Testimony of

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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 2011National 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.