NQF

THE NATIONAL QUALITY FORUM

STATEMENT OF

JANET CORRIGAN

CEO AND PRESIDENT
NATIONAL QUALITY FORUM

BEFORE THE

SENATE HEALTH, EDUCATION, LABOR AND PENSIONS COMMITTEE

"INVESTING IN HEALTH IT: A STIMULUS FOR A HEALTHIER AMERICA"

January 15, 2009

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Chairman Kennedy, Chairwoman Mikulski, Ranking Member Enzi and Members of this Committee, thank you for inviting me here today to talk about Health Information Technology (HIT) in the stimulus package, and its potential to help us move toward making higher-performing, lower-cost healthcare available to every American.

My name is Janet Corrigan. I am the President and CEO of the National Quality Forum. NQF is a private sector standard-setting organization with more than 375 members representing virtually every sector of the health care system. NQF operates under a three-part mission to improve the quality of American health care by:

- setting national priorities and goals for performance improvement;
- endorsing national consensus standards for measuring and publicly reporting on performance; and
- promoting the attainment of national goals through education and outreach programs.

NQF endorsement, which involves rigorous, evidence-based review and a formal Consensus Development Process, has become the "gold standard" for health care performance measures. Major health care purchasers, including the Centers for Medicare & Medicaid Services, rely on NQF-endorsed measures to ensure that the measures are scientifically sound, relevant and help standardize and raise the bar for performance across the industry. To date, NQF has endorsed more than 500 measures. A standardized performance measurement and reporting system is a core building block for creating a higher quality, more affordable health care system, and is necessary to successfully implement virtually all reform strategies. Investing in health information technology is critical to routinely assessing performance.

I commend the Committee for focusing needed attention on how HIT investments can achieve maximum benefit – both for our economy and the quality of care our patients receive. You've probably heard it said that a crisis is a terrible thing to waste. Crises provide a prime opportunity to force clearer thinking and prioritization of our actions and investments. I believe this to be true of the current economic crisis and Congress and the Administration's efforts to address it, particularly when it comes to healthcare.

Healthcare spending and our economy are inextricably linked. We can no longer sustain healthcare spending at a rate that will reach more than 20 percent of the GDP by 2020. After a stock market freefall in 2008, the nation's financial condition dropped to what is considered the worst economy in 70 years. Experts now agree that we have not yet hit bottom and that 2009 may bring the worst conditions faced in generations. We cannot continue to act as we always have. We can no longer afford the health care system we have, particularly considering that 30 percent of spending is wasteful – $600-700 billion dollars spent on care that is often unnecessary and even harmful care. HIT is not *just* a good idea, not *just* an innovation – HIT is essential if we hope to achieve the goals we have set to achieve higher quality, affordable care that fuels rather than drains our economy.

In my comments today, I am going to focus on the importance of strengthening the linkage between HIT investments and improvements in patient care. More specifically, I intend to cover three points. First, Federal funding to promote adoption of HIT is an essential foundation for improving health care safety, quality and affordability. Second, investments in HIT will result in far greater improvement in patient care if steps are taken to ensure that electronic health records (EHRs) and personal health records (PHRs) possess the necessary capabilities to support performance measurement, reporting, and improvement. Third, HIT investments and incentives should be tied to the *effective use* of HIT to improve patient safety, outcomes and experience of care, not just having it.

HIT'S ROLE IN IMPROVING QUALITY

We are making progress in improving healthcare performance, but it is happening at a slower pace than it should. For example, the National Health Care Quality Report shows an average annual improvement of only 1.9% on a selected set of performance measures between 2000 and 2004. By contrast, the rate of healthcare expenditures grew 7.6% during the same time period. There is entrenched overuse, misuse and underuse of services. These gaps in quality, use and access affect everyone, but place the greatest burden on minorities. Efforts to close the disparities gap have to date had little impact.

There are many examples of efforts to improve quality in hospitals, small and large ambulatory practices, and long-term care settings that have been substantial and life-saving. But the health care sector lacks the ability to bring these innovations to scale; best practices in care delivery may take years if not decades to spread throughout a community and the nation.

One reason for this slow rate of improvement is that our current health care delivery system is extraordinarily fragmented. The average Medicare patient sees two primary care physicians and five specialists annually, across a median of four different practices. The fragmentation of care is even more pronounced for patients with chronic conditions; for example, a Medicare patient with coronary artery disease sees three primary care physicians and seven specialists in a given year. This kind of fragmentation, particularly for the chronically ill, makes it extremely challenging to coordinate care and share information in a timely way that is responsive to patients' needs. HIT can facilitate the exchange of patient information and communication between providers and across care settings, which can create safer, more effective and patient-centered care.

Much of the health care sector lacks critical organizational supports necessary to consistently provide effective, safe and efficient care across the entire patient-focused episode. HIT is one of those critical organizational supports, but I want to emphasize that HIT is not enough on its own to transform the delivery system. HIT is a *tool* that must be used effectively. In its landmark report, Crossing the Quality Chasm, the Institute of Medicine emphasized the importance of *using* HIT to:

- Design care processes based on best practices
- Translate new clinical knowledge and skills into practice
- Support the work of multi-disciplinary teams
- Enable the coordination of care across patient conditions, services and settings
- Measure and improve performance

Investments in HIT will have the greatest impact if pursued within a broader policy agenda that encourages the development of higher levels of organizational capacity in all practice settings.

Investment in HIT *now* will also enable more effective implementation of other elements of a comprehensive reform agenda over the coming years including: availability of information on the effectiveness of alternative treatments; reform of payment programs to promote value; and informed patient choice and shared decision-making. Virtually all of these strategies will require more

comprehensive performance information than is currently available -- performance information on the entire patient-focused episode including measures of patient outcomes, care processes, and resource use.

HIT THAT SUPPORTS PERFORMANCE MEASUREMENT AND IMPROVEMENT

Funds for HIT included in the stimulus provide an opportunity to take important steps towards the establishment of a secure, interoperable, nationwide health information network. With strong leadership from the Office of the National Coordinator, working collaboratively with a wide variety of stakeholders, a good deal of progress has been made in recent years. The current state of the technology and standards is adequate to support this investment now.

At the same time, we should continue our efforts to ensure that EHRs and PHRs possess the necessary capabilities to support performance measurement, reporting, and improvement. In short, EHRs and PHRs must capture the necessary data to calculate measures; and provide clinical decision support (CDS) to providers to enhance performance. Establishing an HIT infrastructure to fully support performance measurement and improvement requires close and ongoing collaboration between the "quality community" and the "HIT community."

Efforts are now well underway to create such a "bridge." In 2007, with initial support from the Agency for Healthcare Research and Quality and pursuant to recommendations of America's Health Information Community (now a public-private partnership known as the National eHealth Collaborative), NQF established the Health Information Technology Expert Panel (HITEP), chaired by Paul Tang, MD, Palo Alto Medical Foundation. The initial work of HITEP has focused on identifying the types of data that must be captured in EHRs to calculate the performance measures that are currently used by Medicare for public reporting purposes. HITEP is now working collaboratively with the Health Information Technology Standards Panel (HITSP), to translate the "Quality Data Set" into HIT standards, and the Certification Commission for Health Information Technology, to promote the development of EHRs capable of supporting performance measurement and improvement.

I encourage you to build upon this important collaborative work and not to reinvent the wheel. The "Quality Data Set" will support both public reporting *and* enhanced patient care. It will enable both real-time feedback to clinicians on their performance *and* clinical decision-support (i.e. prompts and reminders to a clinician to ask a question or supply a drug; alerts that inform a clinician that

something is amiss, such as a drug being prescribed that will react badly to another prescribed drug).

INCENTIVES FOR USING, NOT JUST HAVING HIT

Federal funding to promote the adoption of HIT will only result in improvements in care if HIT systems are used to perform key value-enhancing functions, including:

- exchanging data on prescriptions, laboratory tests, and imaging procedures;
- developing evidence on the safety and effectiveness of treatments; and
- reporting on safety, quality and affordability.

Interoperability and technical capabilities are important, but investments will prove most effective if tied to process changes that improve patient safety and clinical outcomes, while making the health care experience more meaningful.

HIT investments and incentives should be tied to the *effective use* of HIT to improve patient safety, outcomes and experience of care, not just having it. To support this need, NQF has endorsed a set of performance measures emphasizing HIT use in five areas: electronic prescribing, interoperability/ information exchange, care management, quality registries, and the medical home. For example, the two care management measures endorsed by NQF assess the use of HIT to identify specific patients in need of care, track their preferences and lab results, and assist the clinician in providing evidence-based care according to national guidelines using automated alerts and reminders. To ensure information about patients doesn't fall through cracks in the healthcare delivery system, the first of these NQF measures addresses HIT used during a patient-clinician visit and the second addresses capturing and sharing clinical results between visits.

In conclusion, the NQF supports Federal funding to promote the adoption of HIT as an essential foundation for improving health care safety, quality and affordability, but it is important to invest wisely. This investment will yield far greater returns in terms of higher quality, more affordable care, if steps are taken now to ensure that EHRs and PHRs possess the necessary capabilities to support performance measurement and improvement; and if investments are tied to the *effective use* of HIT to enhance patient care.

Thank you again for your focus on how HIT can drive improvements in healthcare quality and efficiency.