Testimony Before the Joint Economic Committee

A Hearing On: "Arming Health Care Consumers with Better Information and Incentives"

Statement of

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Mr. Chairman, thank you for inviting me to join you for this important hearing on "Arming Health Care Consumers with Better Information and Incentives." Ensuring that consumers have the information and tools they need to make the health care choices that are right for them is a high priority of this Administration and, especially, of the Department of Health and Human Services (HHS). HHS is committed to ensuring that Americans can easily obtain understandable information about the quality and price of health care. To realize this vision, Secretary Leavitt has articulated four objectives: promote quality transparency, promote price transparency, facilitate the greater use of health information technology, and transform health care so its incentives support a consumer-oriented – or patient focused -- health care system.

The Agency for Healthcare Research and Quality (AHRQ), which I direct, is a science partner for the Centers for Medicare & Medicaid Services (CMS) and other HHS agencies to advance these objectives. As a science partner, our job is to assure that Department priorities are based on valid, unbiased, credible science. As consumers seek to play a more active role in decisions about their health and health care, there are multiple opportunities for providing them with customized, scientific information. My comments today will focus on consumer information intended to help consumers make market and treatment decisions.

AHRQ's Experience Working with Consumers: Three Lessons

I want to begin my testimony by emphasizing three lessons from our work with consumers. ***First, informed choice only occurs when consumers can assess the "value" of a health care good or service, and consumers can only assess value when they have both price and quality information***. In fact, Secretary Leavitt has made Health Care Value Incentives a HHS Priority.

He has stressed transparency for information on both quality and price because both are essential to good decision making. I should also note that while this factual information informs consumer choice, only the consumer can make the most appropriate decisions after weighing this objective information against his or her preferences, tolerance for risk or uncertainty, unique circumstances, and assessment of acceptable trade-offs.

Second, transparency is critical for enhancing consumer choice and improving competitiveness. My agency's research on consumer choice demonstrates that where the message comes from makes a profound difference. The increased availability of information on health and health care means that consumers are increasingly skeptical of the impartiality of the information they receive. As my colleague CMS Administrator Mark McClellan has stated, such transparency is just as critical for physicians. Measurement is at the heart of public reporting and potential value-based purchasing initiatives, but physicians and other providers need to know that these measures are valid, appropriate, and widely accepted.

Finally, we must not assume that we can approach consumer choice as a "Field of Dreams." To paraphrase the movie's tagline, we cannot assume that by providing consumers with more information that they will necessarily use it. For many health care consumers, the problem is not a lack of information. It is, Mr. Chairman, as your hearing title suggests, a need for better information: information that is pulled together so that alternatives can be easily compared, easily understood, and easily acted upon. Unfortunately, it is not easy or simple to develop or present information in these ways. But I am delighted to report we are making progress.

Providing Consumers with Better Information

Mr. Chairman, my testimony is organized around the two broad types of decisions that consumers make. The first are marketplace decisions, in which consumers or purchasers need to select a health plan, a clinician, a hospital, or a long-term care facility. The second are decisions that patients and their caregivers must make among alternative treatments and the management of their conditions. It also includes the types of benefit design decisions that health plans and purchasers make so that their benefit packages support health care that works. For both types of consumer decisions, we need good evidence on what works and effective strategies to ensure that this information is available and that it can be used or implemented.

Marketplace Decisions

Some of the most basic and important marketplace decisions are: Which health plan that my employer offers is right for me? How do I know which primary care physicians, specialists, or health care facilities provide quality care? If my father needs a cardiac bypass procedure, how do I know which surgeon and which hospital are the best?

For developing information for these types of decisions, the *Consumer Reports* approach to evaluating alternative goods or services is a helpful practical model. We take on faith with *Consumer Reports* what we are now struggling with in health care: that the measures address the most relevant factors, that the measures are applied fairly and consistently, and that the results are portrayed in ways that are valid and easily understood.

Measuring the Right Things Well. Mr. Chairman, I will address public reporting and value-based purchasing in a moment. But since neither can succeed unless we measure the right things well, I want to provide three examples of the types of measures that AHRQ develops and validates. AHRQ is a leader in this area. Many of the reporting and value-based purchasing experiments across the country are relying, at least in part, on our work.

Over a decade ago, AHRQ responded to concerns that there was often a "disconnect" between the satisfaction surveys developed and released by health plans and the experience of enrollees. Our response was not to develop a government-administered survey but to create a tool that would ensure a valid assessment of enrollees' experience with their health plans and make it available for use by public and private sector plans and purchasers. By consumer experience of care, I mean such issues as whether patients received the right care, how quickly, were they treated with respect, whether their caregivers communicated with them in ways that they could understand, and whether they were invited to participate in decision making regarding their care.

AHRQ developed the Consumer Assessment of Health Providers and Systems – or CAHPS – survey, and it is now accepted as the industry standard. Today, over 123 million Americans, including Federal employees and military dependents, can use CAHPS data to make decisions about their health plans. Mr. Chairman, you and your staff have access to CAHPS data to make decisions about your Federal Employees Health Benefits Program coverage. AHRQ does not collect CAHPS data but provides technical assistance on how to communicate the findings.

As the health plan survey evolved into the industry standard, CMS and others urged us to provide similar tools for the industry to use in other areas. We have now developed, tested, and validated survey instruments for assessing children with special health care needs, behavioral health, and learning more about why Medicare beneficiaries disenroll from managed care plans. Over the next 18 months we will complete development of survey instruments that will address additional settings, populations, and types of services. As with our prior work, these will not be AHRQ-conducted surveys; these survey instruments will be in the public domain for use by others. These include hospitals, Medicare prescription drug plans, in-center hemodialysis, clinicians and group practices, Preferred Provider Organizations, and recognizing that some nursing home residents are cognitively impaired, we are developing both a survey for residents and their families. CMS recently asked us to work with them on development of a survey for home health care services.

To assist hospitals in their clinical quality improvement initiatives, AHRQ also developed four sets of Quality Indicators. Inpatient Quality Indicators examine mortality, utilization, and volume for leading conditions and procedures. Patient Safety Indicators identify post-operative complications and iatrogenic (physician-caused) harms. Pediatric Quality Indicators are focused on those 17 years old and younger. For systems, which include hospitals and primary care practices, Prevention Quality Indicators measure ambulatory care sensitive conditions, i.e., conditions for which a patient should rarely need to be admitted to the hospital if the primary care system is working properly. In the last 3 years we have seen an increasing trend by States and others to use the Quality Indicators for public reporting, and at least one CMS demonstration

project is using them to test whether the quality of inpatient care for Medicare beneficiaries improves when financial incentives are provided.

AHRQ has also launched an exciting project to develop and validate efficiency measures. Nearly every report promoting public reporting calls for the addition of efficiency measures, but there are few, if any, efficiency measures for which there is widespread support. This is a high priority for purchasers, but providers have expressed concerns. The provider community believes that efficiency measures should support, and not undermine, our shared goal of encouraging appropriate high quality care. AHRQ agrees. For example, primary care practices should have incentives to help those patients who have one or more chronic illnesses learn to effectively manage their condition(s) in an efficient manner, in order to avoid risks to patient health, and large costs from avoidable emergency room visits, hospitalizations, or complications. Appropriately constructed measures need to take such issues into account in determining efficiency.

We already are consulting all of the interested parties and leading experts and reviewing existing knowledge regarding efficiency measures. We expect to complete development and evaluation of efficiency measures by the end of this year. This will be an important addition to public and private sector initiatives because it will enable them to do what they cannot do now: compare the efficiency of their practice or their facility with the competition.

Public Reporting. A number of public reporting initiatives are drawing on our work. Of the States that have public reporting of health quality information, at least 8 States are using one or

more sets of Quality Indicators that my agency developed. The states are: Colorado, Florida, Massachusetts, New York, Oregon, Texas, New York, and Utah.

To provide actual examples of reports of quality information created by a number of organizations, AHRQ will soon make available on our website, ***www.TalkingQuality.gov*** , a Report Card Compendium, a directory of over 200 sources of comparative information on the quality of health plans and providers. This directory provides in a single location an easily searchable database of report examples, which will allow report developers to explore and assess different approaches to formatting information, displaying data, and explaining why quality information is important to consumers and other purchasers. Since it also provides (with their permission) information on the organization and individuals who developed each report, the Compendium will allow users to locate and network with one another concerning new strategies and ideas for report development. This is critical because information relating to how these reports cards were developed, how they were disseminated and used, and how they were received is rarely published. The Report Card Compendium includes reports on health plans, hospitals, medical groups/clinics, individual physicians, managed behavioral health organizations, nursing homes, home health agencies, and dialysis facilities.

I am delighted to report that the health care industry and health professional societies have stepped up to the plate to help develop public reporting initiatives. The Ambulatory Care Quality Alliance (AQA) is a consortium of private sector groups that I chair. Eighteen months ago, the American Academy of Family Physicians, the American College of Physicians, and America's Health Insurance Plans asked AHRQ to serve as a neutral convener for this

collaborative effort to determine how to promote uniformity in quality measurement and reporting in outpatient settings across public and private payers. Substantial physician leadership in AQA now includes the American Medical Association and many major medical societies.

In addition to enthusiasm for identifying common measures to promote uniformity and facilitate improvement efforts, physicians are interested in their validity and use. Specifically, physicians want assurances: that measures are based on the best science and will be updated as the science changes; that we will address unanticipated consequences such as reports that discourage physicians from seeing the most difficult patients; and that any incentives will be fair and equitable. Not surprisingly, physicians are more willing to trust measures that are developed by neutral scientific parties.

AHRQ and CMS are also active participants and partners in the Hospital Quality Alliance, a public-private partnership that is committed to developing and making available standardized measures of hospital quality. Over the last three years, the Alliance has built a system of quality reporting for hospitals. The result is the HHS website, Hospital Compare (***www.hospitalcompare.hhs.gov***), which provides easily accessible comparative quality information. We are very pleased that the Hospital Quality Alliance will use the Hospital CAHPS survey, which we have developed for CMS to provide information on consumers' experiences with their hospital care. The survey is now being field tested. We are especially pleased that the Alliance has publicly stated that HCAHPS, "represents a quantum leap towards the goal of consumer-directed health care decision-making."

Value-Based Purchasing. Value-based purchasing is the concept of rewarding providers based upon their quality and efficiency. There are, of course, financial incentives inherent in all payment systems, so the issue is not incentives versus no incentives. As Secretary Leavitt points out, the challenge is that existing incentives are often poorly aligned; all too often they do not support our goals of improving efficiency and promoting quality.

AHRQ is working with CMS, the Blue Cross plans, the RWJ Rewarding Quality Initiative, and others to provide technical assistance and to assist in the evaluation of the value-based purchasing experiments now underway. Some of these experiments, such as the CMS Premier quality incentive demonstration, are using our Quality Indicators as part of their measure sets.

As interest began to grow in value-based purchasing initiatives, AHRQ undertook a synthesis of the existing literature. While the evidence was not conclusive when we released our report last year, the gaps in evidence are beginning to fill in. The evidence shows that measurable improvements have been seen in large-scale tests that reward increased use of preventive screenings and other processes that improve quality and safety. We developed *Pay for Performance: A Decision Guide for Purchasers to Consider,* which we released last week. These efforts underscore the importance of understanding how value-based purchasing programs are designed, so that all participants understand the rules.

Treatment Decisions

Let me now turn to treatment decisions.

Understanding What Works and For Whom. As I noted, one of AHRQ's basic activities is to understand what treatments and interventions work and do not work. There are three reasons why AHRQ's work is critical in assessing health care's state of the art. First, with our increasing investment in basic and biomedical research, there has been an exponential increase in the number of scientific findings, and a similar increase in the proportion of clinical decisions where there are two or more treatment options. This makes it increasingly difficult for physicians to keep abreast of the literature and put the latest findings into perspective. Second, research shows that that there is a 17-year time lag between discovery and when most Americans benefit from that discovery. AHRQ and other HHS agencies are committed to reducing that time lag. Finally, academia rewards original research, not synthesis of existing knowledge. So synthesis of our exploding knowledge base is the exception, rather than the rule.

Section 1013 of the Medicare Modernization Act (MMA) significantly expanded AHRQ's ability to develop state-of-the-art evidence syntheses for the conditions and interventions of significance for Medicare, Medicaid, and State Children's Health Insurance Programs. To respond to the MMA mandate, we established the Effective Health Care Program to provide current, unbiased evidence about the comparative effectiveness of different health care interventions. Where the Effective Health Care Program breaks new ground is how we undertake these syntheses: the process is transparent, they will be routinely updated as warranted by new discoveries, and consumer-friendly versions will be produced of every finding.

Our initial report compared the effectiveness of treatments for gastroesophageal reflux disease (GERD). This report is a good example of the opportunities for greater patient involvement in

decision making. The report found that patients who had surgery to treat GERD did so in the hope that they would no longer require ongoing medication. Yet despite the costs and risks, nearly two-thirds needed to continue taking medication. For patients receiving pharmaceutical therapy, there was a large difference in the cost, but not in the effectiveness, of the different classes of medications.

This information is already being used by purchasers to improve the quality of their health benefit plans. For example, the National Business Group on Health, in its work supporting the National Committee on Evidence-Based Benefit Design, has summarized the information for purchasers and identified benefit design options for health benefits managers.

Translating Knowledge Effectively. Communicating information to patients and consumers about medical decision making can be daunting. The subject matter is often complex; statistical odds or risks of developing a disease or complication are extremely difficult to communicate; and the end result, all too often, is misunderstanding. It can often be difficult to reach consumers who are "health illiterate" or who have reached a saturation point with health care information.

A member of our National Advisory Council, Judy Hibbard, a professor in the University of Oregon's Department of Planning, Public Policy, and Management, is an expert in the field of patient and consumer communication. We have relied on her insights in developing many of our products. She has identified three major factors that affect whether a consumer uses this type of information:

- Consumers need to understand the importance of the information to their lives. The information must be understandable, salient, and framed in ways that consumers can easily grasp.
- Consumers often need specific skills to understand and use the information. For example, health literacy and the ability to understand numerical information like the odds of developing a disease or complication are important.
- Finally, motivation of consumers to use the information is critical. In fact, a high level of motivation can compensate for a low level of these skills.

We have come to appreciate that the task is not merely translating a document into a specific reading level. What is required is a better understanding of the audience for the information: what will make specific health messages meaningful to those who need to act upon them. We also need to make the action steps concrete.

We are beginning to address these challenges. We are structuring the recommendations of the U.S. Preventive Services Task Force, which AHRQ sponsors, so they can be used digitally. By the end of the year, we will have a web-based interactive program where an individual can type in his or her age, sex, or other relevant information and understand more clearly what services the Task Force recommends they receive, and how often.

Interestingly, the issue of clarifying action steps extends to clinicians. As decision support systems – whether in Personal Digital Assistants or desktop computers – become more pervasive, we are discovering that these programs do not easily accommodate findings that are

framed in terms of factors that physicians need to consider. The information must be reformatted to provide specific action steps that match the demographics of the patient being treated.

In the short term, we are restructuring our recent findings so that they can be more easily incorporated into decision support systems. In the long term, it is clearly more efficient to incorporate this focus into our work from the outset. So we have begun to change our process for developing evidence syntheses so that the results can readily be used by patients interactively on the Web or by caregivers in decision support systems. Our first prototype is an interactive database of articles on the costs and benefits of health IT; we will now apply this approach to the work of the U.S. Preventive Services Task Force. Over the next 3 years, we expect this approach will become an integral part of all of our synthesis work. This should make an important contribution to reducing the 17-year time lag between discovery and widespread adoption.

Patients with Chronic Illness. A substantial proportion of health care expenditures are focused on caring for individuals with multiple chronic illnesses. Judy Hibbard is also helping us to think through the challenge of motivating chronically ill patients to take an active role in the management of their care. While most health plans have developed or incorporated disease management strategies into their programs, this is only the first step in what is a much longer process. We sometimes forget the often overwhelming myriad of decisions and actions that a chronic care patient must take. Combined with the difficulties of navigating a highly complex delivery system, it is not surprising that few patients actually try. When you consider that fewer than 50 percent of patients actually quit smoking after a heart attack – an event that should motivate even the most intransigent smoker – it seems less surprising that it can be difficult to

motivate chronic care patients to take an active role in managing their care and their lifestyle. AHRQ will increasingly focus attention on how we can effectively engage patients with chronic illnesses in their care.

Conclusion

Mr. Chairman, in closing, I believe that we are making significant progress toward our shared goal of enhancing patient choice. The industry deserves great credit for creating the Hospital Quality Alliance and Ambulatory Care Quality Alliance to advance public reporting. Similarly, the leadership of Dr. Mark McClellan and his team at CMS has played a critical role in the progress we have made to date.

As I noted during my opening remarks, we need to keep our eye on the ball: ensuring that all of us – as consumers and taxpayers – are getting real value for our health care dollars. Second, we need to recognize that all of these efforts succeed or fail based on the transparency of the process. The more transparent we make measuring the right thing well, the more likely that health care providers and consumers will accept the results. Third, we need to be realistic about the challenges of getting consumers to use this information in making health care decisions. This will not occur magically. We need to focus on how to best engage consumers more effectively in their health care decisions.

My closing observation is that we must not overlook the significant response of the provider community to public reporting already. Health care systems are increasingly looking at how they can redesign their systems and processes for quality and value. We are supporting or

providing technical assistance for a number of exciting projects intended to help build the evidence base for how systems can improve. For example, we are providing support to a public system's effort to apply the automotive concept of "lean" processes to health care, another project to more effectively measure waste, and a large collaborative effort to reduce avoidable injuries, in a first step toward developing "fail safe" hospitals. As we explore public reporting and value-based purchasing, interest in redesign for efficiency, quality, effectiveness, and safety will only increase.

By serving as a "science partner" for these efforts, we will ensure that the lessons learned from these cutting edge initiatives will be rapidly shared throughout the health care industry. In fact, we will launch a web-based Innovations Clearinghouse later this year to serve as a platform for rapid dissemination. We also hope to make additional contributions through the types of system redesign projects I just mentioned, our continuing work in patient safety, and our support for the Administration's broader health IT agenda.

Mr. Chairman, this concludes my prepared statement. I will be delighted to answer questions.