

Agency for Healthcare Research and Quality
Attention: Nancy Wilson, MD, MPH - Room 3216
540 Gaither Road
Rockville, MD 20850

October 15, 2010

Dear Dr. Wilson:

The Society of Hospital Medicine (SHM) represents the nation's 30,000 hospitalist physicians whose primary professional focus is the general medical care of hospitalized patients. SHM is an organization dedicated to promoting the highest quality care for all hospitalized patients, and we commend the efforts of the Secretary of Health and Human Services to create the National Health Care Quality Strategy and Plan as called for by the Affordable Care Act (ACA). SHM supports efforts to dramatically improve our health care system by both elevating the health status of Americans and establishing a sustainable health care system that no longer threatens the financial stability of the country. We believe HHS has put in place the tools to advance these goals and we appreciate the opportunity to provide input into the framework and specifically, provide input on feedback questions 1-6, as detailed below.

Feedback Question:

1. *Are the proposed Principles for the National Strategy appropriate? What is missing or how could the principles be better guides for the Framework, Priorities and Goals?*

Following are the core principles of the National Quality Strategy that are meant to guide all strategies, goals and improvement efforts:

- Person-centeredness and family engagement.
- Address all ages, populations, service locations and sources of coverage.
- Eliminate disparities in care.
- Align the efforts of the public and private sectors.

SHM believes that these are appropriate core principles to guide the direction and goals of a national health care quality strategy. These principles are in alignment with the SHM mission to promote the highest quality care for hospitalized patients and enhance the practice of the 30,000 physicians practicing hospital medicine. Hospitalists are responsible for providing care to a substantial number of patients including Medicare beneficiaries who require hospitalization. SHM recognizes that embracing the core principles of the National Quality Strategy will have a significant impact on quality and affordability of care for the population of hospitalized patients whom we serve.

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SHM appreciates the invitation to offer specific feedback as to what is missing from the list of core principles and how to further develop the strategy that will assure high quality and affordable health care. A priority for the National Quality Strategy is the opportunity to eliminate from the U.S. health care system the wasteful and excessive spending on the nation's medical liability system that exceeded \$55 billion in 2008 ("National Costs of the Medical Liability System," *Health Affairs*, September 2010). A core principle to enhance quality of care and affordability would be tort reform that refocuses on reducing medical errors, promoting a culture of patient safety and encouraging evidence-based care by hospitals and physicians without resorting to defensive medicine practices. The current HHS and AHRQ funded pilot projects could result in reforms that will augment the core principles and be supported by the National Quality Strategy Framework that has been proposed.

Feedback Question:

2. Is the proposed Framework for the National Strategy sound and easily understood? Does the Framework set the right initial direction for the National Health Care Quality Strategy and Plan? How can it be improved?

SHM supports the proposed organization of the National Quality Strategy around a framework of better care, affordable care and improving health and wellness at all levels.

SHM would just clarify that the framework component for affordable care should specify that reining in unsustainable costs for families, government and the private sector should occur without compromising quality of care.

Priorities of the National Quality Strategy

Within each of the major components of the framework, the National Quality Strategy needs to identify specific priorities that represent the primary objectives for the initial period of implementation.

HHS is seeking broad public input to help identify priorities, while it conducts a review of leading private sector initiatives and current Federal and State programs.

Feedback Question:

3. Using the legislative criteria for establishing national priorities, what national priorities do you think should be addressed in the initial National Health Care Quality Strategy and Plan in each of the following areas:

a. Better Care: Person-centered care that works for patients and providers.

Better care should expressly address the quality, safety, access, and reliability of how care is delivered and how patients rate their experience in receiving such care;

b. Affordable Care: Care that reins in unsustainable costs for families, government, and the private sector to make it more affordable; and

c. Healthy People/Healthy Communities: The promotion of health and wellness at all levels.

SHM offers the following suggestions for the initial focus of the national priorities in the areas specified above:

1) Better Care

- a) Improve access to care through mechanisms other than the office visit. Examples would be telemedicine, email consultations, remote consultations via webcam, web-based patient communication, web-based patient education and counseling, web-based patient monitoring capabilities (e.g. glycemic control, management of anticoagulation, hypertension), web based patient health records, etc.)
- b) Improve patient safety across all settings of care. This includes but is not limited to focusing on healthcare associated infections, medication errors, and transitions of care
- c) Improve management of patients at the end of life
- d) Improve the management of patients with chronic medical illness

2) Affordable care

- a) Limiting overuse of medical technology, procedures, and medications that are not supported by evidence
- b) Eliminate the excessive and wasteful spending on the medical liability system through implementing meaningful tort reform.

3) Healthy People/Communities

- a) Reduce cigarette consumption
- b) Reduce alcoholism
- c) Reduce obesity
- d) Reduce abuse of prescription and illicit drugs

Feedback Question:

4. *What aspirational goals should be set for the next 5 years, and to what extent should achievable goals be identified for a shorter timeframe?*

While five years is a relatively short period of time to make marked changes in the health care system, much can be done and the following are what we consider the most important goals for this time period. We have chosen 4 broad categories rather than specific prescriptions as significant improvement in quality and cost will require changes in the fundamentals of the health care system: 1) transform fee for service reimbursement into payment for outcomes; 2) Elevate the role of prevention; 3) Promote health IT; and 4) Extend care coordination to the home after hospital discharge and between outpatient visits. Of these 4 described in more detail below, we believe that a shorter timeframe is mostly applicable to #s 3 and 4, health IT and home health, because these are already being broadly implemented and resources exist to make big strides in less than 5 years. They are also less disruptive to the fabric of the current system and can be implemented faster with little downside.

- 1) Evolve from a fee for service payment model into one that focuses on episodes and quality of care**

We recommend continued focus on moving away from the fee-for-service based valuation of procedures, services and episodes of care, and moving toward reimbursement of care that leads to decreased utilization, prevention of later stages of illness and good control of chronic illness before and after hospitalization. This will require shifting resources away from costly interventions and directing resources towards processes and providers that promote wellness, coordination of care, increased efficiency of the system around the episode of care, and improved self-care. This will require disincentives for high cost imaging and procedural modalities that are without proven benefit and providing incentives to expand access to and improving the quality of primary care services. This will include outreach to patients at home to impact care coordination of quality outside the doctor's office and hospital.

2) Elevate the role of prevention and lifestyle change in the national culture and health care system.

Much of the cause of the high cost of care and suboptimal outcomes in the U.S. lies not just with our dysfunctional health care system but also with the dramatic rise in preventable diseases that are caused primarily by lifestyle choices. Concerted efforts to decrease smoking have paid off in lowering rates of mortality from cancer. The same and more needs to be done for obesity, diabetes and coronary artery disease. Industry, schools, employers, and health care agencies need to be engaged at the highest level to introduce measures that will increase physical fitness and decrease obesity both as primary and secondary prevention. It will not be enough to improve our processes of care if our patient population continues to accrue more severe illnesses at younger ages.

3) Continue focus on incentivizing and promoting the meaningful use of electronic medical records.

The allocation of resources to accelerate the adoption of electronic health records has already helped hospitals and physicians provide safer and more efficient care more easily, and also enhances communication with other providers. In the hospital setting, medication orders are safer with computerized order entry; transitions of care are safer and lead to better patient experiences with electronic medication reconciliation; coordination of care, communication and handoffs are safer with electronic documentation including physician progress notes. These gains need to be consolidated and extended as we are still in the infancy of the electronic medical age.

4) Expand nursing care to the home after discharge and between outpatient MD visits

Research data has confirmed that outreach to patients between episodes of acute illness reduces risk of readmission to the hospital and may even prevent initial hospitalizations. There is a great opportunity to improve patient outcomes through better coordination of care between the different settings involved in patient care. Care coordination must be extended beyond the walls of the hospital to maintain the benefits conferred during an acute hospitalization. Resources are lacking for many patients to adequately manage chronic diseases independently. An example could be as simple as a phone call from a

pharmacist after discharge from the hospital or remote monitoring and communication over the Internet.

Feedback Question:

5. Are there existing, well-established, and widely used measures that can be used or adapted to assess progress towards these goals? What measures would best guide public and private sector action, as well as support assessing the nation's progress to meeting the goals in the National Quality Strategy?

SHM represents the hospitalist's perspective of caring for complex hospitalized patients with multiple co morbid illnesses. There are currently measures available and being used in the hospital setting to reduce medical errors, enhance the patient experience, and to monitor readmission rates. For example, medical reconciliation has been shown to prevent medication errors in hospitalized patients. There are other interventions to enhance medication safety that include monitoring for drug-drug interactions, side effect profiles and medication costs that could be put in place to further increase patient safety.

Hospital readmission rates are another area of focused measurement that will be impacted through the ACA provisions. SHM supports the goals of improving care coordination and improving the transitions of care for hospital admissions and discharges. Not all hospital readmissions can be prevented and we support developing a methodology for readmission measures that could effectively determine necessary and unavoidable readmissions.

Measuring the patient experience of a hospitalization is currently being done with the Hospital Consumer Assessment of the Health Care Provider Survey (HCAHPS). SHM supports the continued measurement of this important outcome and incentivizing hospitals and other providers' efforts to improve on the patient's experience of their care.

Health care acquired infections (HAIs) and Hospital Acquired Conditions (HACs) are currently measured and reported by hospitals. The soon to be implemented Hospital Value-based Purchasing Program will include payment differentials to hospitals for the rates of HAIs and HACs and this should be an important incentive for hospitals to improve patient outcomes. The Hospital Compare, or Core Measures that are part of the Reporting Hospital Quality Data for Annual Payment Update program have been in place for some time. Results of this program have been to improve care for hospitalized patients for disease specific conditions of pneumonia, heart failure, heart attack as well as improving care for surgical procedures. SHM would advocate for additional performance measures that focus on the coordination of care to reduce readmissions, improve patient safety and improve the patient experience of care. Of particular importance would be transition of care measures that improve the coordination of care between the hospitalist and primary care physician. An example for these measures has been proposed by the AMA's Physician Consortium for Performance Improvement and endorsed by the National Quality Forum, and include performance measures for medication reconciliation and the provision of transition records to the patient and their PCP from the hospital-based provider. These measures will promote better care coordination and give the patient an improved understanding of their treatment plan and provide the opportunity for better patient care coordination. This should result in decreased costs of care by reducing hospital readmissions.

Feedback Question 6:

The success of the National Health Care Quality Strategy and Plan is, in large part, dependent on the ability of diverse stakeholders across both the public and private sectors to work together. Do you have recommendations on how key entities, sectors, or stakeholders can best be engaged to drive progress based on the National Health Care Quality Strategy and Plan?

SHM is aware that it will take a significant display of political will, community education and broad-ranged support for the evolving health care reform legislation to see the public-private partnership become a reality. Health Exchanges are an excellent example of how the government via state or federal legislation can define common benefit structures and rules of participation so that various private insurers can compete. Defining common claims processing will reduce administrative overhead. Defining common quality and patient satisfaction metrics can empower patients to request and expect higher value health care. The Government can also move current private practice models of health care delivery toward the NHCQSP goals with payment reform that creates incentives for the Medical Home concept. Legislation can support uniform IT platform adoption, and provide the much needed medical liability reform. To allow the increased collaboration and the necessary alignment of incentives among various components of the private health system there will need to be legislation that removes constraints now in place with the Stark laws, anti-trust and anti-kickback laws, and other statutes preventing the corporate practice of medicine. The business community will need to support health behaviors on the part of employees and governmental tax incentives in turn could support this intervention by employers. The location of primary care clinics and other health care services in government offices and schools could enhance access by bringing health care closer to consumers. The public-private partnership will be essential to achieving the NHCQSP goals.

Please feel free to contact myself or Jill Epstein, Senior Advisor, Performance & Standards, at 404-788-5581 or jepstein@hospitalmedicine.org if you have any questions regarding our comments.

Sincerely,



Jeff Wiese, MD, SFHM
President, SHM