and use**—These criteria evaluate whether the measure can be appropriately used in accountability and improvement efforts.
 - **Feasibility**— These criteria require evaluators to review the administrative burden involved with collecting information on the measure. If a measure is deemed too burdensome, alternative approaches need to be considered.
 - **An assessment of related and competing measures**— These criteria require evaluators to determine whether the measure is duplicative of other measures in the field. NQF endorses best-in-class measures and where appropriate combines (harmonizes) similar measures to reduce burden associated with requests to report near-identical or “look-alike” measures.
2. **NQF convenes diverse, private sector healthcare stakeholders to provide input into the quality improvement efforts of both private purchasers and the Department of Health and Human Services (HHS).**

In addition to bringing clinical experts together to provide a scientific and clinical review of quality measures, NQF also brings diverse public and private sector stakeholders together to drive consensus on quality improvement goals, priorities, and activities. These stakeholders include patient representatives, physicians, nurses, hospitals, labor, health plans, other quality organizations and government representatives.

More specifically, the NQF-convened National Priorities Partnership (NPP) provides input to HHS on its overarching National Quality Strategy (NQS), which is focused on improving care, increasing affordability, and building healthier communities. Getting the public and private sectors “on the same page” about where to focus quality improvement efforts is critical given the size, heterogeneity, and complexity of our healthcare system.

In addition, the NQF-convened Measure Applications Partnership (MAP) makes recommendations on which measures should be used in Federal public reporting and payment programs in advance of HHS issuing related regulations, including Hospital Value Based Purchasing and the Physician Quality Reporting System (PQRS), among others. MAP recommendations help facilitate Federal programs as well as public and private “alignment” by focusing on coordinating the use of the same measures across sectors, where appropriate. For example, are blood pressure measures defined the same way in the PQRS and Meaningful Use programs? Are patient deaths calculated in a standardized way so that they may be tracked and compared across hospitals and across time?

A major result of this consensus building is creating a standard portfolio of measures that is accepted as the “gold standard,” with the measures increasingly used by public and private purchasers as well as accrediting/certifying organizations. This uniformity of quality priorities and specific measures helps lessen reporting burden on providers and sends strong signals about quality improvement goals. To this point: a recent analysis shows that about 28 percent of NQF’s library of measures are being used by two or more sectors, including the Federal government, private payers, states, communities, physician specialty societies, and others. Also, we know that the Federal government is actively using about half

of NQF's portfolio of measures in its various programs. Given its size and reach, the Federal government is an important actor in encouraging all sectors to focus on the same quality improvement goals, and NQF measures are a critical tool in this effort.

Despite this progress, some recent Congressional payment reform proposals suggest room for an additional measure review process. Setting up an additional process for approving measures would simply result in more cost and redundancy and will do little to improve care.

I strongly urge that you retain one central hub of measure review and endorsement — such as has been created at NQF — which allows for the most inclusive and effective process for bringing new quality measures into the system. To address concerns that I have heard, I am also committed to making NQF's endorsement process more efficient and responsive to community needs, including exploring the notion of establishing criteria for and endorsing measurement systems such as registries. Further, having multi-stakeholder input into measure selection is a critical strategy for driving alignment and needs to be retained.

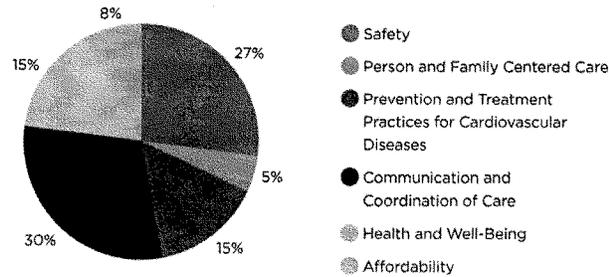
An Overall Assessment of the Current State of Quality Measures

A key question before the Committee is "Where are we on quality measurement activities?"

As described above, NQF began endorsing performance measures about a decade ago.

Based on this work, the field now has a library of about 700 NQF-endorsed measures from which hospitals, nursing homes, health plans, physicians, nurses, and others can select to focus their quality improvement activities. Most of the measures in the NQF-library are condition specific (e.g., cardiac care) and focus on clinical quality or patient safety. NQF looks to priorities in the HHS National Quality (see chart below) as a guide to where we should focus our endorsement efforts to support the nation's quality improvement goals. Current goals include an increased focus on person and family centered care, improving affordability and increasing population health (part of health/well-being).

How NQF-Endorsed Measures Stack Up Against National Quality Strategy Priorities (2012)

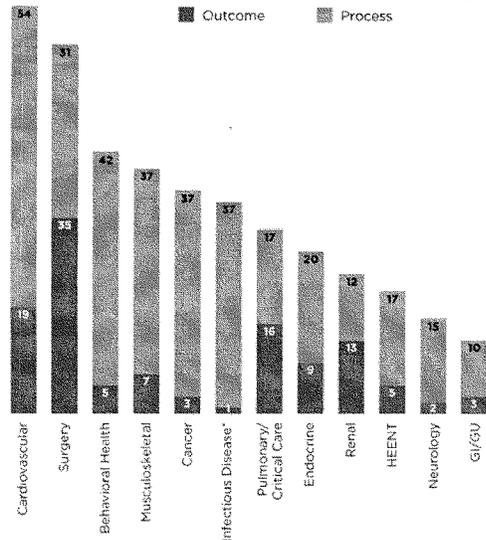


There is also a need to ramp up our review of “cross-cutting measures” that can evaluate the impact of care provided across settings and on increasing the proportion of “outcome measures” (i.e., measures that reflect the end results of care) in our portfolio.

Regarding outcome measures, we are working hard to transform our quality system away from focusing on “process measures,” which have served as the building blocks for quality improvement efforts, to a system focused on the end results or outcomes. Based on these efforts, the percentage of outcome measures in the NQF portfolio has grown from 18 percent to 27 percent over the last 2 years.

As we increase our focus on outcome measures, we have made progress in some areas, like surgery and cardiac care, but much work lies ahead to bring more outcome measures into our system. See the chart below for more specificity about NQF-endorsed, condition-specific measures.

Measures Receiving NQF Endorsement in 2012, by Category



*Additional outcome measures captured in safety areas (not shown).

While we are working to bring more “high impact” measures into the system, we are also working to strategically streamline our measures to ensure only the best-in-class are on the market.

In this vein, in 2012 NQF retired more measures from its portfolio than it added with respect to new measures. NQF removes measures that are no longer effective or evidence-based; replaces existing measures with those that are better, reflect new medical evidence, or are more relevant; and expands the portfolio to bring in measures that fill gaps and can help achieve the National Quality Strategy.

That said, there is always more work to be done to ensure NQF is retaining and endorsing the best possible measures so as to limit the reporting burden on health care providers, where appropriate.

NQF's Portfolio of Endorsed Measures: 2012 at a Glance

Let me provide further details on NQF's measure endorsement efforts in 2012.

Last year, NQF completed 16 endorsement projects — reviewing 430 submitted measures and endorsing 301 new and existing measures, or about 70 percent of those reviewed. This included 81 new measures and 220 measures that maintained their endorsement after being considered in light of any new evidence and/or against new competing measures submitted to NQF for consideration.

More specifically in 2012, NQF endorsed:

- **Patient safety measures.** Preventable medical errors cost the United States close to \$29 billion per year in additional healthcare expenses, lost worker productivity, and disability.¹ NQF endorsed 32 patient safety measures in 2012, including healthcare-associated infections, falls, medication safety, and pressure ulcers.
- **Resource use measures.** The full spectrum of healthcare stakeholders, including consumers and business leaders, is increasingly attuned to affordability and focused on how we can measure and reduce healthcare expenditures while improving care. NQF endorsed its first set of resource use measures in January 2012, and it endorsed an additional set in April 2012. These measures are primed to offer a more complete picture of what drives healthcare costs. Used in concert with quality measures, they will enable stakeholders to identify opportunities for creating a higher value healthcare system.
- **Patient experience measures.** Measures endorsed include a measure evaluating patient satisfaction during hospitalization for surgical procedures; measures focused on effective provider communication with patients regarding disease management, medication adherence, and test results; seven related measures that address health literacy, availability of language services, and patient engagement with providers; and measures that evaluate how bereaved family members perceive care provided to loved ones in long-term care facilities and hospitals.
- **Harmonized behavioral health measures.** In 2012, NQF endorsed 10 measures related to mental health and substance abuse, including measures of treatment for individuals experiencing alcohol or drug dependent episodes; diabetes and cardiovascular health screening for people with schizophrenia or bipolar disorder; and post-care follow-up rates for hospitalized individuals with mental illness. As a part of this process, NQF also brought together CMS and the National Committee for Quality Assurance (NCQA) to integrate two related measures into one measure, addressing antipsychotic medication adherence in patients with schizophrenia.
- **A measurement framework for those with multiple chronic conditions.** People with multiple chronic conditions (MCCs) now comprise more than 25 percent of the U.S. population^{2,3} and are more likely to receive care that is fragmented, incomplete, inefficient, and ineffective.^{4,5,6,7,8} Despite the growing prevalence of people with MCCs, existing quality measures typically do not address issues associated with their care, largely because of data-sharing challenges and because measures are typically limited to addressing a singular disease and/or specific setting. As a response to these challenges, NQF endorsed a measurement framework for developers to use that establishes a shared vision for effectively measuring the quality of care for individuals with MCCs.
- **Healthcare disparities measures.** Research from the Institute of Medicine shows that racial and ethnic minorities often receive lower quality care than their white counterparts, even after controlling for insurance coverage, socioeconomic status, and comorbidities.⁹ NQF commissioned a paper outlining methodological issues and an approach to identify measures that are more sensitive to disparities and as such should be stratified. From there, NQF endorsed 12 performance measures, focused on patient-provider communication, cultural competence, language services, and others.

What are Some Examples of How NQF-Endorsed Quality Measures Have Driven Care Improvements or Reduced Costs?

While there is still great progress to be made, NQF-endorsed measures have helped spur care improvements on the ground and, in some cases, have helped make a dent in our nation's rising healthcare costs.

A few examples of how NQF-endorsed measures have made a difference include:

- **Quality Measures have Helped Drive Patient Safety Improvements**
 - **Many hospital acquired infections are on the decline through the use of standardized quality measures, including central line associated blood stream infections (CLABSIs):** The use of quality measures and the underlying clinical guidelines they are based on have contributed to patient safety gains in hospitals, including a CDC-reported 58 percent reduction in CLABSIs between 2001 and 2009. This represents up to 6,000 lives saved and approximately \$1.8 billion saved in cumulative excess healthcare costs.¹⁰
 - **Hospitals that implement safe practices have better outcomes:** A peer reviewed study of more than 650 hospitals showed a decline in mortality in those hospitals that have fully implemented NQF-endorsed Safe Practices.¹¹
- **Quality Measures have Contributed to Better Health Outcomes**
 - **Improvements in Medicare's ESRD Quality Incentive Program:** In just two years, the majority of dialysis facilities showed significant improvement on the program's three clinical process measures related to dialysis adequacy and anemia management, which have a tight link to improvements in ESRD patient outcomes. Improvements on these process measures and early fistula placement are associated with a decrease in ESRD-related hospitalizations and death.^{12,13}
 - **A reduction in inappropriate, early elective deliveries before 39 weeks is resulting in healthier babies and lower costs:** Reports from the field suggest that current early delivery rates of 10 to 15 percent can be brought below 5 percent if quality guidelines developed by the American College of Obstetrics and Gynecology are followed, avoiding an estimated 500,000 days in NICUs and about \$1 billion in costs. Once this measure is publicly reported in 2014, it will allow patients to assess whether hospitals are prioritizing the safety of babies and Moms or unwittingly putting them in jeopardy.¹⁴
 - **Hospital readmission rates are coming down:** Before the adoption of hospital readmission measures and a related quality improvement and payment program, the 30-day all-cause hospital readmission rate held steady between 2008 and 2011 at an average of 19 percent. Once NQF-endorsed readmissions measures were adopted, the readmission rate dropped to 18.4 percent for the full year of 2012 and to 17.8 percent for the final quarter of 2012. While this is an early finding, it is promising.¹⁵
- **Quality Measurement is Also Helping in Prevention Efforts and Chronic Care Management**
 - **Focus on diabetes care greatly reduces worse effects of the disease on patients.** A long-time effort at HealthPartners in Minnesota to effectively care for patients with diabetes has greatly reduced the long-term effects of the disease. More specifically, data given to NQF from HealthPartners comparing over 32,000 HealthPartners members with diabetes in 2011 to the same number of members in 2000, members suffered 386 fewer heart attacks and 71 fewer leg amputations, and 692 people did not experience eye complications. This is a major success in chronic care management.

- **Publicly reporting measures improved physician group performance:** Physician groups in Wisconsin that publicly reported NQF-endorsed quality measures between 2004 and 2009 improved patient care on key indicators, e.g., cholesterol control and breast cancer screening, outperforming the rest of Wisconsin, nearby states of Iowa and South Dakota, and the United States as a whole.¹⁶
- **A multi-prong approach to measurement plus payment incentives demonstrated results over 10 years:** Two hundred physician groups in California associated with the Integrated Healthcare Association have participated in a pay-for-performance program over a number of years. In 2012, 47 of the physician groups received performance awards for meeting benchmark performance for meaningful use of health IT, patient experience, and clinical measures in key areas: cardiac, diabetes, musculoskeletal, respiratory, and prevention.¹⁷
- **The bar for quality measures gets raised over time.** A long-standing NQF-endorsed measure related to the use of beta blockers within seven days after an acute myocardial infarction (AMI) provides an example of driving real change in our health system. As focus on this measure ramped up over time, mortality for heart attack patients fell. Based on the progress in this area (nearly 100 percent compliance at this time), this measure was retired, and a new measure entered the system where progress still lacks. This new measure focuses on patient use of beta blockers for six months after an AMI which can help prevent another AMI and further reduces patient mortality.

Despite these compelling examples, the nation has not come as fast or as far as expected.

There is no single reason why we haven't made even greater gains, but a number of roadblocks continue to stand in the way of improving quality further and reducing costs. These include:

- **Our ability to capture and report clinically rich and meaningful performance measures information, despite increased penetration of electronic health records.** Although between 70 and 75 percent of practicing physicians¹⁸ and approximately 80 percent of all eligible hospitals and critical access hospitals in the United States have received an incentive payment for adopting, implementing, upgrading, or meaningfully using an EHR,¹⁹ this has not yet translated into accurate electronic capture and reporting of performance results as part of the care process. In fact, only about 10 percent of measures submitted to NQF for endorsement are e-Measures, or specified for use in an electronic environment. Also, reports from the field suggest that EHRs are not consistently producing reliable quality data;²⁰
- **The quality measurement community now has the data to begin developing outcome measures, but more must be done to encourage all stakeholders to work together towards shared quality goals.** Recent public and private campaigns to address well recognized quality problems, e.g., healthcare acquired infections and early elective deliveries, have proved or are beginning to prove successful and should be replicated for other pressing problems.²¹ These campaigns should also include a focus on training in quality measurement science, culture change, and work redesign.
- **A lack of alignment across sectors, which has produced a tsunami of quality reporting requirements.** Despite efforts to align across stakeholders, hospitals and physicians still face requests for reporting of "look alike" measures and are inundated with requests for data. More must be done to find consensus among sectors on which measures should be used to improve care.

- **Leaders of physician and nursing organizations need to invest more in quality and help lead the way forward.** Quality and resource stewardship is a key tenet of a 21st century definition of professionalism and should be woven into the fabric of practice and viewed as a fundamental focus of clinician leadership.

What is on the horizon for measurement and quality improvement?

Against the backdrop of the progress we've made and the challenges we still face, we are now looking toward what is on the horizon for the quality measurement movement.

As in strategies related to care delivery and payment reform, our efforts will continue to focus on how quality measurement can be used to make our system more patient-centered and better coordinated. Our efforts will also continue to focus on how measurement can be used to drive down costs, while also increasing value in our health system.

To achieve these goals, I believe the future of quality measurement includes:

- **A continued and increasing focus on patient experience and patient reported outcomes.** Our healthcare system is still more provider-centered than patient-centered, and our measures reflect as much. To turn in a new direction, we need more emphasis on assessments of patient experience of care and self-reporting of health status and functioning. One way to do this may include partnering with other sectors to leverage technologies (such as smart phone applications) that can help facilitate the sharing of information. This and other innovative ideas should be explored.²²
- **Placing a priority on bringing measures into the market that move beyond a single, discrete focus to a broader view of patient care.** A key goal of NQF is bringing more "composite measures" and cross-cutting measures into the health system. The composite measures combine quality information within a given clinical area to provide patients, providers, and payers a more holistic and summary view of care in a given area; cross-cutting measures can provide information about care that spans clinical settings and providers.
- **Ramping up our efforts to figure out how to really assess "value." We must continue to strive toward driving value — the intersection of cost and quality — in our health system.** This is a key focus of the hundreds of experts involved in NQF processes and is critical as the health system continues to shift toward value based purchasing programs.
- **Continuing to work within NQF to ensure we are operating as efficiently, effectively, and inclusively as possible.** At NQF, we are continuously evolving our endorsement process as the science of measurement changes and as the needs of measure developers and other stakeholders evolve. More specifically, we are:
 - **Continuing to strategically manage the NQF portfolio of endorsed measures** – bringing in high priority measures to fill gaps and removing measures whose value has diminished;
 - **Speeding up the review and endorsement processes** – This plan builds upon the success NQF has already had in reducing the measure review cycle time from 12 to 7 months. It includes setting up standing committees and moving away from committees appointed for

each project. Standing committees would reduce project start-up time; reduce time between measure submission and measure review; and move to single flow processing of measures, encouraging developers to submit measures whenever they are available and ready for consideration.

- **Continuing to leverage existing multi-stakeholder forums to further alignment and address challenging measure and measure information issues.** Recent examples include using our multi-stakeholder processes to review and work through difficult issues related to the implementation of hospital readmissions measures and fostering tighter alignment in use of the same measures across different stakeholders.

What will it take to get there?

As I close out my testimony, I thought I would take a few more moments to outline critical activities that we — as a quality community — should undertake to help move our quality improvement efforts forward.

These ideas include:

- **More upstream, strategic, and coordinated measure development that is laser focused on filling high priority gaps.** Today, while there are many talented individuals and organizations out in the field developing measures, there is little coordination or organization in this area. This has resulted in duplicative measures being developed, and there is no clear sense in the community about the top ten measure gaps that need filling. HHS can help drive this and NQF can play an important role.²³
- **Electronic systems to facilitate measure development and endorsement processes.** Electronic systems will help facilitate a more iterative, faster measure development process and help support a more seamless inter-digitation between development and endorsement. NQF is working on this with CMS, ONC, and measure developers.²⁴
- **An evolution of the current review and endorsement process to meet changing needs.** A recognition that registries and other strategies such as Choosing Wisely contribute to quality improvement. More must be done to appropriately leverage these activities to improve quality and reduce administrative burden on providers. Congress has recognized the need for more flexibility and the recent fiscal cliff bill suggested openness to innovation.
- **More measurement information “sense making” for patients/families and policymakers.** We need to move from a focus on many measures, to measures that really matter to providers, to patients, and to purchasers — after all, our primary audience should be the end users of healthcare and those charged with oversight of healthcare resources.
- **Finally, we need continued support in both the public and private sectors for the measurement and quality improvement enterprise.** Neither the public nor private sector can make progress alone. Continued achievements will require commitments of resources, time, and focus. Without this support, quality improvement efforts will stop short at a time when real progress is on the horizon.²⁵

While the quality community is proud of the advancements we have made over the last decade, we are also excited for the opportunities and possibilities that lay ahead to further improve our nation's healthcare system. We look forward to continuing down this quality road together.

Thank you, again, for the opportunity to provide this testimony on behalf of the National Quality Forum.

I look forward to answering your questions

¹ Institute of Medicine. *To Err is Human*. Washington, DC: National Academies Press; 2001.

² Department of Health and Human Services (HHS), Office of the Assistant Secretary for Health (ASH). *Initiatives*, Washington, DC: HHS, ASH: 2011. Available at <http://www.hhs.gov/ophhs/initiatives/mcc/index.html>. Last accessed December 2011.

³ Thorpe KE, Howard DH. The rise in spending among Medicare beneficiaries: the role of chronic disease prevalence and changes in treatment intensity. *Health Aff*. 2006;25(5):w378-w388.

⁴ Gijssen R, Hoeymans N, Schellevis FG, et al. Causes and consequences of comorbidity: a review. *J Clin Epidemiol*. 2001;54(7):661-674.

⁵ Boulton C, Wieland GD. Comprehensive primary care for older patients with multiple chronic conditions: "nobody rushes you through". *JAMA*. 2010;304(17):1936-1943.

⁶ Parekh AK, Barton MB. The challenge of multiple comorbidity for the US health care system. *JAMA*. 2010;303(13):1303-1304.

⁷ Wolff JL, Starfield B, Anderson G. Prevalence, expenditures, and complications of multiple chronic conditions in the elderly. *Arch Intern Med*. 2002;162(20):2269-2276.

⁸ Boyd CM, Boulton C, Shadmi E, et al. Guided care for multimorbid older adults. *Gerontologist*. 2007;47(5):697-704.

⁹ Institute of Medicine (IOM). *Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care*. Washington, DC: National Academies Press; 2003. Available at <http://www.nap.edu/openbook.php?isbn=030908265X>. Last accessed August 2012.

¹⁰ Centers for Disease Control and Prevention. "Vital Signs: Central Line Bloodstream Infections—United States, 2008 and 2009." *Morbidity and Mortality Weekly Report*, 60:243-248, 2011.

¹¹ Department of Health and Human Services (HHS), Office of the Assistant Secretary for Health (ASH). *Initiatives*, Washington, DC: HHS, ASH: 2011. Available at <http://www.hhs.gov/ophhs/initiatives/mcc/index.html>. Last accessed December 2011.

¹² Rocco MV, MD, Frankenfield DL, DrPH, Hopson SD, MSPH, et al. Relationship between Clinical Performance Measures and Outcomes among Patients Receiving Long-Term Hemodialysis. *Annals of Internal Medicine* 2006; 145:512-519.

¹³ Berenson RA, Pronovost PJ, Krumholz HM. "Achieving the Potential of Health Care Performance Measures, *Timely Analysis of Immediate Health Policy Issues*." Robert Wood Johnson Foundation Urban Institute, May 2013.

¹⁴ Clark SL, MD, Donna RF, RN, MN, Janet AM, RN, et al. Reduction in elective delivery at <39 weeks of gestation: comparative effectiveness of 3 approaches to change and the impact on neonatal intensive care admission and stillbirth. *American Journal of Obstetrics and Gynecology*. November 2010.

¹⁵ Gerhardt G, Yemane A, Hickman P, et al. *Medicare & Medicaid Research Review*, 3(2):E1-E12, 2013.

¹⁶ Lamb, GC, Smith, MA, Weeks, WB, Queram, C. Publicly Reported Quality-Of-Care Measures Influenced Wisconsin Physician Groups To Improve Performance. *Health Affairs*, March 2013 32:536-543.

¹⁷ Ernst, Cindy R. "Integrated Healthcare Association Honors Top Performing and Most Improved California Physician Organizations." September 12, 2012. Integrated Healthcare Association. Print.

¹⁸ Terry, K. "EHR Adoption Passes the Tipping Point." *InformationWeek Healthcare* 2 October 2012.

¹⁹ Department of Health and Human Services, Press Office. "Doctors and Hospitals' use of health IT more than doubles since 2012." May 22, 2012. Accessed on June 24, 2013, <http://www.hhs.gov/news/press/2013pres/05/20130522a.html>.

²⁰ DesRoches CM, DrPH, Audet AM, MD, Painter M, MD, et al. "Meeting Meaningful Use Criteria and Managing Patient Populations: A National Survey of Practicing Physicians." *Annals of Internal Medicine* 2013;158(11):791-799.

²¹ Berenson RA, Pronovost PJ, Krumholz HM. "Achieving the Potential of Health Care Performance Measures, Timely Analysis of Immediate Health Policy Issues." Robert Wood Johnson Foundation Urban Institute, May 2013.

²² Ibid.

²³ Conway PH, MD, MSc, Mostashari F, MD, MPH, Clancy C, MD, The Future of Quality Measurement for Improvement and Accountability, *JAMA*, 2013; 309(21): 2215-2216.

²⁴ Ibid.

²⁵ Berenson RA, Pronovost PJ, Krumholz HM. "Achieving the Potential of Health Care Performance Measures, Timely Analysis of Immediate Health Policy Issues." Robert Wood Johnson Foundation Urban Institute May 2013.

Appendix A - National Quality Forum Board of Directors

William L. Roper, MD, MPH, Chair Dean, School of Medicine Vice Chancellor for Medical Affairs and Chief Executive Officer, UNC Health Care System, University of North Carolina at Chapel Hill	Helen Darling, MA, Vice Chair President, National Business Group on Health
Christine K. Cassel, MD Incoming President and CEO	Gerald M. Shea, Treasurer and Interim CEO Assistant to the President for External Affairs, AFL-CIO
Lawrence M. Becker Director, HR Strategic Partnerships Xerox Corporation	JudyAnn Bigby, MD Secretary, Executive Office of Health and Human Services Commonwealth of Massachusetts
Leonardo Cuello Staff Attorney National Health Law Program	Jack Cochran, MD, FACS Executive Director The Permanente Federation
Maureen Corry Executive Director Childbirth Connection	Joyce Dubow Senior Health Care Reform Director AARP Office of the Executive Vice-President for Policy and Strategy
Robert Galvin, MD, MBA Chief Executive Officer, Equity Healthcare The Blackstone Group	Ardis D. Hoven, MD Chair, Board of Trustees American Medical Association
Charles N. Kahn, III, MPH President Federation of American Hospitals	Donald Kemper Chairman and CEO Healthwise, Inc.
William Kramer Executive Director for National Health Policy Pacific Business Group on Health	Harold D. Miller President and CEO Network for Regional Healthcare Improvement
Elizabeth Mitchell CEO, Maine Health Management Coalition	Dolores L. Mitchell Executive Director Commonwealth of Massachusetts Group Insurance Commission
Mary D. Naylor, PhD, RN, FAAN Director, New Courtland Center for Transitions & Health and Marian S. Ware Professor in Gerontology University of Pennsylvania School of Nursing	Debra L. Ness President National Partnership for Women & Families
Samuel R. Nussbaum, MD Executive VP and Chief Medical Officer WellPoint, Inc.	J. Marc Overhage, MD, PhD Chief Medical Informatics Officer Siemens Medical Solutions, Inc.

John C. Rother, JD President and CEO National Coalition on Health Care	Bernard M. Rosof, MD Chair, Board of Directors Huntington Hospital, and Chair, Physician Consortium for Performance Improvement (PCPI)
Bruce Siegel, MD, MPH President and Chief Executive Officer National Association of Public Hospitals and Health Systems (NAPH)	John Tooker, MD, MBA, FACP Associate Executive Vice President American College of Physicians
Richard J. Umbdenstock, FACHE President and CEO American Hospital Association	
DHHS REPRESENTATIVES	
CMS Centers for Medicare & Medicaid Services Designee: Patrick Conway, MD Chief Medical Officer	AHRQ Carolyn M. Clancy, MD Director, AHRQ Designee: Nancy Wilson, MD, MPH Senior Advisor to the Director
HRSA Mary Wakefield, PhD, RN Administrator, Health Resources and Services Administration Designee: Terry Adirim, MD Director, Office of Special Health Affairs	CDC Thomas R. Frieden, MD, MPH Director, Centers for Disease Control and Prevention Designee: Peter A. Briss, MD, MPH Captain, U.S. Public Health Service Medical Director
EX OFFICIO (NON-VOTING)	
Ann Monroe Chair, Consensus Standards Approval Committee President, Health Foundation for Western and Central New York	Paul C. Tang, MD, MS Chair, Health Information Technology Advisory Committee Vice President and Chief Medical Information Officer Palo Alto Medical Foundation

**STATEMENT OF HON. ORRIN G. HATCH, RANKING MEMBER
U.S. SENATE COMMITTEE ON FINANCE HEARING OF JUNE 26, 2013
HEALTH CARE QUALITY: THE PATH FORWARD**

WASHINGTON – U.S. Senator Orrin Hatch (R-Utah), Ranking Member of the Senate Finance Committee, delivered the following opening statement at a committee hearing evaluating efforts to advance high quality healthcare in America:

I'm pleased that we're having a series of hearings addressing different parts of our healthcare system.

Last week's hearing showed us that transparency goes beyond price to include quality as well. Indeed, the price-quality equation should help us determine the value of our healthcare.

Currently there is so much marketing around provider quality, particularly with regard to hospitals.

Everyone seems to be claiming to be the best at something. Many of these claims are based on proprietary data, making it hard for consumers to have an accurate picture of our healthcare system.

Perhaps quality is in the eye of the beholder.

I hope that today's hearing will help us to better understand another very important part of our healthcare system. For years, providers, payers, and federal programs have been consumed with measuring quality with an eye towards altering the payment system to reward better quality care.

I understand how complicated it can be.

My concern is that the system as it currently stands seems quite unorganized, focusing on far too many things. We need to be very mindful that the primary purpose of quality measurement is to promote quality improvement.

To be clear, I think a focus on measurement is the appropriate first step in building a solid foundation for quality. However, I wonder whether we have the right tools in place to help clinicians learn how to improve, rather than simply showing them how they compare to their peers.

Assessing a starting point is important, but ultimately the goal should be to improve care for every patient and that means giving clinicians the necessary resources in terms of best practices and care management.

It also means providing clinicians with clear and consistent definitions of clinical concepts. If our collective goal is to ensure that every patient receives the right care, in the right place, and at the right time, providers need to know how those are defined and determined.

Because data will be determined by measurement, it's imperative that we get measurement right in first place.

Providers should have confidence in the data being used to assess their care and the payment for that care.

In addition, we need to remember that the job of a clinician is to provide care to patients, not spend an unreasonable part of their day inputting data for measurement purposes.

It seems to me that, in order for quality programs to be successful, the collection of data needs to be as streamlined as possible and simply be an outgrowth of routine clinician workflow.

I have the good fortune to represent a state with some of the highest quality healthcare providers in the nation. They are constantly striving to do better, and I commend them for that. However, I am aware that some providers in this country are struggling to make improvements.

I think we need to understand and appreciate that resources vary greatly across this country and this has an impact on quality data. Sometimes quality scores might not truly reflect the care being given at an institution.

But, I want to be clear about this – efficient and high-quality care must be an expectation that we have, not merely a goal. And we cannot accept providers not making quality a top priority.

Our witnesses this morning will share with us all of the activities going on in the quality space today, both in the Medicare and Medicaid programs, as well as the private sector. With so much at stake, and so many taxpayer dollars going into various reporting initiatives, I would encourage all of us to work together to ensure that the process is well thought out, streamlined, and moves us towards improving outcomes in care, which is the ultimate goal.

And so, Chairman Baucus, thank you, once again, for convening this hearing today and I look forward to hearing from our witnesses and learning about our collective progress in advancing high quality health care in this country.

###



221 MAIN STREET, SUITE 1500
SAN FRANCISCO, CA 94105
PBGH.ORG
OFFICE 415.281.8660
FACSIMILE 415.520.0927

Statement for the Record

Pacific Business Group on Health

Hearing before the United States Senate Committee on Finance

"Health Care Quality: The Path Forward"

June 26, 2013

Statement of:

David Lansky, Ph.D.

President and CEO

Pacific Business Group on Health

Introduction

Good morning. My name is David Lansky, and I am the President and Chief Executive Officer of the Pacific Business Group on Health (PBGH). On behalf of PBGH, I would like to express our appreciation to Chairman Max Baucus and Ranking Minority Member Orrin Hatch for convening today's hearing on the path forward for improving health care quality. I applaud the Committee for its efforts to promote the use of performance measures to drive improvements in our health care system.

Background

The Pacific Business Group on Health represents large health care purchasers who are working together to improve the quality and affordability of health care. PBGH consists of 60 member organizations, with employees in all 50 states, which provide health care coverage to 10 million Americans and their dependents. Our members include many large national employers such as GE, Wal-Mart, Boeing, Tesla, Target, Disney, Intel, Chevron, Wells Fargo and Safeway, as well as public sector purchasers such as CalPERS and the City and County of San Francisco.¹ PBGH and its members have been leaders, both in California and nationally, in implementing innovations in care delivery, provider payment, and consumer choice.

I have served in a variety of leadership roles in quality measurement and health information technology. I have served as a board member or advisor to the National Quality Forum, the National Priorities Partnership, the Joint Commission, the National Patient Safety Foundation, the Leapfrog Group, and the Medicare Beneficiary Education Advisory Panel. I also was the founding President of the Foundation for Accountability (FACCT), a public-private venture developing quality measures and web-based tools to help consumers and purchasers assess the value of health care services and providers. I currently serve as the purchaser representative on the federal Health Information Technology Policy Committee and, until recently, I chaired its Quality Measures Workgroup. I also serve as a member of the Congressional Budget Office's Panel of Health Advisers.

¹ Full list of PBGH members can be found at <http://www.pbgh.org/about/members>.

In 1979, I began working for a heart surgeon in Oregon who happened to have been the co-inventor of the first successful artificial heart valve – which he had implanted in a patient in 1959. Dr. Albert Starr was remarkable in many ways, but most important to me was his passionate belief in the continuous improvement of medical care. He believed that the state-of-the-art techniques he used in 1959 or 1979 would be regarded as antiquated or even foolish twenty or fifty years later. And he was committed to being among those who discovered the better way. So when he began implanting heart valves in 1959, and later performing bypass surgery, he committed himself to keeping track of every patient until he or she died, and of monitoring changes to their overall health and cardiac health every year. As a result, he built one of the world's largest databases on patient outcomes from heart surgery, and was able to publish the first studies of the long-term effectiveness of different heart implants and surgical techniques. He subjected himself to rigorous, continuous measurement of his patients' outcomes because he wanted to learn what worked and what didn't, and because he cared about whether his treatments helped his patients to live longer and healthier lives.

I have known many physicians with personal dedication similar to Dr. Starr's. They have demonstrated that it is possible to measure the results of medical care in systematic ways, and in ways that matter to you and me as patients, and to the employers and government agencies who pay the bills. After I have heart surgery or a stent, will I feel less chest pain? Will I be able to climb stairs, play golf, and live a normal life? If I have a knee replacement, how likely is it that I will have a serious infection or dislocation of the new joint? Will I be able to walk or play tennis, will I feel less pain? If my child has asthma, will treatment help him play school sports, sleep through the night, and stay out of the emergency room? Which doctor in my town is better at helping my child achieve a normal life?

These are the outcomes American families and employers care about – improvements in quality of life, functioning, and longevity. Alas, we have been operating a measurement enterprise for over twenty years that leaves us unable today to make any of these straightforward judgments about the quality of doctors, hospitals, or health care organizations.

Quality Measurement

There are many reasons to measure quality systematically. Of course one is Dr. Starr's: to help clinicians evaluate and improve the care they provide. But in today's environment, three other reasons are at least as important. First, patients have a fundamental right to know whether they are likely to receive good care from a doctor or hospital they are considering. Increasingly, patients are bearing a large proportion of the costs of care, and must make decisions about where to seek care while weighing the likely benefits and costs of the services they are considering. We do the American people a disservice if we impose increasing costs on them with no information on quality.

Second, employers and other purchasers of care are committed to improving the value of the health care services they pay for. PBGH's member organizations are experiencing annual increases in health care costs well above inflation. These increases are eroding their profitability and competitiveness and undercutting employee wages – and workers and companies do not appear to be receiving any increase in value for these extraordinary expenditures. In no other area of their business do our members incur ever-increasing costs with no corresponding benefit. PBGH members are committed to identifying those providers most likely to achieve good results and using innovative contracting and benefit designs to assist patients in getting care from those providers. This is a fundamental and almost universal strategy of PBGH's member companies, but they are unable to execute it effectively without standardized, comparative quality information.

Finally, we have a well-documented national failure in accountability. Our society is spending upwards of \$2.8 trillion dollars every year on health care – and our federal government is responsible for \$750 billion of that. It is unconscionable that we have virtually no information to indicate if these dollars are well spent. Innumerable research studies from communities and institutions throughout the country suggest that much of this spending is unnecessary or even harmful. So the third reason to measure health care quality is to evaluate and improve the effectiveness and accountability of our health care system.

Purchaser Perspective on Quality Measurement

I am speaking with you today on behalf of large health care purchasers. I cannot overstate their frustration with our government, with their insurance carriers, and with the community of health professionals and institutions. We have collectively failed to establish the infrastructure that would permit a robust health care marketplace to exist. Instead, the absence of useful quality information leaves them and the American people in an unacceptable situation, where the only information to differentiate hospitals or clinics or doctors is their price tag. It's as if the SEC had mandated disclosure of the price of a security -- but nothing about the company itself or its financial performance -- and we expected investors to make smart choices.

Recent efforts at establishing national standards for quality measurement were stimulated by three factors: first, prior to the 1990s, in the absence of national standards, every health plan and every purchaser came up with its own way of measuring performance. This created chaos and unreasonable burden for the individual providers who were being measured, leading to general recognition that a standardized set of performance measures should be developed. A second factor was Congressional direction to the Medicare program to shift hospital and physician payment towards "value" -- which required some fair and objective way of measuring quality. In addition, introduction of new Medicare payment models such as Medicare Advantage, accountable care organizations, and episode payments naturally raised questions about whether these models provided care that was as good as or better than the prevailing system, and CMS was appropriately obligated to apply strong evaluative measures to these programs. In all of these cases, we recognized that the production of standardized national quality measures is a public good. It cannot be achieved by the private sector alone. It is the responsibility of the government to ensure the availability of quality performance information that permits the health care market to work. And the government has thus far failed to meet this responsibility. As a result, the market does not work, putting millions of people at risk of poor quality outcomes and perpetuating the tsunami of unaccountable spending that is sabotaging our economy.

Today, however -- almost 20 years since the widespread adoption of the HEDIS and CAHPS measures for managed care plans, and fifteen years since President Clinton's commission on

health care quality² recommended an accelerated process for developing quality measures – we still do not have the performance measures we need. At a strategic planning session last week, I asked the members of PBGH to rate the value of the existing performance measurement enterprise to meet their needs. Their response? “Abysmal.” Today, these private sector leaders are developing innovative provider contracts and benefit designs, but find themselves forced to develop their own quality requirements and measures. They need better measures now. For my members, new measures are needed within 18 or 24 months – much more quickly than the cycle time of today’s quality measurement enterprise. The failure to create a useful and responsive national strategy and reporting infrastructure will lead to a proliferation of new measures – some valuable and some meaningless, but all creating headaches and costs for doctors and hospitals across America. A proliferation of *ad hoc* measures will not lead to a much-needed improvement in patients’ understanding of their own care.

Health care purchasers encourage the Congress to take note of four observations and to take steps to remedy them:

1. The quality measurement enterprise has failed to meet the needs of consumers and purchasers. Those who receive and pay for health care should be the primary voice in identifying the quality measures to be used in holding physicians and hospitals accountable for providing high quality patient-centered care.
2. The measures available today are not capable of driving a successful private sector health care market. We need to rapidly develop and use measures that matter most to consumers, purchasers, providers and health plans.
3. The nation does not yet have the information infrastructure needed to support a viable health care marketplace. Federal leadership is needed to go beyond the EHR incentive program created in 2009.
4. Congress has already legislated a quality measurement framework but the government has failed to fulfill its mandate. Congress should hold HHS accountable for establishing

² The President’s Advisory Commission on Consumer Protection and Quality in the Health Care Industry said, in 1998: “Steps should be taken to ensure that comparative information on health care quality is valid, reliable, comprehensive, and available in the public domain for use by consumers, purchasers, practitioners, quality oversight organizations, and others,” and “applicable to each sector of the industry (i.e., health plans, hospitals, nursing homes, individual physician practices, etc.)” See <http://archive.ahrq.gov/hcqual/final/execsum.html>.

the information tools and infrastructure to support a successful health care marketplace.

1. Ensure that the Measurement Enterprise reflects the needs of patients and purchasers

Many parties have a stake in the development and use of better health care performance measures. PBGH has worked collaboratively with providers, payers, consumers and other stakeholders to support efforts to improve health care quality and outcomes while at the same time getting better value for the health care dollar. We engage in, and sometimes lead, multi-stakeholder collaborative processes to develop, evaluate, endorse, and recommend performance measures for use in federal and California-based reporting and payment programs. Provider involvement is critical in this process, but the ultimate stakeholders and decision-makers are those who receive and pay for medical care. Congress should make explicit that the process for developing and implementing standardized performance measures must reflect the interests of patients, purchasers, and society at large.

2. Develop and Require Collection of Better Performance Measures

There is wide variation in the quality of care patients receive from health care providers. Useful measures will permit patients and purchasers to discriminate among available service providers along the dimensions they care most about and are most likely to affect their well-being. Organizations like the National Quality Forum and federal initiatives such as the National Quality Strategy have laid out a sensible framework for evaluating quality performance, but we remain unable to put useful comparative information into the hands of the public. That is the only important test of the measurement enterprise.

Among the nearly 700 measures endorsed to-date by the National Quality Forum, the large majority are clinical process or structural measures³ yet the health care system exists to improve health outcomes. While process and structural measures can be useful to providers in quality improvement initiatives, consumers and purchasers care most about outcomes. Indeed,

³ "Developing a Viable Physician Payment Policy". Statement of: Frank G. Opelka, MD, FACS, National Quality Forum. House Ways & Means Committee, Health Subcommittee hearing, May 7, 2013. <http://waysandmeans.house.gov/calendar/eventsingle.aspx?EventID=332173>.

national standardization and implementation of process measures “locks in” the care processes of today that may not be the most useful tomorrow, and actually impedes innovation. We believe that outcome measures should be nationally standardized with that information widely available to the public, but that process measures should be developed and implemented by providers and professional societies in whatever ways they deem helpful towards improving the publicly reported outcomes. That way, patients have the information they most need to guide their choice of providers and treatments, and providers can identify priority areas and drive rapid improvement.

As an example of where the performance measurement enterprise has not served us well to date, consider total joint replacement. Knee and hip surgeries have become the highest volume—and highest cost—procedures for both Medicare and private payers. From 2001 to 2009, the rate of primary hip replacements increased by 52%, while the rate of primary knee replacements almost doubled.⁴ We know a great deal about what patients want to know following a knee replacement, and there are widely used measures available and already in use in clinical registries around the world. Yet the Physician Quality Reporting System, which provides incentives (and, in 2015, penalties) for merely reporting data, does not include any of the measures of interest to patients and purchasers. For the most recent 2011 reporting year, an orthopedic surgeon could have selected any three of about 20 measures relevant to his or her specialty. Of the top five measures actually reported, four pertain to when antibiotics were administered and stopped, and the fifth counts whether the surgeon is using a computerized medical record. The average performance for all reporting orthopedic surgeons was above 92% on each of these five measures, which would not permit any useful comparisons.⁵ Moreover, data on even these low-value measures are not made available to the public.

Yet far better measures are already available and in use throughout the U.S. and the world. The Minnesota Statewide Quality Reporting and Measurement System requires all orthopedic surgeons in the state to measure patient outcomes one year after surgery (with an optional

⁴ The Agency for Healthcare Research and Quality. National and regional estimates on hospital use for all patients from The HCUP Nationwide Inpatient Sample (NIS). <http://hcupnet.ahrq.gov/>. Accessed June 3, 2013.

⁵ APPENDIX. 2011 Reporting Experience Including Trends (2008-2012). Physician Quality Reporting System and Electronic Prescribing (eRx) Incentive Program. Accessed at: <http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/PQRS/index.htm>! June 22, 2013.

three-month post-surgery follow-up as well), and ask standardized questions about pain and functioning.⁶ Similarly, the California Joint Replacement Registry is a voluntary system in which surgeons are tracking the outcomes of hip and knee replacements, and have committed to issue public reports of outcomes data.⁷

We strongly recommend that Congress provide support for the rapid development and use of better performance measures, with a focus on priority “gap” areas such as patient-reported outcomes, patient experience of care, care coordination, appropriateness of care, and total resource use. The new measures should adhere to certain technical specifications to ensure their value for use by consumers and purchasers.⁸

In addition, Congress should direct CMS to accelerate the development, endorsement and prioritization of standardized measures. CMS could either continue reliance on a multi-stakeholder consensus process under a new and more stringent mandate, or take on this responsibility directly in order to expedite action. The criteria for continued funding of the measurement enterprise should include:

1. Definition and application of consumer-oriented criteria for measures development and adoption, including review of the statistical criteria required and consumer testing for relevance and importance
2. Rapid and large-scale implementation of measures that address public needs
3. Measurement priorities and timelines determined by expected uses of funded measures in payment and recognition programs deployed by CMS and other purchasers
4. Collaboration with publishers so that performance information is designed for and distributed to the public through generally accessed channels.

Finally, Congress should embed these more useful measures into new recognition and payment programs, including PQRS, the EHR Incentive Program, and the physician value-based modifier. In particular, the current interest in replacing the Sustainable Growth Rate mechanism with a value-based payment update could take advantage of these value-oriented measures by tying

⁶ http://www.mnmed.org/Portals/mma/PDFs/SQRMS_Dec_5_2012_webinar.pdf and http://www.health.state.mn.us/healthreform/measurement/2010_TotalKneeReplacement.pdf.

⁷ <http://www.caljrr.org/>

⁸ For more information, refer to *Ten Criteria for Meaningful and Usable Measures of Performance*.

positive incentives to collection and reporting of measures of appropriateness, patient-reported outcomes, care coordination, and other high-value domains.

3. Develop needed information infrastructure

We also recommend that Congress direct HHS and the Office of the National Coordinator for Health IT to prioritize the accelerated use of inter-operable electronic health records and clinical registries as sources of performance data. The EHR incentive program, known widely as “meaningful use,” has achieved remarkable levels of adoption of computerized health records across the nation’s hospitals and doctors’ offices. Yet information technology has rapidly evolved – to take advantage of the internet, cloud computing, and mobile devices – and our understanding of the serious consequences of fragmented care delivery has also evolved. Federal dollars are no longer needed to stimulate adoption of basic clinical computing technology, but federal funding is needed to support the public good of coordinating and measuring care delivered over an episode or a period of time. ONC and CMS should be charged with implementing a framework that will allow for evaluation of a patient’s care over time, including the appropriateness of care decisions, their outcomes, and the total resources consumed. This information framework should also permit Congress and the public to assess whether new models of care, such as episode payment, accountable care organizations, and even the new insurance marketplaces are contributing to improved health.

This framework should include accelerated use of claims and other administrative data, building upon the new Qualified Entity program defined by Section 10332 of the Affordable Care Act. CMS beneficiary data could be used, for example, to identify patients who could be contacted to assess their health outcomes or patient experience. Qualified entities could be permitted to develop alternative information products for decision support, quality improvement and other appropriate uses, and to integrate laboratory results and other clinical data when producing quality reports.

4. Require the Secretary of the Department of Health and Human Services to meet Congressional intent

In Section 10331 of the Affordable Care Act, Congress required the Secretary of HHS to accelerate provision of quality information to the public in specific terms:

“Not later than January 1, 2013, and with respect to reporting periods that begin no earlier than January 1, 2012, the Secretary shall also implement a plan for making publicly available through Physician Compare, consistent with subsection (c), information on physician performance that provides comparable information for the public on quality and patient experience measures with respect to physicians enrolled in the Medicare program ...

To the extent scientifically sound measures that are developed consistent with the requirements of this section are available, such information, to the extent practicable, shall include--

- (A) measures collected under the Physician Quality Reporting Initiative;
- (B) an assessment of patient health outcomes and the functional status of patients;
- (C) an assessment of the continuity and coordination of care and care transitions, including episodes of care and risk-adjusted resource use;
- (D) an assessment of efficiency;
- (E) an assessment of patient experience and patient, caregiver, and family engagement;
- (F) an assessment of the safety, effectiveness, and timeliness of care.”

Yet today, there is less information available on Physician Compare than in the Yellow Pages, Yelp, or any health plan provider directory.⁹ Patients will turn to whatever information is available to them, and the available cost and quality information will increasingly dictate where patients go for care and the corresponding market signals transmitted to providers. Recognizing this, Congress required rapid implementation of Physician Compare and other important information channels, but the agencies have thus far failed to implement this mandate. Private purchasers, such as PBGH member organizations, are now developing their own measurement dashboards to fill the vacuum left by federal inaction. The recent model contract issued by the

⁹ Compare, for example, a search for orthopedic surgeons in San Francisco: <http://www.medicare.gov/find-a-doctor/provider-results.aspx?searchtype=PHP&specgrpid=24&loc=941118&pref=No&specids=20&gender=Unknown&dist=15&lat=37.78229&lng=-122.4637> with a similar search on Yelp: http://www.yelp.com/search?find_desc=orthopedic+surgeon&find_loc=San+Francisco%2C+CA&ns=1#find_loc=san+francisco,+ca

new health insurance marketplace known as Covered California included a request for health plans to address fourteen quality initiatives so that the public could be made aware of each plan's quality-focused services.¹⁰ In developing contracts for Accountable Care Organizations, bundled payments, and direct primary care services, many of our members are developing their own quality requirements to address gaps in the publicly available information and to assist their employees in selecting high-value providers. It is imperative that the federal agencies provide the data needed for consumer and purchaser choice over the next 24 months. As part of fulfilling this statutory commitment, HHS should:

1. Require collection and disclosure of patient-reported outcome measures that have been successfully used in the U.S. and other countries, including measures for ophthalmology, orthopedic surgery, and cardiac surgery;
2. Require that results for all measures submitted by providers to federal recognition and payment programs, including the Physician Quality Reporting System, the "qualified entity" program, and the EHR Incentive Program, be made available to the public on Physician Compare;
3. Align measures between public and private purchasing programs to ensure that services provided to all patients are reflected in publicly available data, to minimize burden on providers, and to ensure that recognition and payment programs are providing consistent signals to the market.

Conclusion

PBGH members provide health insurance coverage to over 10 million Americans and incur over \$50 billion in health spending each year. In national surveys, over three-quarters of US employers say they do not expect to continue providing health benefits ten years from now.¹¹ Purchasers believe that a health care marketplace where providers compete based on their ability to improve health outcomes and efficiently manage resources can produce a sustainable system that improves the health of all Americans. But time is short. Such a system must be

¹⁰<http://www.healthexchange.ca.gov/Solicitations/Documents/130521%20CoveredCA%20QHP%20Model%20Contract-%20Attachments%20clean%20for%20posting%205-22-13.pdf>, pages 15-16.

¹¹ *18th Annual Towers Watson/National Business Group on Health Employer Survey on Purchasing Value in Health Care (2013)* accessed at <http://www.towerswatson.com/en/Insights/IC-Types/Survey-Research-Results/2013/03/Towers-Watson-NBGH-Employer-Survey-on-Value-in-Purchasing-Health-Care>

based on reliable performance information in the public domain. Just as we created the SEC, and fuel-efficiency ratings, and nutrition labels to drive successful markets, we must create a flow of information that consumers and purchasers can use to make critical health decisions. You have the opportunity to direct federal resources to address this vital national interest and you have the support of major employers to accelerate this agenda.

Thank you for your interest in the purchasers' perspective.

B | ENGELBERG CENTER for
Health Care Reform
at BROOKINGS

Health Care Quality: The Path Forward

Testimony of Mark McClellan MD, PhD
Director and Senior Fellow
Engelberg Center for Health Care Reform, The Brookings Institution
June 26, 2013

Chairman Baucus, Ranking Member Hatch, and members of the Committee, thank you for this opportunity to discuss the current landscape and next steps for improving the quality of health care. I appreciate your leadership in focusing the nation's attention on improving quality, as this is fundamental to achieving better health outcomes while avoiding unnecessary costs. Simply expanding health insurance coverage to promote access, or trying to lower costs by cutting prices or covered services, will not achieve the best health and the lowest health care costs for Americans. Improving how care is delivered is essential. Health care providers and patients have many good ideas for how to improve quality and lower costs, but often these approaches are not supported well or at all by fee-for-service payments, traditional insurance benefit designs, or current health care regulations.

Much of my work, and the work of my collaborators and colleagues, remains focused on health care policy reforms, reforms in the private sector, and public-private collaborations to support providers and patients in their efforts to get to better care. I am a Senior Fellow at the Brookings Institution, where I direct a range of projects related to improving innovation and value in health care. I co-chair of the Quality Alliance Steering Committee, a multi-stakeholder group of employers, insurers, providers, and consumers that focuses on overcoming the practical challenges in implementing quality measures and using them to improve care. I chair the Roundtable on Value and Science-Driven Health Care of the Institute of Medicine (IOM), which focuses on improving clinical evidence and its use to achieve better

care. I chair the Clinician Workgroup of the National Quality Forum (NQF)'s Measure Application Partnership (MAP), which prioritizes and recommends performance measures for implementation in Medicare and other Federal programs. Previously, as Administrator for the Centers for Medicare & Medicaid Services, I oversaw the implementation of a range of quality-related payment reforms, including provider reporting on quality and patient experience, and payment reforms related to "shared savings" and accountable care.

Opportunities for Improving Health Care Quality

We've made a lot of progress to support better quality care in recent years. Building on bipartisan legislation and support from the Congress, Medicare has established quality reporting systems for providers. There is more activity than ever around the development of quality measures, thanks to private organizations like the American Medical Association's Physician Consortium for Performance Improvement (PCPI) and the National Committee for Quality Assurance, as well as public support and initiatives in the Centers for Medicare and Medicaid Services (CMS) and the Agency for Healthcare Research and Quality (AHRQ). The National Quality Forum (NQF) has taken important steps including assisting with the prioritization of measures for development and implementation, and especially in "endorsing" quality measures to promote the consistent use of meaningful, well-understood measures.

Today, there are numerous and diverse quality improvement initiatives underway at all levels of the health care system – federal, state, regional, local, and within health care organizations – that are putting quality measures to use. Quality improvement initiatives within and across health care organizations are core to these efforts. They require measurement in order to identify opportunities for improvement, often through "registries" that enable providers to assess and track how their patients are doing in terms of key aspects of care and potential complications in order to identify areas for improvement. Quality measures are also being used for payment reforms, which can enable health care providers to get more resources to take steps like setting up registries and implementing other changes in

care delivery to improve care and avoid unnecessary costs. As an illustration, fee-for-service payments in Medicare, Medicaid, and the private sector have historically provided little financial support for many activities that can improve patient care and potentially reduce costs. Examples include taking time and implementing systems to coordinate care to avoid duplicative or inappropriate services; answering patient calls or emails to avoid the cost and delay of an office visit; and spending more time with a complex patient (or implementing a care team with a nurse practitioner, pharmacist, and other non-physician clinicians) to improve medication adherence, lifestyle changes, or other care management steps that can enable patients to prevent their diseases or health risks from progressing. Private payers, employers, Medicare, and Medicaid are all undertaking a range of payment reforms to provide better support for such activities, generally in conjunction with using quality measures. Finally, quality measures are used increasingly in public reporting, thanks to national efforts like those supported by Medicare as well as impressive regional efforts, such as Puget Sound Health Alliance, Minnesota Community Measurement, Wisconsin Collaborative for Healthcare Quality, Pittsburgh Regional Health Initiative, and many others.

But you only have to look at the evidence on what these quality measures show to know we have a long way to go. Last September, in its report on “Best Care at Lower Costs: The Path to Continuously Learning Health Care in America,” the IOM noted that patients get effective care only about half the time, that gaps in coordination remain widespread, that serious preventable medical errors are common, and that perhaps more than 30 percent of health care costs could be avoided as a result of improving quality and efficiency. These are not new findings; studies have been using progressively better quality measures to document gaps in quality and broad variations in costs that are not related to quality for decades.

We also still have a long way to go in quality measurement. Many important quality measures available today have not been widely or consistently implemented. We lack robust quality measures for many important aspects of health care. We don’t have reliable, widely available quality measures for most of the things that really matter to patients, like the experience of care for patients like them, or measures related to their outcomes like how well they can function, work, and undertake their activities of daily

life. And as you heard at last week's very important hearing, we don't have reliable and consistent information on the price and costs of care. Again, these are not new problems.

Some of the challenges facing quality measurement include: lack of alignment of key measures between public and private sector quality improvement efforts; issues regarding data transfer such as merging data across different information technology systems; ensuring secure protection of sensitive patient data and proprietary information; and developing, endorsing, and implementing measures of value – that is, sets of measures that include both quality and cost information. But the most important obstacle to greater use and impact of quality measures is that, today, quality still doesn't matter that much in health care financing systems, including Medicare and Medicaid.

Policy Reforms to Support Better Quality and Lower Costs

Recently, along with a group of health care leaders and experts, I authored a report on "Person-Centered Health Care Reform: A Framework for Improving Care and Slowing Health Care Cost Growth," which described how to address the persistent problem of health care quality in all parts of our health care system. The report was the third in a Brookings series on "Bending the Curve" of rising health care costs. It included a wide range of health care experts as well as public policy leaders including Dan Crippen, Glenn Hubbard, Peter Orszag, Mike Leavitt, Donna Shalala, and Tom Daschle. What all of us concluded together was that the best way – really, the only way – to assure that we could achieve health care that was financially sustainable was to reform our health care financing and regulatory policies to do much more to support better-quality care and lower costs at the person level.

Our report proposes a framework for reforming health care financing and regulation to achieve better, higher-value care for each person. It describes a specific series of steps building on current initiatives to improve the way care is delivered in each part of our health care system, including Medicare and Medicaid, the employer and individual insurance markets, as well as antitrust enforcement and other regulatory reforms. The estimated net savings in the overall plan are around \$300 billion at the federal

level over the next decade (2014 – 2023). After gradual implementation of the proposed reforms over the coming decade, long-term savings from better care and sustainable spending growth will exceed \$1 trillion over 20 years. While this framework focuses on lower costs through supporting reforms in health care delivery, it can be combined with other reforms to achieve additional reductions in health care costs.

The report recognizes that we live in a time of unprecedented breakthroughs in genomics, systems biology, and other biomedical sciences that are leading to better prevention and to innovative combinations of treatments based increasingly on each person's characteristics and preferences. Furthermore, improvements in wireless technologies and other non-medical technologies make it possible to prevent complications, and deliver care at home and in other settings different from traditional medical care. To take advantage of these opportunities to improve care, health care financing must shift away from paying on a fee-for-service basis for specific medical services, and toward paying for coordinated care that meets each patient's needs.

Focusing on person-level quality of care as the fundamental strategy for addressing health care cost growth is in some ways new, but it builds on promising ideas and trends throughout our health care system. Our group is by no means the only ones who have reached this conclusion. A broad variety of recent reports, from the Simpson-Bowles Commission, the Bipartisan Policy Center, and others, all agree that the most important thing that policymakers can do now to improve health care quality is to make feasible changes in health care payments and benefits so that they can better support patient-centered care. Improving quality in health care is difficult, it must be done carefully to avoid unintended consequences, and the quality and cost problems won't be solved overnight. But so long as providers are generally paid more for more services rather than better quality, and so long as patients get more benefits and more financial support when they use more services rather than take steps toward better health and using care more effectively, our policies are not providing the needed support and momentum for solving these problems.

The same principle applies to achieving better quality measures. Just as it is hard for patients to understand prices when they have to add up dozens or hundreds of specific fees for specific services, it is hard to get a meaningful picture of the overall quality of care at the patient level from quality measures that have to accompany dozens of specific services across different types of providers. While these specific aspects of care all matter, what really matters to most patients is how these specific services or aspects of care come together for their specific needs. For a knee replacement, putting all of these services and processes of care together, were they treated well, did they avoid any safety problems and complications, and is their knee function improved? For patients at risk of complications from a chronic disease like diabetes or high blood pressure, are they using the medications that minimize the chance of the disease progressing, and are they getting support in making the changes in their lifestyle, so that they are really reducing their risk of disease progression? For a life-threatening condition like cancer, were they and their family included in the process for making decisions about care, and did their many treatment decisions end up to good results and the best possible experience of care based on their particular circumstances and preferences? Especially if they have multiple health issues, as Medicare beneficiaries often do, patients also care about how they can get the best quality of life overall for themselves and their caregivers. Finally, are these results being achieved at the lowest cost? These are multidimensional, complex, and highly personal issues that cannot be measured perfectly and that, in the end, depend on health care providers being able to focus on the needs and goals of each individual patient. If health care financing and regulation could be better aligned with the aims of clinicians and their patients, there would be more support and better incentives both for developing and using measures that matter, as well as for actually improving care.

Next Steps for Improving Quality of Care and Quality Measurement

As I have noted, the problem of quality is not just or mainly a problem of quality measurement. It is a problem of providing better support for the hard work and reforms in care delivery needed to improve quality and lowering costs as a result. Despite the challenges, many clinicians and health care

organizations are making progress, reflecting their fundamental professional commitment to better care and better health for their patients, as well as progress to date in policy reforms to support better care. But without further steps to support better care at the patient level, progress on both quality improvement and quality measurement will be slow.

I have four recommendations for the Committee:

1. Take further steps to transition payment systems in public programs to case-and person-level payments.

To support quality measures that really matter to patients, further payment reforms building on recent trends in the public and private sectors are needed. Medicare has taken some notable steps toward payments that focus on the episode or person level of care. These include diagnosis-related group (DRG) payments for hospitals and the recent penalties for readmissions, person-level payments and quality measures in the Medicare Advantage program, person-level payments in accountable-care organization (ACO) payment reforms like the Medicare Shared Savings Program and the Pioneer pilot program, and past and current episode-based payment pilots. But most Medicare payments are still siloed and based on fee-for-service. Our recent report on “Person-Centered Health Care Reform ” describes a way to transition to greater use of episode- and person-level payments in Medicare. The basic idea is that it can happen gradually, starting now, with a modest element of case-based or episode payments in physician payment, post-acute care payment, and other payment systems that currently pay primarily or entirely on a volume and intensity basis, rather than on the basis of patient need and quality. This will help focus the development and improvement of performance measures that reflect the outcomes, experiences, and other key aspects of quality of care at the episode and person level.

Even though current quality measures at the episode or person level are far from ideal, providers and patients can still benefit from the shift of a component of their payment from fee-for-service, because it gives providers more ability to provide individual patients with what they need, rather than just what’s

covered in fee-for-service. A wide range of physician specialties have identified specific ways in which a limited amount of their fee-for-service payments could be shifted to episode- or person-level payments in the near term to get better results while reducing overall costs. For primary care physicians, this is the payment reform idea behind the patient-centered medical home. The same idea applies to specialists as well. For example, clinical leaders from the American College of Cardiology, the Society of Thoracic Surgeons, and others have described the concept of the “Heart Team” working across specialties like cardiology, interventional cardiology, and cardiac surgery to more effectively identify which patients with different types of heart disease should be referred for specialty care, what tests should be performed to support their care, what information they should receive to make the best decision about care in their own circumstances, and how all of these experts can best work together for each patient. Shifting a part of the payments that specialists receive for performing procedures that are not well coordinated now into a case-based payment for their patient – and providing an opportunity to share in the overall health care cost savings that could occur – would provide better support for the Heart Team approach. Similarly, some oncologists have started to implement “Oncology Medical Homes” for their cancer patients, which provide ongoing tracking for the patient’s status and use of evidence-based treatment, and more staff support for preventing emergency room visits and hospitalizations (e.g., after-hours access to a member of the patient’s oncology team), among other things. But unless some of the payment for oncologists shifts from current fee-for-service activities, such as the intensity of chemotherapy use and use of imaging, it is very difficult for oncologists to put the resources into these activities that can improve quality of care and prevent costly complications. Radiologists and other physicians who provide technical services in collaboration with other providers could also benefit from such a payment, as it would enable them to devote more effort toward making sure that the right tests are being used – and used well – rather than just being reimbursed based on volume.

Case- or patient-level quality measures have not yet been fully developed to support the adoption of such payment systems for all health care providers, and sudden major changes in payment could

disrupt needed care. But starting an incremental transition in this direction would provide a strong and predictable foundation for making more progress on the development and use of meaningful quality measures – and more importantly, it could help improve quality of care. As the Finance Committee considers legislation in the near future on Medicare physician payment, and possibly other areas such as payment for post-acute care and other Medicare services, including steps away from payments for specific services and toward patient- or case-level payments would provide important momentum for achieving better patient care.

2. Take further steps to implement case- and person-level quality measures in public programs.

In conjunction with clear steps to implement payment reforms that enable providers to focus more on quality of care, outcomes, and experience at the patient level, reforms should also include clear and predictable expectations for meaningful progress on accompanying quality measures. A growing number of performance measures are in use in both the public and private sectors, in part due to the momentum provided by their inclusion in Medicare’s payment systems. But as I have noted, relatively few measures address outcomes that matter for patients and patient experience. Although available outcome and experience measures have important limitations, describing a clear path by which they will be incorporated in Medicare’s payment system *and beginning to do so* will provide momentum for their further refinement and endorsement.

A growing set of case- and patient-level measures are becoming available, or could transition into more widespread use. For example, patient experience measures have been developed and endorsed for a wide range of settings of care, and for the overall care experience of many types of patients, yet the use of patient experience measures outside of the hospital and ACO setting is limited. With respect to cardiovascular disease risk, process measures like “Body Mass Index-Screening and Follow-Up” are in relatively widespread use. A more meaningful, outcome-oriented measure is the result of screening and followup: a person’s long-term cardiovascular disease risk and changes in that risk. Many such measures

have been developed, such as the cardiovascular risk assessment of the National Cardiovascular Education Program and Heart Health Risk Assessment used by Kaiser Permanente. An even broader measure that is being implemented in some health care organizations is a ten-year mortality predictor developed by Drs. Elliott Fisher, Chris Murray, and colleagues at Dartmouth Medical School and the University of Washington. This measure incorporates twelve major health and behavioral risk factors (e.g., smoking and blood pressure) and can be used to counsel and engage patients in addition to track risk reductions. Because improvements in measures like these will significantly improve outcomes that matter to patients, they are much more “patient-centered.” For elective joint replacement for osteoarthritis of hip or knee, post-operation complication rates like readmissions are coming into more prominent use. Stronger next steps would be to include measures of patient experience and functional outcomes, both reported by patients themselves. Such measures are being used in some programs, and are being further developed and implemented through quality improvement initiatives like the High-Value Healthcare Collaborative. Reflecting the need for further refinements in these measures, as well as the fact that even the most effective providers cannot control all or most of the factors that influence important patient outcomes, these outcome-oriented performance measures need only have a limited role in payment, at least initially. In fact, they might not be tied directly to payment amounts at all; many Medicare payment systems have first used measures for quality improvement, and only later for public reporting or performance-based payment.

This emphasis on key outcome and experience measures could help drive greater use of many other supporting measures of quality. In many quality improvement initiatives today, to support providers’ efforts to achieve better outcomes, entire sets or systems of measures have been developed, including many evidence-based clinical processes of care or “structural” features of care systems. These detailed measures assist health care providers in identifying specific ways to improve outcomes, and also help develop new evidence on ways to achieve better outcomes in the future. For example, to support improvements in outcomes, the Society of Thoracic Surgeons’ National Database on Coronary Artery

Bypass Grafting includes NQF-endorsed measures of risk-adjusted mortality and morbidity after surgery (and for some patients, the database includes longer-term outcomes). It also includes many details on perioperative medications and operative care processes, which have been used both to help surgeons identify opportunities for improving care and to better understand which processes of care lead to better outcomes. The American College of Cardiology and other medical specialties have also supported the development of clinical registries with detailed measures of processes of care and an increasing emphasis on the outcomes that these processes are intended to affect.

Many providers and collaborations across providers are moving forward on implementing patient registries and tracking systems with detailed quality assessments, as part of a strategy to implement or prepare for reimbursement systems in which payment is moving to the patient level. These payment reforms include ACOs, bundled payments, and other types of capitated payments. For example, many ACOs are working with expert advisers and implementing reforms in their information technology systems to develop increasingly sophisticated clinical and operational “dashboards” of measures that enable them to improve patient outcomes and reduce overall costs. Under those payment systems, quality improvement that leads to improvements in patient experience and outcomes can receive much more financial support. Other organizations – such as the Joint Commission, the Premier Healthcare Alliance, and the High-Value Healthcare Collaborative, as well as many consulting groups – are also implementing systems of measures to help hospitals, healthcare systems, and other providers improve care. Implementing meaningful patient outcome and experience measures can help leverage all of these important activities.

3. Support the NQF and a streamlined process for developing, endorsing, and incorporating more meaningful quality measures into public programs.

NQF serves very important roles in helping to improve quality through better quality measurement. It has identified priority areas of measure development, it “endorses” quality measures, and

it helps provide guidance for the implementation of measures in public programs. As Dr. Chris Cassel has noted, the NQF endorsement process helps assure that quality measures are consistent and to prevent the administrative burdens and difficulties of comparisons across measures that intend to assess the same aspect of quality but are specified in somewhat different ways. Through input from a wide range of stakeholder groups, the NQF process also helps assure that measures are both feasible and can significantly improve quality. NQF is working on ways to continue to improve the efficiency and impact of its prioritization and endorsement process.

The Clinician Workgroup of the NQF's Measure Application Partnership (MAP) has helped illustrate how this can be done. Among other things, the MAP is responsible for making recommendations on which quality measures should be adopted in Medicare's payment systems for clinicians, which should be rejected, and which need further development. Because of the diversity of measures needed for the vast array of specialties and clinical care in the Physician Quality Reporting System (PQRS), the MAP has had to make recommendations related to adoption for literally hundreds of quality measures each year. To manage this workload with limited time and staff budget, the MAP developed a set of principles to guide our recommendation process and to make it predictable for interested stakeholders. I would like to highlight three general considerations to employ moving forward to enable a flexible, faster mechanism for achieving consensus around meaningful measures:

- (1) Identify a core set of endorsed outcome-oriented measures that are relevant to almost all clinicians, regardless of specialty. The core set should focus on patient experience and engagement, outcomes related to care coordination like readmissions, measures of important safety complications, and measures of population and preventive health. The core set should also include patient-reported outcomes and other key outcomes; the relevant outcomes will vary by condition. While more endorsed measures in these areas are needed, many measures have been endorsed (e.g., patient experience measures, surgical and hospital complications, outcomes for common ophthalmologic procedures, etc.).
- (2) Align measures across multiple programs, to reduce administrative burdens and achieve greater impact. For example, clinician quality measures for Meaningful Use, the Physician Quality Reporting

System, and Value-Based Payment Modifiers should be as consistent as possible; the equivalent programs for hospitals and other providers could also be aligned. Integrating these multiple payment adjustments into a simpler, more comprehensive system like a case-based or person-based payment as I have described (Recommendation #2) would help achieve this goal. Further steps toward measure alignment in public programs would reduce the cost and complexity of the endorsement and adoption of meaningful measures.

(3) Provide a lower-cost pathway for promising but less-developed measures to transition into more widespread use and NQF endorsement. In particular, the Clinician MAP in some cases has supported the use of measures that are not yet endorsed, if they have begun to be used, appear likely to meet the key criteria for endorsement, fill an important gap in the available quality measures, and they are expected to be submitted for endorsement. Such measures could be used for quality improvement (as in the PQRS, in which measures have not been publicly reported) as experience accumulates before inclusion in public reporting or used to adjust payments.

These principles, along with continuing support for the measure endorsement process, could help promote the more rapid development and endorsement of high-priority, outcome-oriented measures, reduce the complexity of measure development, and provide a means for refining key measures and demonstrating their effectiveness. By providing a more predictable pathway toward using non-endorsed measures where endorsed measures are not yet available, this approach would likely generate more private interest and support for the measure development process, thereby limiting the need for public funding. By focusing on the most important patient-level measures, it is likely that health care providers and organizations will continue to develop and adopt more sophisticated internal performance measurement “dashboards” to back up these key measures.

4. Support collaborations to implement quality measures using existing and emerging electronic data systems.

Even with payment reforms to support the development and use of endorsed, outcome-oriented quality measures, getting them into effective use to achieve quality improvements will still be challenging for many providers and their partners in improving care, such as electronic health record vendors, and insurers and other organizations providing decision support services. Effective *implementation* of quality measures – obtaining accurate data needed for performance measures, doing so in a timely and reliable way, and finding ways to improve on performance while still paying attention to all of the other pressures of clinical practice – is difficult and occupies much of the effort of quality improvement collaborations around the country. A number of steps in public programs could make quality measurement and quality improvement easier for providers.

Quality measures should be designed so that they can be implemented from data systems used in the actual delivery of care. This is not only less costly than requiring providers to do after-the-fact chart abstractions or other data collection that can distract from a direct focus on meeting the needs of their patients. It would also help make sure providers know where the gaps in quality are, so they can take more timely and informed steps to close the gaps, rather than getting a surprise after the fact when it is too late to help patients or perhaps even to correct errors in the measures. Understanding the gaps and taking informed steps to close gaps in care requires real-time communication of relevant health information to help coordinate care across providers and settings.

In addition to real-time, patient-level, and clinical information, providers need data regarding services rendered by other providers involved in that patient's care, and the associated costs. This requires effective data sharing between providers and health care payers, particularly CMS. CMS has taken major steps in recent years to make relevant claims data available to providers involved in reforms like the Medicare Shared Savings Program, with beneficiary opt-out. A number of issues remain in terms of the ease of use of such data, such as the ability of providers (especially smaller providers) to support timely integration with clinical data sources and to be able to understand how the individual claims map into claims-based performance measures. CMS needs resources and encouragement to build on these efforts;

without data, it is difficult to improve or measure quality. CMS should aim to make appropriate, timely claims data and quality and cost measures based on these claims available in an interpretable form to all providers. This would help all providers identify steps they could take to improve quality, it would provide a standard base of performance measures that could be used more quickly and routinely in CMS evaluations of CMMI pilots and any other payment reforms. It would create more momentum for effective quality measurement and improvement.

Better capabilities in electronic record systems are also needed, to combine the data needed for meaningful quality measures and to enable the measures themselves. Electronic health record vendors are working to adapt their systems to the increasing importance of coordinated care for patients across different providers, and to achieve interoperability in practice and not just in theory across different EHR systems that may contribute to the care of a patient. In the meantime, a number of health care organizations and companies have developed technical products and support services to pull together data from multiple sources, including electronic clinical records and claims, for use in improving patient care. These efforts should be supported. For example, providers that are able to report electronically on outcome-oriented performance measures for their patients should qualify for “Meaningful Use” payments. The emphasis should be on whether data are actually flowing to enable better patient care, not on the specific features of an individual EHR system. CMS has taken some promising steps in this direction of aligning performance-based payment toward patient-level performance measures. An example of this approach is CMS enabling physicians in organizations that participate in the Medicare Shared Savings Program to receive meaningful use payments for reporting electronically on the patient-level performance measures included in that program.

Payers including CMS should also have standard mechanisms in place to accept these performance measures electronically. CMS has made progress in this regard as well, as demonstrated by the ability to report measures through its Group Practice Reporting Option, qualified Physician Quality Reporting registries, or via a qualified electronic health record product, or through a qualified data

submission vendor. Such options should be available for data submission for all Medicare performance measures.

This brings me to a final necessary point: collaboration for consistent and efficient implementation of measures is needed to assure that data are really being used consistently. Some have called for a “Securities and Exchange Commission” for health care quality and cost measures, to assure accurate and consistent reporting of measures on a nationwide basis. But given the complexity of health care data, what is most needed now is a means for helping health care providers turn very complex data into consistent and reliable measures for use in quality improvement.

There are some good examples of collaborations to support the reliable use of complex health care data. For active drug safety surveillance on a national scale, the Food and Drug Administration (FDA) has begun to rely on the Sentinel Initiative, a public-private partnership with limited government funding and significant in-kind contributions from a diverse range of private-sector partners, all of whom have a shared interest in developing more timely and valid evidence on drug safety. The initiative has a “coordinating center” to help ensure that the data models and analyses of potential drug safety issues based on the data models related to drug safety are being constructed consistently across different organizations. Similarly, the quality improvement initiatives I have described have developed or are developing consistent ways to share data for quality improvement purposes, devoting considerable effort to addressing the consistency of data submissions from each participant. Given clear guidance about measures that their participating providers would need to use, such groups could be very helpful in overcoming the practical issues in speeding the availability and use of meaningful quality measures.

The Quality Alliance Steering Committee provides a forum for identifying and sharing promising ways in which quality improvement efforts around the country are implementing and using quality measures effectively. This requires many practical, nuts-and-bolts steps even after quality measures have been defined and endorsed. *Consistent application* of a measure requires the parties who are using the

measure (e.g., clinicians working with different insurers or EHR vendors) to work out the practical application of each element in the measure, including its numerator, denominator, and exclusions, in a wide variety of administrative and clinical data systems that each have their own specific idiosyncrasies. Because of the complexity of health care data, this is not simply a “standard setting” process; it is a practical means of assuring that standards are being applied to various real-world data systems in a consistent and appropriate way. Public policies intended to support the use of better quality measures in quality improvement initiatives should recognize and encourage these efforts to turn very complex and often messy and incomplete health care data into meaningful information that providers and patients can use to improve care.

Conclusion

I have highlighted four feasible next steps on the path to high-quality care:

- 1. Take further steps to transition payment systems in public programs to case-and person-level payments;**
- 2. Take further steps to implement case- and person-level quality measures in public programs;**
- 3. Support the NQF and a streamlined process for developing, endorsing, and incorporating more meaningful quality measures into public programs;**
- 4. Support collaborations to implement quality measures using existing and emerging electronic data systems.**

These ideas build upon some promising recent developments, and reflect the tremendous potential for further improvements in health outcomes from recent advances within the biomedical sciences and outside of traditional health care. Most importantly, they reflect the opportunities to do more to support patients and health care providers in improving care and thereby avoiding unnecessary health care costs. Thank you for opportunity to speak today about this challenging but critically important topic, and for your leadership in improving the quality of care for all Americans.



Testimony of

Elizabeth A. McGlynn, Ph.D.

**Director, Kaiser Permanente Center for Effectiveness and Safety Research
on behalf of the**

Kaiser Permanente Medical Care Program

**to the
U.S. Senate Committee on Finance**

Hearing on "Health Care Quality: The Path Forward"

June 26, 2013

Thank you for the invitation to be here today. I am Dr. Elizabeth McGlynn, Director of the Center for Effectiveness and Safety Research at Kaiser Permanente and former associate director of RAND Health. Over a 27-year career as a researcher, I have focused on evaluating healthcare delivery, quality measurement and health system performance.

I am testifying today from my perspective as an expert on health care quality and also on behalf of the national Kaiser Permanente Medical Care Program, the largest integrated healthcare delivery system in the United States, which provides comprehensive healthcare services to more than 9 million members in nine states (California, Colorado, Georgia, Hawaii, Maryland, Ohio, Oregon, Virginia and Washington) and the District of Columbia.

Kaiser Permanente has a long history of generating important clinical research findings that contribute to improving the prevention and treatment of a variety of health problems. My experience at Kaiser Permanente over the past two years has provided me with a closer look at the challenge of measuring and providing high quality care on the front lines of the delivery system and this has enhanced my thinking about the importance of quality improvement and quality measurement.

To make significant progress on healthcare quality, I believe we should come to a common understanding of where we are today and adopt recommendations for the future that will significantly enhance the likelihood that we can consistently achieve high quality in our healthcare delivery system.

First, while we have made progress on understanding and incorporating quality in healthcare, we are far from finished. We need to make sure we measure the right things well and then translate what we have learned into healthcare delivery system improvement that results in better outcomes. We cannot afford the “voltage drops” that occur regularly today – the failure to translate lessons learned into action.

Second, effective measurement requires a clear sense of purpose: What do we want to accomplish and what measures will help us get there? In the complex environment of healthcare delivery, these are essential, first order questions.

Third, good measures – those that can reliably assess health outcomes or care delivery performance – do not magically emerge. They require an investment in clinical and analytical expertise, testing, and continued refinement.

Fourth, if we are truly going to chart a path forward, we should plan for the future. That means considering quality measurement in the context of emerging systems, new data sources, measures that are meaningful, different applications of measurement, and expectations about what the delivery system can achieve.

Finally, the Federal government has a critical role to play in bringing the right stakeholders and experts together, coming to consensus with them on goals and co-

developing a strategy for action. Also, the Federal government must listen to different viewpoints, develop flexible responses, and be committed to promoting and rewarding innovation.

I would like to take a deeper look at these five points.

I'll start with the historical perspective.

First, are we making progress on quality?

Yes!

When I started conducting research on quality, the first – and often the only – question I was asked was, why is this important? That question was generally followed by an assertion that our health system is the best in the world and our quality unparalleled! An unfounded assertion, as it turns out, because in 2003, my colleagues and I found that American adults were receiving 55% of recommended care for the leading causes of death and disability. In 2006 we reported that American children were receiving 47% of recommended ambulatory care. Those results illustrated how critical it is to measure quality so that we know the truth about the performance of our healthcare delivery system. Such evidence establishes the nature and order of magnitude of the problem and provides insights into how we might direct healthcare resources to achieve more effective and efficient care delivery.

I am no longer asked why we should measure healthcare quality. As this hearing demonstrates, the question we are asking now is how to do it right. That in itself indicates progress. Also, we can point to examples throughout the country of exemplary improvement and performance in a wide variety of areas, so we know it is possible to deliver on the promise of high quality health care.

Within Kaiser Permanente, for example, we were able to use our electronic health records to assess the delivery of preventive care interventions such as mammography screening – an important tool in early detection of breast cancer. But measurement was only the first step; we were then able to set goals for improvement, and use our integrated care delivery system to proactively promote preventive screening. As a result, our rates are among the highest in the nation and our patients benefit. My very first interaction with the Kaiser Permanente delivery system as a new employee resulted in me being scheduled for an overdue mammogram. We also have examples of measures from HEDIS – such as whether patients are prescribed beta blockers after heart attacks – that have been “retired” from use because results for that measure now show a consistent, national high level of performance.

The exemplary performance that many point out has been called “islands of excellence” because we do not see consistently high performance in all parts of the health care system. The 2011 National Healthcare Quality Report from AHRQ shows that, across

more than 150 measures of healthcare quality tracked for several years, the median rate of change was 2.5% per year; across measures of health access the median rate of change was -0.8% per year. And fewer than 20% of disparities in quality experienced by most racial and ethnic minorities and poor individuals showed evidence that the gap was closing. We need to do better across the entire system, not just in a few sectors of the delivery system or for certain segments of the population.

These results aren't surprising because making progress on quality is hard work. Improving healthcare quality requires a team approach to problem-solving; it requires robust and timely information, effective leadership, and it might be easier to achieve if the way we paid for healthcare rewarded higher quality, not greater quantity. For example, we've learned at Kaiser Permanente that everyone in the workforce must be engaged in the quality journey, from the person who answers the phone to the receptionist who greets you when you arrive for an appointment to all of the clinicians that you see in the course of a visit.

Everyone has a part to play – and no one part is more or less important than another. For example, my overdue mammogram was identified and addressed by the person I called to schedule an appointment with a doctor for a medication refill. To get that type of engagement you need to train everyone and get them on the same page and they need access to information at the right time and the power to act on that information. To achieve these systems requires investments of time, resources, appropriate use of technology tools, and a commitment to coordinate care across the system. In our case, the overarching vision is: make the right thing easy to do. This approach at Kaiser Permanente has led to greater employee satisfaction and improved performance – which in turn means better health for our members – and that is ultimately the point of the enterprise.

Second, as I mentioned in my introduction, clarity of purpose is key.

To move forward, we need to ask two important questions: What are we trying to achieve and what measures will best help us to assess our progress?

I was a member (along with Dr. Chris Cassel) of the Strategic Framework Board, which produced a report for the leadership of the National Quality Forum. A decade ago, this group created a vision for a national quality measurement system. Central to that vision was having a clear sense of purpose – goals for the country – that stakeholders in the public and private sectors could accept and promote. This approach is how most successful organizations develop strategies for success: they define key goals; then use well-designed metrics to help them stay on a trajectory toward achieving those goals.

The goals for U.S. healthcare and healthcare quality should be audacious – on par with landing a man on the moon, or to put it in a health context, eliminating smallpox. Today an equivalent goal might be drastically reducing obesity or cutting rates of diabetes in half. Setting ambitious goals is what the National Quality Strategy and the Million Hearts

Campaign set out to do. But we need to build on this process with a broader multi-stakeholder base and active engagement of the public.

Without a clear set of goals and a commitment to reaching them, measurement all too often becomes a separate enterprise. It is not surprising that we hear different and conflicting claims about quality measures: There are too many, too few, not the right measures. To some degree, all those observations are right because we have no clearly articulated plan for how measurement contributes to goals that propel the health system forward.

Third, how do we make sure that we have the right set and number of healthcare quality measures to help us track our healthcare goals and truly drive toward value in healthcare?

Effective measurement has to derive from a robust development process that is closely linked to established goals. Measurement should also provide timely feedback to keep us on track to meet those goals.

The majority of the measures in use today were created through earlier investments in quality measure development and without a clear purpose appropriate for current needs. They are, in a sense, outdated technology. A significant number of existing measures were created when quality reporting was a new enterprise. Delivery system reform was not yet a major focus of the national healthcare agenda, fee-for-service was the primary payment mechanism, and claims data – the administrative data used for payment – were all we routinely had for use in measurement. Measures must pass the “fit for purpose” test; that is, the measure is appropriate for use in a specific application. Measures that may work well for public reporting, for example, may not be useful for value-based purchasing. Because the context in healthcare has changed, we need to re-examine the measures in use and ask whether they are appropriate for the task at hand.

Investing in measure development work starts with conceptualization (what are we trying to measure and why) moves on to definition (how do we measure the concept) then to testing (whether the measure works the way we intended) and finally to implementation and the ongoing need for refinement. Again, the Strategic Framework Board illustrated how to connect the measure development enterprise to the health goals for the country.

A set of common goals translated into high level outcome measures (e.g., life expectancy or total cost of care) might foster a shared sense of purpose across our currently fragmented system. Such an approach would mean aiming high, but might help us move further along the path faster.

Fourth, new quality measures should embrace the future rather than the past.

Healthcare is not static and measures should keep pace with changes and advancements in technology, clinical knowledge, priority health problems, and organizational know-

how. For example, healthcare providers are moving away from paper-based systems; with the increased adoption of electronic health records, information technology has finally started to be a tool for change in health care. That means we have new opportunities for measures that are more meaningful to doctors, because they are derived from richer, clinical data rather than administrative claims. We can also develop measures that are more meaningful to patients, specifically measures designed to help patients make better, more informed choices about healthcare, based on reliable information about the quality of care.

Once they are tested and shown to be valid, measures derived from electronic data can be available for use without unnecessary delay and integrated more easily into delivery systems and clinical care, through evidence-based best practices and clinical guidelines that reflect goals for improvement. They can connect care delivery on the front lines with the overarching goals for the health of the country. In this way, measurement becomes an integral part of high quality care delivery rather than its own enterprise.

As some existing incentive and value-based purchasing programs have begun to demonstrate, reliable quality measurement that drives improved performance may help to shape payment policies. Data-driven measures can be flexible in the sense that they can be designed to drive toward achieving ground-breaking advancements in population health or target particular subgroups of patients, like those with multiple, complex health needs.

What quality measurement and improvement might look like in the future could reflect trends towards more data availability, greater attention to delivering value, greater consumer engagement, and care delivery innovations.

While electronic clinical quality measures are still in early stages of development, validation and adoption, there is huge potential to utilize the data in electronic health record systems. Thanks to wider adoption, electronic health records (EHRs) have undergone upgrades in function, data standards and performance that will make it easier to use them to construct measures. So we should anticipate and accelerate these technological innovations rather than playing it safe by doing what we have always done (i.e., using measures based on claims data).

In addition to provider-based technology like EHRs, consumer mobile devices can incorporate technology to enable real-time feedback on health status, experiences with the health care system, and exposure to a variety of health risks – data that may be incorporated into quality measurement systems and quality improvement programs. The explosion in the availability of “apps” in healthcare is incredible, representing a valuable technology that can enable much broader as well as more timely and representative assessments of what works and what doesn’t work in the healthcare system.

The need to improve the quality of our healthcare delivery system should foster an integrated model as the norm, not the exception. Payment should reward quality. And the

measures should not be overly prescriptive – they should not lock doctors and systems and patients into one-size-fits-all approaches to care delivery.

This vision differs from the current approach to healthcare quality, which continues to emphasize reliance on claims data as the critical information source, such as the trend towards all-payer claims databases as the way to evaluate and control both costs and quality. Input from consumers is usually in the form of self-reported survey data that can take months or even years to collect, clean and analyze. Current reimbursement is fee-for-service, with silos by setting and payer and few links to quality outcomes. Healthcare is fragmented, with little coordination among providers and no connection to a clear purpose that aims at achieving defined healthcare goals. If we cling to the past in our measurement strategy, we will stifle important innovation in all of these domains.

Finally, the Federal Government has an important leadership role to play.

Moving forward will require both an investment in measures development and in setting priorities for the country. Making sure that the “product” of that investment (both goals and measures) serves the public interest is an appropriate and important role for government.

Because public funds for healthcare represent a significant portion of the total healthcare expenditure, about 46%, there will be a direct benefit to government as a purchaser of healthcare services from promoting and supporting a national quality initiative.

To be able to respond to continual changes in the delivery system and promote health priorities, Federal programs for quality improvement should be inclusive, engaging multiple stakeholders in measure development. Quality programs should also ensure transparency in how scoring methodologies are derived and applied. Ideally, quality programs should reward exemplary performance by encouraging high performers to devote resources to innovation. That may require offering “credit” to payers or providers that demonstrate consistent high achievement in quality so they can translate their innovations into designing and testing new measures.

Another important role for the Federal government is to continue the movement to link payment to quality standards. Programs like the Five-Star Quality Rating System for Medicare Advantage plans have already begun to shift the value equation by giving plans that rank high on quality bonuses that must be reinvested in benefits for enrollees. The program also gives consumers information about quality rankings. And a recent study shows that consumers are paying attention: enrolling at higher rates in better quality Medicare Advantage plans. For hospitals and physicians, value-based purchasing and public reporting raise the visibility of quality for consumers and purchasers.

Another way the Federal government can provide leadership on moving quality forward is to better educate the American public about value in healthcare, and give them clear, easily accessible and reliable information about the quality of providers, hospitals, plans,

health systems, treatments, drugs, devices and preventive measures. Consumers are both beneficiaries and drivers of quality improvement when they have the ability to make educated choices about the quality of the care they receive. They need to understand that more is not better, that more expensive is not necessarily higher quality, and that they will be better off if they are more actively engaged in decisions about their care.

Thank you to the Committee for the opportunity to provide this testimony. I would be happy to respond to any questions.

COMMUNICATION



STATEMENT of the

Wisconsin Health Information Organization (WHIO), Colorado Center for Improving Value in Health Care (CIVHC), Wisconsin Medical Society, ThedaCare Center for Healthcare Value and Wisconsin Collaborative for Healthcare Quality

to the United States Senate Finance Committee

Re: Health Care Quality: The Path Forward

June 26, 2013

On behalf of the Wisconsin Health Information Organization (WHIO), the Colorado Center for Improving Value in Health Care (CIVHC), the Wisconsin Medical Society, the ThedaCare Center for Healthcare Value, and the Wisconsin Collaborative for Healthcare Quality, we are submitting this statement for the record in connection with the June 26, 2013 hearing on "Health Care Quality: The Path Forward."

We appreciate the Committee's attention to this important topic. Our organizations fully support the development and implementation of cost and quality measures as tools to drive improvement in our health care system. We also believe that in order for these tools to be effective at changing behaviors, there must be mechanisms through which cost and quality measurement can be translated into data that providers, patients and purchasers can act on.

All Payer Claims Databases (APCDs) provide health information across providers and communities to improve the transparency, quality and efficiency of health care. WHIO and CIVHC both function as administrators for APCDs in their respective states. WHIO is Wisconsin's most comprehensive source of health claims information, holding data covering more than 249.6 million claims for care provided to 3.7 million Wisconsin residents. Colorado's APCD was established by statute and mandates claims submissions from commercial payers and the state's Medicaid program; it currently includes claims for nearly half the covered lives in the state and is on track to reflect virtually all covered Coloradans in the next two years. WHIO and CIVHC are working within their respective states to empower health care decision makers with useful information to make better informed decisions.

330 E. Lakeside Street Madison, WI 53715

- Permit QEs to charge a fee to subscribers accessing data and reports. QEs are required to pay CMS for access to the data; they also incur costs for integrating and maintaining the data systems to support the analysis. A number of APCDs rely upon subscriber fees to operate. Without allowing these financing models, QEs will be forced to rely on public funding, which may or may not be available.

We again thank the Committee for its continued work in this area. The goal of performance measurement is performance improvement, and robust data and analytics are key to the process. We believe that the changes outlined above go hand in hand with this Committee's desire to further develop meaningful performance measures and to move Medicare closer to a system built around the value and not the volume of care.

