

Introduction

Good morning, and thank you for allowing me the opportunity to speak with you today on consumer information about hospital quality. I am Nancy Foster, senior associate director of health policy for the American Hospital Association (AHA), which represents nearly 5,000 hospitals, health systems and other health care providers. In this capacity, I provide policy guidance on issues of health care quality and safety.

Half of my 25-year career in the health care field has been devoted specifically to the improvement of health care quality. Prior to joining the AHA, as coordinator of quality activities for the Agency for Healthcare Research and Quality (AHRQ), I managed daily operations of the Department of Health and Human Services' Patient Safety Task Force and the Quality Interagency Coordination (QuIC) Task Force, which brought the federal agencies together to improve health care quality. I also coordinated research on patient safety and quality. And, while at the U.S. Naval Hospital in Yokosuka, Japan, and Georgetown University's Department of Medicine, I planned and initiated ways to incorporate quality improvement practices into care.

For the past year, on behalf of the AHA, I have worked with hospital groups, government agencies, accrediting organizations, consumer groups and others to develop and coordinate a national initiative that will supply useful information to the public about the quality of care hospitals provide, and assistance to hospitals so that they can improve their performance. I'd like to begin today by telling you about the genesis of this groundbreaking hospital-led initiative, which demonstrates providers' commitment to sharing information with the public and encouraging continued quality improvement.

Hospitals: Committed to Quality Improvement and Patient Safety

Hospital care is the single largest component of health care in the United States. We treated 612 million outpatients and 109 million emergencies, performed 27 million

surgeries and delivered more than 4 million babies in the year 2001 alone. Caring for hundreds of millions of ill and injured patients is an extraordinary responsibility, and it is a responsibility that hospitals take very seriously. Hospitals believe that every patient who enters their doors deserves the guarantee of safe, high-quality care. As such, quality and patient safety are the cornerstones of every hospital's mission, and caregivers constantly strive to improve safety and outcomes.

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

The Difficult Job of Creating Hospital "Report Cards"

The media attention surrounding medical errors; the advent of the Internet, which has made information on virtually any topic instantly available; and the influence of the reform-minded "baby boomers" who have turned their attention to health care now that their parents – and they themselves – are aging; have led to overwhelming public demand for more and better information about hospitals' safety and performance. As a result, there has been a proliferation of quality measurement activities: Organizations such as the Joint Commission on Accreditation of Healthcare Organizations (JCAHO), states, hospitals, researchers, insurers and other payers, the business community, consumer organizations, commercial enterprises that compile and sell "report cards," and the media all offer the public different concepts of quality and relevant data. A 1994 study by the California Office of Statewide Health Planning and Development identified two national published report cards, 30 statewide and regional report cards, and seven corporate report

cards – and the number of organizations trying to collect and use quality data has exploded since then.

The type of information contained in report cards and ratings systems varies dramatically. A 2000 Rand Health report, *Dying to Know: Public Release of Information about Quality of Health Care*, outlines just a few examples of the more than 100 indicators used by health care report cards:

- Overall in-hospital mortality rates,
- Mortality rates for specific procedures,
- Cardiac surgery intervention rates,
- Cervical and breast screening rates,
- Immunization rates,
- Provision of post-hospitalization care for a mental illness,
- Check-ups for new mothers,
- Overall patient satisfaction rates,
- Rate of complaints against providers, and
- Doctors' communication skills.

Not only does the information differ from rating system to rating system, it is collected using different methodologies, and the validity and reliability of the data are highly variable. Providers are confused by the disparate ratings and rankings. And, the potential for confusing the public with incomplete, poorly analyzed, conflicting and even misleading information is enormous.

In the 1990s, for example, three U.S. automakers – GM, Chrysler and Ford – individually decided to produce report cards to help their employees choose hospitals and health plans. Each report card, however, relied on different sets of performance measures, different collecting procedures and different databases, and as a result, the same hospital was often ranked differently from one report card to another. Since members of the same

family often work for different automakers, families often received disparate information about hospitals' performance. Recognizing that they were confusing the very people they were trying to help, the automakers ultimately decided to come together to create a unified approach to rating area providers.

Though, as I will describe in a moment, America's hospitals share the goal of most report card efforts to provide useful information to the public and providers, we must realize that achieving this goal is very difficult. Many bright people have tried, but most efforts have not been embraced by the public they were intended to inform, as reported in Menemeyer's review of the HCFA mortality data, Mukamel's assessment of the use of New York State data, and Schauffer and Mordavsky's review of the literature about consumer report cards that had been published in the peer-reviewed literature since 1995. The challenges we face in creating meaningful information – not just data – that is valuable to the public and providers include:

I. The public's inattention to quality information

First, despite their dramatic proliferation, report cards gauging hospital and health plan performance have a negligible effect on consumers' decisions. As reported in the May 27th issue of *The Journal of the American Medical Association (JAMA)*, a survey of nearly 500 patients who had undergone coronary artery bypass graft (CABG) surgery at one of the four hospitals rated in Pennsylvania's *Consumer Guide*, only 12 percent were aware of a report card on cardiac surgery mortality before undergoing surgery, and fewer than 1 percent knew the correct rating of their surgeon or provider and reported that it had a moderate to major impact on their selection. The study's authors, Eric Schneider, M.D. and Arnold Epstein, M.D., concluded that, "the public values anecdotal reports from relatives and friends more than objective reports from other sources such as the government and the news media."

II. Competing, trusted sources of information

Second, as suggested by the 1998 Schneider and Epstein study, report cards and rating systems compete against many other trusted sources of information. According to a 2000 Kaiser Family Foundation/AHRQ survey of more than 2,000 adults, only 4 percent of adults had used information comparing the quality of hospitals to make a decision about hospitals; yet, 73 percent of those surveyed felt confident they had enough information to make the right decision the last time they had to choose a hospital. This is perhaps explained by the fact that people rely more on family and friends and doctor referrals than on data displays from third-party resources. Sixty-three percent said their family and friends would have “a lot” of influence on their choice of a hospital, and 64 percent said the same of their doctor. Compare that with only 12 percent who said that newspapers or magazines would have “a lot” of influence on their choice of provider and only 15 percent who said the same of government agencies. In fact, 62 percent said they would choose a hospital that their family and friends had used for many years without problems over a hospital that is rated higher.

III. Measuring the right elements

Perhaps the greatest challenge in reporting quality information to the public is determining what information to measure and report. Often, information that is important to the public – the coordination of care and the communication skills of doctors – is not information for which we currently have scientific measures. And even when specific measures do exist, we have to be sure they paint an accurate picture of hospital quality.

For instance, the indicators selected by The Leapfrog Group, a coalition of large private and public sector employers, may not reflect the quality of care provided. Leapfrog promotes hospital accountability and quality improvement by focusing on three patient-safety practices, including hospitals’ staffing of Intensive Care Units (ICUs) with trained physician ICU specialists, or “intensivists.” Though intensivists have been associated with better intensive care outcomes, the standard is not an indicator of broad hospital quality, as the ICU represents only a small portion of hospital care. Moreover, The

Leapfrog Group's initially narrow definition of an intensivist made it virtually impossible for hospitals to meet the standard. The Leapfrog Group also steers members' employees to hospitals using Computerized Physician Order Entry (CPOE). When used, CPOE systems are a way to reduce the chance of a medication error; however, they also require an estimated \$7.9 million initial investment, putting them, at least in the near future, beyond the reach of many hospitals, or straining hospitals' capacity to invest in other key life-saving technologies. Furthermore, there are many other practices that, with widespread implementation and adherence, also can improve medication safety with less cost and complexity. The Leapfrog Group has refined its list of patient-safety practices, in part based on hospitals' recommendations, and their measures are better as a result.

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

IV. Turning data into useful information

A final challenge, which I will discuss more in-depth in a moment, is finding a way to turn data into information that is meaningful and useful to both the public and caregivers. Much of the data collected is on highly clinical measures, such as the rate of assessment of left ventricular dysfunction for heart failure patients. What does this information mean to the average person, and how does he or she use it? And how do patients balance competing indicators? For instance, one hospital might have a lower infection rate, but another might have a lower rate of unanticipated outcomes: In such an instance, which

should the patient choose to undergo a surgical procedure? Finally, how do we ensure that the data is “actionable,” that health care providers can use it to improve the delivery of care and patients’ outcomes?

The Hospital-Led Quality Initiative: A Public Resource on Hospital Performance

Despite the significant problems associated with hospital report cards, hospitals are committed to providing the public with the information they need to be active partners in health care decision-making. Even if consumers do not use quality information as a resource, hospitals’ willingness to be held publicly accountable will help strengthen public trust and confidence in the health care system. Hospitals also recognize the valuable role data collection and reporting plays in ensuring continued improvement in safety and outcomes. By arming caregivers with evidence-based, universally accepted standards of care, hospitals ensure that patients receive the most appropriate care – no matter where they live or which hospital they choose.

To lead this effort, the AHA last fall partnered with the Association of American Medical Colleges (AAMC) and the Federation of American Hospitals (FAH) to develop a common framework for collecting and publicly sharing quality measures of patient care in our nation’s hospitals. On December 12, 2002, these hospital groups, with the strong support of the U.S. Department of Health and Human Services and its Centers for Medicare & Medicaid Services (CMS), the Agency for Healthcare Research and Quality (AHRQ), the Joint Commission on Accreditation of Healthcare Organizations (JCAHO), the National Quality Forum (NQF), the AARP and the AFL-CIO, announced an unprecedented national initiative that will:

- Provide the public with meaningful, relevant and easily understood information about hospital quality;
- Foster hospital and physician efforts to improve care, while streamlining or replacing duplicative and burdensome hospital reporting requirements now in place;
- Standardize data collection priorities; and
- Provide hospitals with a sense of predictability about public reporting expectations.

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

- For acute myocardial infarction (heart attack)
 - Aspirin at arrival
 - Aspirin at discharge
 - Beta blocker at arrival
 - Beta blocker at discharge
 - ACE inhibitor for left ventricular systolic dysfunction
- For heart failure
 - Left ventricular function assessment
 - ACE inhibitor for left ventricular systolic dysfunction
- For Pneumonia
 - Initial antibiotic timing
 - Pneumococcal vaccination
 - Oxygenation assessment

These measures were carefully selected based on their scientific validity and near universal acceptance. JCAHO and CMS use these measures, and the National Quality

Forum endorsed them as part of their core set for hospitals. Once data on these measures has been collected and analyzed by CMS-approved Quality Improvement Organizations, it will be posted to the CMS Web site, www.cms.gov as early as this summer. Though the CMS Web site is intended primarily for health professionals, the ultimate goal is to post hospitals' performance information to the Medicare Web site, www.medicare.gov, for public use as early as the summer of 2004 along with similar information currently available on nursing home quality.

A mere three weeks after The Quality Initiative was opened to hospital enrollment, 410 individual hospitals formally had pledged their participation, and another 200 hospitals had volunteered to participate through a pilot project in Maryland, Arizona and New York. This immediate and overwhelming response demonstrates the commitment of America's hospitals to making meaningful information available to the public at a national level.

The Road Ahead: The Challenges of Public Data Reporting

Though we are pleased with the widespread support the Quality Initiative has received from hospitals, accrediting organizations, government agencies, and quality and consumer groups alike, many challenges still lie ahead. One of the greatest challenges in implementing the quality initiative will be translating the highly clinical data collected into information that is useful and relevant to the public. Most of the standards currently available were designed for use by clinicians to lead to better outcomes; they were not intended to help the average "lay person" select a provider. Thus, much effort must be devoted to determining how best to shape and present information in an accessible, user-friendly format before its availability is widely publicized.

How the information is described and explained on the public Web site, www.medicare.gov, will be based in large part on the pilot-testing conducted in Arizona, Maryland and New York during 2003. In addition to participating in the reporting of the

initial 10 clinical measures, hospitals in these three states also will be testing a draft of a patient experience of care survey, called H-CAPS, which is being developed by CMS and AHRQ. Since research demonstrates that patients' choices are influenced by other people – family, friends and family physicians – not objective reports, this tool likely will become an integral component of the public reporting process. The survey might examine patients' experiences with wait times, caregivers' communication skills, support given upon discharge, and other components of a hospital visit, and the results could be divided according to patients' gender, age and ethnicity so that those seeking information can read about the experiences of people most like themselves.

Another significant challenge will be to develop and implement additional measures of patient care. While the 10 measures initially selected for public reporting will provide caregivers and the public alike with valuable information regarding hospital performance, they are just a starting point. Our goal is to create additional measures based on the Institute of Medicine's 20 areas of priority, including diabetes, pregnancy and childbirth, and depression. However, pinpointing specific measures that are proven applicable across all hospitals, directly linked to improved quality care, demonstrated through scientific evidence, accepted by all stakeholders, demonstrated to be superior to other practices designed to achieve the same quality objective, and appropriately tested in their intended settings – as urged by *The Challenge of Assessing Patient Safety in America's Hospitals*, a study released in January of 2002 – will be no easy task.

There also will be significant challenges in collecting valid, consistent data on the 10 initially selected measures. First, while the measures were built around patients with a specific disease or disorder and do not account for patients with co-existing conditions; yet, as the patient-population continues to age, doctors and hospitals will see more and more patients with several co-existing conditions, which could have a dramatic effect on outcomes. In addition, there are not yet standards governing the timing of the delivery of care. Does the clock begin when a patient crosses the hospital's threshold? Is it when the patient first sees a doctor? Or, is it when the patient is transferred to the appropriate care

setting? The timing of care could have a sizeable impact on both data collection and outcomes.

The Role of Competition in Fostering Cooperation on Quality

Ultimately, the key to quality improvement is cooperation. Quality improvement can only be achieved if hospitals work together and with doctors and other professionals to share suitable information about processes, procedures and outcomes in an increasingly robust manner. Some hospitals believe that the most effective method for doing so is as a system of hospitals; others – such as the Northern New England Cardiovascular Disease Study Group, a regional consortium of hospitals that develops and exchanges specified information concerning the treatment of cardiovascular disease – have found that clinical integration among hospitals and other providers to be an effective method. The policies of the antitrust agencies should encourage hospitals to work together on quality matters with the greatest confidence that there are no antitrust or competition barriers to exchanging suitable quality information and developing appropriate shared systems or protocols to implement those quality measures. Similarly, we must be mindful that competition can generate some undesirable results. For example, Baker and colleagues reported in *Medical Care* in 2002 that the Cleveland Health Quality Choice program, which rated hospitals on inpatient mortality, seemed to have led to a significant decline in in-hospital deaths but an off-setting increase in deaths within 30 days post-discharge.

At the same time, it is important to be cognizant of other barriers to cooperation between care providers. To the extent that the antitrust agencies wish to foster the exchange of quality information among hospitals, other impediments, such as onerous accounting requirements under the HIPAA medical privacy law, must be addressed.

Conclusion

Though there are many challenges associated with performance reporting, America's hospitals are committed to providing patients with the information they need to make

appropriate choices. Our goal also is to give clinicians the tools they need for decision-making so that patients do not have to choose a hospital based on quality. The Quality Initiative is an important step toward achieving that reality, and hospitals look forward to serving as leaders on this front.

Thank you for your time today.